**WHY** Is Chronic Pain

**So Overwhelming**

For So Many People?

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Guest speaker

Rehab First Medical Seminar

London Hunt and Country Club

***“Caring is good medicine”***

– Bill Moyers –

Dr. Michael MacDonald – A Brief Bio

Dr. Michael R. MacDonald is a psychologist who has devoted his career to helping people with severe and disabling forms of chronic pain and fibromyalgia. Ninety per cent of his patients, over the past 30 years, have suffered from physical injuries and pain following car or work accidents. He is well known for his caring approach, his deep understanding of how accidents and chronic pain affect peoples’ lives, and for his work as an expert witness in court.

A more detailed background and CV and be found using the following links:

[http://MacDonaldBryant.com/dr-michael-r-macdonald/](http://macdonaldbryant.com/dr-michael-r-macdonald/)  
<http://www.unbelievablepaincontrol.com/1_michael_macdonald.html>

Preamble

This article is an edited transcript from my invited presentation to the Rehab First Medical Seminar at the London Hunt and Country Club in London, Ontario. Rehab First is a multi-disciplinary assessment and treatment organization, well-known in the health care, legal and insurance communities.

The audience for my presentation was a diverse group made up of rehabilitation therapists, psychologists, medical specialists, physiotherapists, occupational therapists and lawyers.

I tried not to be too academic for this presentation. My goal was to appeal to each person in this diverse audience, on a level that would be meaningful. I wanted a more practical focus, which is the very nature of rehabilitation after all. Hopefully, you all can find something of value. So, sit back and enjoy.

**Hello everyone.**

I see a lot of familiar faces here and want to thank you for coming out. I know time is valuable and I appreciate you devoting your time to come here today. Hopefully, we can learn a few things, have a little fun and not take too long.

I was telling my daughter that I was coming to talk today. She asked about what I was going to talk about. I told her what the topic was going to be. She said with a big smile, “Oh dad, we know that chronic pain is your passion”. Then she laughed. She likes to make fun of me. But, I must admit that working in the field of chronic pain and rehab has been a very exciting career for me. A perfect fit. And I hope this shines through as we talk about one of the most important topics in rehabilitation today.

**Pain – a Big and Complex Problem**

So why is chronic pain so overwhelming for so many people? Let me give you a few teasers.

You can probably guess that people become more disabled as the severity of their pain increases. It also makes sense that one would become more limited if they have more than one area of their body injured and in pain. But, did you know that people with chronic pain plus depression become more disabled, than people with chronic pain alone? The same is also true when people suffer from chronic pain plus clinical anxiety or chronic pain plus post-traumatic stress disorder. Worse still, some people after accidents can suffer from two or more of these common types of injuries. In these cases, their disability levels are even higher.

You may have guessed that these patterns are true. But, do you understand why? Stay tuned and I will fill in the details and answer any of the questions that might come to mind.

Let me start with a little clarification. To me, the word chronic means no cure. It means long-lasting. Chronic pain is long-term pain for which there is no cure. How long-term pain affects people’s lives can be very complicated, and I will be cover this ground in some detail here today. But, the essence of chronic pain is quite simple – pain, long-term, no cure.

There are many different types of chronic pain and many different physical causes. Most of us, here today, are familiar with chronic neck and back pain that can follow from car or work accidents. But the causes of chronic pain can include everything from migraines, arthritis, fibromyalgia, surgeries to cancer and strokes. There are a huge number of medical problems that can lead to chronic or long-term pain. Following car accidents, roughly 15 to 20% of people will develop long-term problems - this is not the majority, but it is still a significant percentage and adds up to a lot of people.

Chronic non-cancer pain is the largest source of disability worldwide, larger than any other category of medical problems. In the United States, chronic pain accounts for more cases than heart disease, diabetes and cancer combined. Worldwide, there are 1.5 billion people suffering from chronic or long-term pain. You can’t get much bigger than that. It is not hard to see why chronic pain is such a huge problem for individuals and society.

