

Understanding Pain

With Mike Stewart

About Mike Stewart

- Has over 20 years of clinical experience as Physiotherapist
- Has worked as Spinal Specialist at NHS for many years
- Has a Masters degree in Clinical Education
- Has travelled across the globe as a lecturer
- Founder, KNOW Pain (www.Knowpain.co.uk)

On what pain is

- Pain is an epidemic. Pain and distress are often interchangeable. In America, 100 million people suffer daily pain, with numbers increasing annually worldwide.
- Pain is a perception and perceptions can be changed. In practice, we see people who get caught in the trap of talking about pain but not doing things – not integrating empowerment and physical activities.

Pain erects a war between us and the outside world, at the same time it restricts us from getting through to the person in pain. – D. Biro

Pain is unshareable. – E. Scarry

On pain education

- Pain education is for everybody. It is not so easy to say that education is only for people with resistant problems. Helping people to make sense of pain is one of the foundations of healthcare and it is an obligation that all clinicians have.
- Pain is an issue for athletes, just as it is for an 80-year-old who has had pain for 35-40 years.
- As pain is isolating and is invisible, we educate not just the patient. We also work with loved ones, with people around them to make sense of pain, because it is confusing.

- Within pain education, clinicians often see pessimistic spirals (i.e. understand pain, make sense of it). Moving away from this model towards optimism, they now look at ways to engage people in the process of dealing with pain (moving beyond; integrate into physical rehabilitation).
- There isn't one therapy that helps pain. It is multifaceted, multidimensional and multilayered. The pain management does not stop with the chiropractor, osteopath, or the physiotherapist. It is often apparent that pain is very much connected "to an emotional situation". Address that and often the pain dissipates.

On things to do for people in pain

- **Patient centered care:** The first thing to do is to show that you care, that you believe the patient. People do not care what you know until they know that you care. Get engaged with them by saying – "your pain is real, let me explain why."
- **Help them feel believed:** Mounting research shows that one of the most important things to do for people in pain is to help them make sense of the experience that they are going through. One essential thing to do is to help people feel believed, an aspect of therapy often missing in healthcare. Sufferers may feel stigmatized and it is not a social legitimized problem. (*Example:* Fibromyalgia is not recognized in Spain. It is simply known as "the needy woman's disease", reflecting societal beliefs about pain that are passed on).

Practical ideas in helping people feel believed

- Empathize: Do not embark on a monologue of information. Ask questions. Guide people towards their own understanding of pain. Cite a shared experience. Agree with the patient that the pain is real, whether it is psychosomatic or traumatic.
- Do not leave knowledge gaps: People who are in pain feel vulnerable and fragile and more often than not have lots of questions and concerns. Provide them sufficient information on how pain works. Recognize too that patients who are in reasonably severe pain have diminished receptiveness and essentially they just want to get fixed. Note that in a 20-minute health care consultation, people take away only 7% to 10% of information.
- Adopt big picture thinking or contextual thinking: Humans are designed to think categorically (we see things in small boxes as it makes things easier for us). It is only when we have a panoramic view of things that we make sense out of everything. As clinicians, start to give people that broad contextual understanding of pain, not just thinking about it coming from one magic single source structure. (*Example:* Put these three groups of three letters together and see what words are formed – Cho Pho Use. These are meaningless. But when you put them closer to each other such that it reads CHOPHOUSE, then it suddenly makes more sense. Things start to emerge once an individual see the bigger picture.)