**Doubt and Confusion**

Within this large group of people with chronic or long-term pain, there are some cases which are easy to understand. They seem to make intuitive sense. They don’t confuse or frustrate us. Ironically, these easier to understand cases can be the most complex medically. For example, sometimes people involved in traumatic accidents, with broken bones, surgeries, and emergency room visits may not recover completely from all of their injuries. They may develop long-term or chronic pain, caused by one or more of their injuries. This is not unexpected nor surprising to us. Serious injuries can lead to serious problems, even long-term ones.

The more confusing and frustrating cases are often the simplest ones. A person might be involved in what seems to be a simple accident or simple fall, develop back or neck pain, and have their lives almost completely dominated by their persistent pain symptoms. They develop strong emotional reactions to their pain, they get panicky about flare-ups, and they can experience serious losses of work, money, independence and family. Their lives fall apart.

These are the cases that are so hard to understand. These are the cases that we struggle with. Why does a simple injury or simple fall create so much pain, anguish, suffering and confusion in so many parts of a person’s life? For the person in pain, this can be very difficult to accept. It doesn’t seem to make sense. Why are my pain and injuries not getting better? Why can’t my doctors do something?

This confusion can also create doubt. For people in pain, the reality of how their bodies are feeling is vivid, relentless and mostly inescapable. No doubt about their day to day experiences. There can be considerable doubt, however, about why flare ups happen, why their pain doesn’t go away or why their injuries can’t be fixed. These are perennial worries for most people who live every day in pain.

For people in the health care, legal or insurance professions, there can be much doubt, confusion, bias and mental traps. This is also true for employers, family and friends. Sometimes, our thinking can go like this.

*Why are things so bad for this person? I don’t get it. I have seen people with a lot worse injuries that aren’t complaining as much and don’t seem to have as much pain. Why is this person with a relatively simple injury and a relatively minor accident suffering so much? It doesn’t make sense.*

Underneath this line of questioning may lie a note of suspicion. You may wonder whether this person’s injuries and pain are as real, or as physical, as the more serious and obvious cases.

If you are doubting the legitimacy of a person’s experience of pain and injury, there is a simple check you can do. You can find out about the losses that the person has incurred, since the onset of their injuries or illnesses. If they have lost work or income, especially month after month, or if there have been significant stresses on their spouses or children, these are strong clues to the reality of their physical pain and suffering. This is how the Workplace Safety and Insurance Board checks on the legitimacy of chronic pain. If an injured worker shows evidence of persistent pain and marked life disruption, they are entitled to chronic pain disability benefits.

This is a simple reality check. Behind this simple check is the assumption that people don’t incur losses if they can avoid them. No sane person would subject themselves (and their families) to losses of work and money, month after month, if they could get better and return to work. This kind of reality check is a lot less expensive and intrusive than hiring private investigators. And by the way, the presence of private investigators in the lives of injured people, tends to make them more anxious and depressed, experience even more pain and ultimately become more disabled. Insurers’ costs just keep rising with this option.

Or, maybe your doubts take on another form. Maybe this person has some psychological problems which you think may account for their complaints of pain and their suffering. Maybe this person’s problems are more related to who they are - a weak fragile person, for example - rather than to the nature of any physical injuries and pain.

This is an easy trap to fall into. A common one that is not very helpful to anyone. There is a long history of psychology and psychiatry creating grand theories to explain medical problems that, with science and time, have been shown to be false. There have been Freudian theories and old ideas about a pain-prone personality. There have been theories about compensation neurosis and hysteria. In the 1950s, some popular theories centered around women not knowing their place in the home. It was thought, back then, that ambitious modern women could cause so much stress for themselves that migraine headaches would develop. Even Dr. Wilbert Fordyce, a driving force behind the development of the multi-disciplinary chronic pain program, came up with a twisted theory. He argued that pain is not a physical problem, it is just behavioral.

Dr. Fordyce proposed that chronic pain is not really a source of disability, it is just work intolerance. Some insurers loved that one.

There is a long history of attempts to minimize and discount the nature and severity of the long-term pain that people experience. But, there has been very little evidence to back up these attempts. A prominent psychological concept used to explain how stress might cause pain is that of somatization. Somatization is thought to occur when a person is experiencing psychological distress and somehow converts this stress into symptoms of pain. No one really knows how this could a work, but many people still believe it does. And this idea is often behind the belief that stress can cause pain. Professor Geert Crombez at Ghent University in Belgium summarized the evidence for this concept well, with the title of his comprehensive review article: *The unbearable lightness of somatization.* As he documents in this extensive review, the unbearable lightness is the total lack of evidence for somatization. Who said academics don’t have a sense of humour.

It can be confusing to figure out the amazingly complex nature of pain. Billions of dollars are devoted every year to research this disabling problem. And incredible progress has been made. There is a long way to go. But, be reassured that many people, all over the world are working hard to find answers. Answers are needed to reduce the overwhelming costs to individuals, families and society. Whoever comes up with a medicine or a cure for chronic pain is going to become rich beyond their wildest dreams.

**Chronic Pain is More than Just Physical Pain**

It is not helpful to discount or diminish any persons’ pain or suffering. By discounting, you are (thinking) or saying to this person, *I think you are suffering a lot* ***less*** *than you say you are.* What you are saying, with your attitude, is that you know more about this person’s inner experience than they do. This is quite an arrogant position to take, even if you are just thinking it. And, understandably, it is hurtful and offensive.

A more useful way to think about another person’s pain is to think about the problem as being **more, not less**. The person’s experience of pain is not less of a real problem; it is **more** of a real problem, because there are more elements to it than just the physical nature of the person’s injury. This is especially useful if you think that the person’s pain is at least partly related to stress.

We all know Tina Fey; a lot of people love her from her Sarah Palin imitations on Saturday Night Live. I saw an interview with her once and she offered a very clever explanation of how to do impromptu comedy. She said it was very simple, *just yes and and.* So, the first person says I had a bad dream last night and you say yes you did, and I bet it was very scary. Then, you take the story off in another direction. For example, you might build on your response by saying, scary dreams are hard for a lot of people. My brother got so scared that he would wet the bed. Each person in the comedy routine then uses the same formula of yes and and to keep it rolling. Very clever I thought.

So how can this formula help us to understand, and communicate about, chronic or long-term pain? The secret is to follow Tina’s lead. You want to think and say, yes you have physical pain, yes I know it has been very hard for you **and** I suspect it has caused a lot of stress in many parts of your life. Now, you have an opening to talk about the stresses caused by the person’s injuries and pain. This simple strategy will help in your own understanding and help you to better communicate your understanding to people with injuries and pain. **Yes and** will also be an important part of the answer to why chronic pain is so overwhelming. That is why I have created a blog, entitled Pain And Loss (PainAndLoss.org). I will circle back to this idea throughout this talk.

But first, we need to take a step back and look at how people communicate about their health and their symptoms. What are people really saying when they describe their painful symptoms? What are patients talking about when they talk about their pain? What do all of us talk about when we talk about pain?

**What Do We Mean When We Talk about Pain?**

For all of us, it would be much easier if our clients were more like computers – logical, clear and rational. Sometimes, we even assume they are like computers, without even being aware of our assumptions. For example, we might ask a patient to rate their pain on a scale from 1 to 10. When they give us a number, we want the number to be only about the specific sensation of pain they experience - not how they feel about their pain, not how it is affecting their lives, not their fears about how bad it can get, not their fears that it may never go away and not their worries that their doctor may not believe or understand them. For us, we want what we consider to be the simple facts. *Just the facts, Ma’am*, as Sergeant Joe Friday would say in every episode of the old television show, *Dragnet.*

In real-life, however, very few people can separate their specific pain sensations from all of its associated meanings and emotions. I am not saying that it is useless to ask for a numerical estimate from people. It is important to try and bring some structure and a systematic approach to our assessments. When you try to interpret the number the person gives you, however, you should be aware that there will usually be multiple meanings and reactions attached to it. Every answer is loaded with meaning. This is a serious limitation when you are trying to get a simple, single answer to a very complex question. Psychologists try to sort out the meanings to health care questions by using questionnaires with tens or hundreds of questions. But this is not practical in many settings.