- Be flexible in your approach (tailor your approach to the needs of the individual in front of you).
- Connect the dots: One of the principal qualities of pain is understanding why. *Why does this hurt?* A clinician can't understand why by just looking at the muscles and the tissues and so on, or by merely looking at people's emotions, thoughts and thinking. Join the dots. This is essential.
- Be creative: Introduce coping strategies – try and shift where their attention goes as a distraction. (*Example*: A patient is convinced that his pain is coming from L4/5 disc. You give him an attention training i.e. mind exercise/concentrate on his thumb. Then after some time, the patient goes back and declares that his pain is now coming from his thumb and it's a shape-shifter felt sometimes in his back, moving towards his shoulder- being there and not there, etc.) Create useful distractions to shift the focus away from pain and towards function, towards movement – and essentially to get them back to doing things.
 - Ask patients to think about drawing their pain. This can chisel people through the brick wall (understand what's going on with the person in pain) and the person in pain can chisel his way out (express his pain visually).
- **Communicate with them**: Communication and education are therapeutic –therapeutic neuroscience education. Clinicians can de-threaten and empower. Use metaphors. They are used all the time by health professionals and by patients to try and make sense of complex experiences that are hard to talk about. They are often used as safe bridges. Things that are distressing to talk about may be expressed in metaphors. Every person is different and, therefore, the approach has to be tailored or changed as appropriate.
 - On whether or not metaphors provide therapeutic value for people in pain: “Metaphors have a way of holding the most truth in the least space”. But, on one hand, they can help people gain connection, expression, control, and understanding. Also, they can confuse and isolate people; and make them feel more vulnerable. The conclusion perhaps is- talk less and listen more.
 - On the use of metaphors to manage pain: Some say metaphors are unhelpful, that clinicians shouldn't be using them, and should stick to literal language when explaining things. Others (Eg. Lakoff and Johnson) argue that they are a fundamental component of communication. Metaphors provide a frame for how people see the world and view things. They give people an understanding of something. They provide a way to try and help people express things.
 - On communication as key to educating people in pain: Guide people towards their own solutions rather than tell them and say, “This is what you need to do.” “Follow this recipe approach.”

- There needs to be frank and honest discussion within a therapeutic alliance that comes back to the importance of communication. Be vigilant on your words. They may contain threat for that individual depending on their experience and on their cognitive biases.

- Make use of appropriate humor. Develop educational skills and how to optimize people's learning – often it is about engaging them.

- **Employ hands-on approach to treatment:** Hands on is an essential part of treating people in pain – people learn through touch. (*Example:* If I talk to you about sensitivity but I don't touch your sensitive shoulder, I've lost you. I'm just providing information and not backing that up with experience.) Touch enables discovery and is an important thing.

- **Be mindful:** Mindfulness is relatively recent, gaining popularity over the last 3 years. It's about trying to find, from the patient's perspective, the things that they've tried that helped in the long term. It's also about finding whether they are ready to try amalgamating a different approach or look at sort of resiliency and self-efficacy.

- Do not force them into doing things that they are uncomfortable with, or that make them feel vulnerable or fragile.

- Shift the focus away from the damage and harm, and structure towards 'what do you need to do to get back to a life that's fulfilling again?'

On the role of amitriptyline in affecting central sensitization

- While there is no panacea with pain, amitriptyline can be really helpful for people in pain. Pain medications are

Example:

- Patients who have fear of bending (or can't do this comfortably) can be tricked into bending differently (like the dog or cat doing that good stretch). The idea isn't wholly about giving a dog/cat stretch exercise for the benefit of stretching, but rather proving that they can still bend their back. That they can still bend, but doing it in a different way. You get to stop their brains (at the subconscious level) from asking the question – "How dangerous is this really?" The aim here is to make them realize that they can do it with less threat.
- This can be a catalyst that can get people to start moving again with some confidence. Then as therapists increase the load, their tolerance increases too so that eventually they get back to doing things that are important to them (i.e. carrying a baby, picking up groceries, putting socks on – things that get them back to a fulfilling life).

an important part of this whole recipe as with the whole range of anticonvulsants. But it is important to look beyond these things too.

On the tailored use of gabapentin

- Tailoring is essential, but is not usually done. With any medication, it is important to increase gradually. And then also to have an understanding whether or not it helps the

patient in the long term. Question like - 'Can there be a degree of dependency?' should also be considered.