Sometimes, the meanings are simple and straight forward. For example, I might fall and sprain my wrist. I go to the hospital and the doctors asks me to rate how severe the pain is when she moves my hand. In this simple circumstance, my answer might be a reasonable, almost computer-like one. There probably wouldn’t be much extra meaning attached to my answer. My injury is simple, hasn’t lasted for very long and my doctor reassures me that it will heal up in normal time. And I believe her.

Unfortunately, life is not so simple for most of the people who suffer from long-term painful injuries and widespread losses to their life. What are these people talking about when they talk about the pain they experience? They are talking about pain **and** multiple meanings of their pain all mixed in together, unconsciously. No matter how much you prompt them to narrow their answers down and make them specific, it is almost impossible for people to separate the pain from what their pain and injuries mean to them.

The meaning can be their physical pain, plus a fear of their pain. What about if my neck pain escalates out of control, like it did the other day? What about if I can’t go back to work? What if I become so limited that I can’t take care of my family? People experience the physical sensations and many additional layers of meaning, stress and emotion, all mixed in together.

Remember Tina Fey from earlier in this talk? When people with long-term pain are talking about pain, they are talking about the physical sensations **and** they are talking about what it means to them. These components are inseparable. Often, the extra meaning involves an element of fear and anxiety. The longer the pain goes on, the more parts of a person’s life becomes disrupted, creating more fears and more uncertainty. When people are talking about pain, all of their sensations, perceptions and meanings become intertwined. And they have little control, or even awareness, of this automatic process.

Sometimes, there is also an element of sadness, grief and depression involved. People with injuries and illnesses may have already lost their job, already lost their home, and their marriage may already be in trouble. They are frightened of even more losses and struggling with the confusion about why their injuries not getting better. So, when they talk about pain, all of this emotion comes in as well. Scientific studies over the past 50 years have helped us to understand how all of this works. (Please refer to a list of some review articles and books in the Reference section below).

An additional element to the meaning of pain and injury is its context. Context affects our understanding and communication about most things. One of the things I learned years ago when I first started working in this field was what the word disability means. When we think of disability, most of us think of spinal cord injuries, paralysis, or severe brain injuries, as examples. But there are many types of injuries and illnesses that be disabling, and disabling in various ways. Disability, in many cases, is relative to what the demands of work and everyday life are for the person. This is the context.

Many years ago, Dr. Barry Death used an example which struck home with me. He said if you lose a piece of your finger, most people wouldn’t think that as a disability. But if you are a concert pianist, a finger injury can be a devastating source of disability. I was reading in the paper the other day about a baseball pitcher, maybe he played for the Blue Jays, who had an injured finger. You wouldn’t think that this could be disabling for an athlete like him. But as a result of only an injured finger, he could not pitch well enough to work. So, for him that was a source of disability and inability to work. Injuries and illnesses become disabling in relation to (the context of) the demands of their work, home or any part of your life. If you have a minor back injury and you have a heavy job as a nurse or construction worker, that minor back injury can be a source of disability. And again, this context and what it means for your life become part of the meaning and part of your experience of pain.

**More to the Story - Interaction and Amplification**

Now to make things even more complicated, you will notice I am using the word more a lot. I want everyone to take home this word - **more**. Put it in your bag along with the word **and**. So far we have discussed pain and meaning. Now we will move on to a third element, which is centered on how pain **and** the meaning of pain work together to create **more** – a more painful experience.

Physical pain and meaning work together by adding to each, in combination. A person might suffer from long-term pain and depression, for example. This is already a lot. But, it is not the whole story. Pain and its meaning, or pain and depression in this case, also work together by interacting and amplifying each other. To understand why chronic or long-term pain is so overwhelming, you have to consider all three elements – pain, meanings of pain and the additional contribution of how pain and meaning interact to create a larger whole. For those of you who like algebra, this pattern can be expressed as pain + meaning + (pain + meaning) - three elements to the equation.

There is a lot of good scientific work done these days trying to understand how this interaction and amplification works. In the old days, the glory days of the Greek philosophers, there was a simple theory of pain. You bang your thumb with a hammer, the signal travels from your thumb, along your arm, up your spinal cord and rings a type of bell in your brain. This signal, received by your brain, says, *yes I have a sore thumb, it hurts and I better do something about it. I better put the hammer away*.

This simple model was popular for hundreds of years, but it didn’t tell the whole story of pain and how it works. As one example, the old theory could not explain why poor sleep can make pain worse. The old theory could also not explain why injured soldiers on the battlefield did not feel any pain, until they were out of action and having their injuries treated in the medic’s tent.

Then in 1965, Ronald Melzack and Patrick Wall published a seminal paper in the journal, *Science*. In this article, Melzack and Wall introduced the gate control theory to explain how the injury, spinal cord and brain all work together to create and modulate the pain a person experiences. One of the main insights from this model is that there are mechanisms in the spinal cord and brain that act like gates that can open or close to allow a higher or lower number of pain signals through. Signals are sent from the site of injury to the spinal cord up to the brain and back down again, continuously. Signals, usually along nerve pathways, are being transmitted, up and down your system, almost like lightning. At every stage, these signals are being processed with nerve and inflammatory information from your body and information about the meaning of pain from your brain. This information can result in a wider opening of the gates, leading to more pain signals getting through to your brain and more pain being experienced. Some situations, like the battlefield can lead to a temporary closing of the gates, until the soldier is out of danger and can focus on getting medical treatment.

I have purposely simplified my explanations here. In reality this is an incredibly complex system that we are still learning about each day. We are also learning that there are many places in the brain that contribute to the processing of pain information. In addition to the gate control theory, Melzack proposed the idea of a pain matrix in the brain. His idea was that signals are sent from an injury to the spinal cord and then to a matrix, or collection, of centers in the brain that work together to process the incoming information. Melzack’s research showed that different sections of the brain talk to each other about signals coming up to the brain from the injury (and spinal cord) and talk to each other about what information to send back down to the injury to help heal it.

To make matters even more complex, recent brain science has discovered that the connections between different parts of the brain are always changing. Biological studies and computer simulations have uncovered new patterns involving the dynamic connectome, ascending and descending modulation pathways, the salience network and the default-mode network. We are learning more each day about how an ever-changing crosstalk of neurological pain information processing works.

Over the past ten years, scientists have learned a lot about these brain connections and patterns, mostly from functional MRI (fMRI) studies. An fMRI is a brain scan that detects patterns of blood flow in the brain. When certain parts of a person’s brain become more active, there is greater blood flow to these areas. A fMRI measures which areas of the brain are the most active when certain things happen to a person. When a person experiences pain, several areas of the brain become more active, leading to greater blood flow in these areas, which can be measured by the fMRI scan. When a person experiences stress or strong emotion, other areas of the brain become more active. Interestingly, the areas of the brain related to pain processing are highly interconnected with the areas of the brain that process emotion. That is why pain and stress can interact and aggravate each other so easily – just like I described earlier. I am glad you are sitting down for all of this. These new discoveries are enough to make your head spin. For those of you wanting even more brain stimulation, I have listed a number of review articles in the Reference section to follow.

**The Chronic Pain Two-Step**

So now we have pain, we have the meanings of pain (often related to fears and losses caused by the painful injuries) and now we have a third element going on; the many ways that each of these parts can amplify and aggravate each other. To make these all a little clearer, I have laid out some examples of how this can work.

Long-term pain can make people afraid that they will never get better.

Such fears can make it harder for them to cope with their injuries, limitations and pain.

Together, higher levels of pain can result.

In turn, more pain creates more fear, even more limitations and coping difficulties and then even more pain

In my book, *Unbelievable Pain Control*, I call this the chronic pain two-step. Pain causes stress, which can lead to even more pain – the two-step. Flare-ups of pain can be triggered by an escalating cycle of pain, stress, more pain, even more stress, even higher levels of pain and on and on.