On the concept of the sensitized spinal segment

- Sensitization takes place peripherally, but also centrally (you can't have one without the other). Within practice, clinicians tend to describe pain to patients in terms of peripheral and central sensitization – using technical words like that. And this can be a problem. From someone who doesn't have a degree in neuroscience, get across in a way that makes sense by using metaphors.

On whether or not physical therapy can heal patients in pain

- Dr. John Sarno and Georgie Oldfield from SIRPA noted on their work that pain can be fixed through the mind by journaling and that physical therapy has very little or no place in healing patients in pain. Trying to fix pain can sometimes be the problem. Some of the evidences suggest that maybe clinicians need to shift from 'fix it' mindset to a 'sick with it' mindset. People with diabetes for example, do not expect a fix. They just accept it and develop coping mechanisms. In similar way, aches and pains can be normal and dealt that way.
- In making sense of pain, distraction is a big factor. Elaine Fox at Oxford University call this attentional bias modification/cognitive bias modification. In patient language it is simply- a shift of attention.

On changes in applying a broader approach to pain

- There is a change, but change is happening slowly. A broad historical view of the paradigm shift in medicine suggests that Louis Pasteur's germ theory took maybe about 170 years for it to become "the accepted norm". When clinicians look at the shift from this very sort of biomedical view to a broader/ encompassing biopsychosocial view of pain, they are living through that change, and they might not be around to see that through its completion. They have to acknowledge that.

On Issues with clinicians

- According to a patient of Karen Litzy- an American physiotherapist -- "Clinicians just wanted to act. They didn't want to listen".
- In a research conducted by Jones and colleagues, it was cited that the most compelling barrier to helping people is the clinician's compelling desire to do something.

Take away message for clinicians

- Never underestimate the complexity of pain, never underestimate the complexity of education (it is an assumed skill that we have but we don't get taught to teach very often). People's problems often lie in their words and thoughts, not ours.
- Provide information and help people to make sense in their own terms and with their own experience.

Relevant key points for clinicians

- The learning starts after CPD. This is where the hard part begins – when one has to sit there and try to help people make sense out of this complex thing that is pain. There's never a quick easy fix. One doesn't come to a two-day course and leave with the answer, as there isn't one answer.
- Many new graduates forget the gems of their training and focus on the pain and not the bigger picture. It is very important to focus on the bigger picture.
- Education, communication, and making sense of pain - these things account for less than 1% of all the program hours. This means that a doctor with five years or six years of undergraduate level, spent 99% of the time on anatomy, pathology, biomechanics, etc. There's that skew towards talking about pathoanatomical language, which is important, but they cannot in 2017 be the cornerstone of what clinicians do with patients. The communication or conversation has to change.

Relevant quotes:

- **On learning and education**

"Spoon feeding in the long run teaches us nothing but the shape of the spoon" – E.M. Foster

"Behavioral change information alone is like throwing spaghetti at a brick". – Fordyce

"Words are the most powerful drug used by mankind." – R. Kipling

"Learning is about experience, everything else is information." – A. Einstein

"To find yourself, think for yourself". – Socrates

"To encounter another human is to encounter another world." – Burlington

"Change the way you look at things, and the things you look at change." –Dyer

"Creativity takes courage." -Matisse

- **On helping people with pain:**

"The consultation is in itself therapeutic." -H. Mantel (referring to consultation with her healthcare professional. Mantel is an author who herself lives with pain)

- **On pain**

"Ongoing pain is less about damage to the tissues, and more about the brain's opinion of the body part."- P. Ward

About KNOW Pain

- For those who want to develop their education or skills in helping patients deal with or develop a healthy relationship with pain, there are different courses across Europe, Australia, New Zealand, Asia, and Hong Kong – more information available at www.knowpain.co.uk.

On how their CPD courses on treating pain have fared

- 100% of the 700 people in 14 countries who've been to the courses have said that they would recommend them to their colleague.