It is not surprising, when this pattern is triggered, that people become burned out trying to cope with their never-ending pain (and losses), then become depressed. Here, you can see how the effects of the chronicity, or the long-term nature of chronic pain, can spread out and disrupt so many parts of a person’s life.

I told you that I was going to try and give you a full picture of how all of this works. I came here today to try and answer the question of why chronic pain is so overwhelming for so many people. So, I hope you will indulge me with a little more patience – because there is even more to this story. There I go to with the **more** again.

Pain, its stressful meanings and the many interactions between pain and meaning are already overwhelming for millions of people worldwide. So far, when I have talked about the stressful meanings of the pain people experience, I have been referring to stresses caused by the person’s injuries and pain. For example, the stresses that follow from fears that the person’s pain may never go away and fears that they will lose everything.

Pain can also be aggravated by other stresses such as personal conflicts, sickness in the family and ongoing health problems, not related to a person’s injuries and pain. A person’s spouse may have a heart attack or stroke, for instance. This is not caused by the injured person’s pain symptoms or an accident they may have been in. Yet, the severity of the pain the person experiences (as well as any depression and anxiety) may still be increased. Almost any type of serious stress can aggravate all of these types of problems – pain, stress, anxiety, depression, post-traumatic stress disorder, etc. A simple way to look at this is that almost anything that makes a person’s life worse is going to make their health worse – and this includes a significant worsening of any pain symptoms.

There are many parts of our brains that connect and affect each other. Activity in parts of the brain related to pain can influence the activity in parts of the brain that regulate stress and vice versa. These parts of our brain are constantly talking to each other. We are really just beginning to understand how all of this incredible complexity really works.

There is a lot going on for people who live every day in pain. I could spend hours discussing even more factors that can aggravate a person’s long-term pain. We haven’t even touched upon substance abuse problems, genetic factors or the stresses that happen when peoples’ benefits get cut off. My hope is that when we think of all this complexity, and the many factors that are beyond a person’s control, it can help all of us to feel a little less frustrated as we go about trying to help people in pain.

It is important to remember that stress does not cause chronic pain. Psychological problems do not cause chronic pain. But, once you have injuries and pain, stress can surely make it worse. Stress can also make it much harder to cope with the losses that often follow from long-term injury and pain. Stresses can aggravate almost any type of chronic or long-term illness or injury. Having a chronic illness is stressful enough, but it can become even worse with the physical aggravation from additional stresses and losses. This is one of the reasons why depression and anxiety are so common in people with chronic injuries, illnesses and pain.

**How Can We Help with such a Big Complex Problem?**

So how can we be more effective in our work with this population? I would like to leave lots of time for questions so I am going to go through a quick top 10 list of ideas. We have a very diverse audience of professionals here, so my suggestions will be general, in nature, and hopefully of some use to you all.

**First**, let us treat chronic pain like any other type of chronic illness or injury. Some chronically painful injuries and illness are relatively minor, some are severe and some are unbelievably complicated. But, having a chronic anything is a heavy and never-ending load to carry, day after day after day. And when this load comes with pain, endless pain, and widespread losses, it is even harder.

**Number two** is called the gentle push. I can’t take credit for this idea, but I really like it. This idea came from a rehab therapist I used to work with, Chris Challenger. He specialized in helping people who were traumatized following car accidents. Despite their terror, his job was to help his clients get back in the car, on the road and driving again.

Chris was quite good at this and used what he called the gentle push. In his words, you have to make them feel safe, give them a sense of control, but gently keep pushing them forward. I think that this same approach can help us in our work with people in pain. You push them a little and they get more pain, but you want to keep pushing them gently, and to show them that pushing themselves will help them (and their lives) in the long run. The opposite approach, the boot camp model, is a push, way too hard, that often results in too much stress, unmanageable increases in pain and more depression and disability.

**Number 3** is about not one, but many small explanations. Often as part of treatment, people ask, *why am I still hurting, why isn’t this getting better?* The temptation is to try to offer them a detailed single explanation that will highlight your expertise, give them an explanation of what their injury is about and what they need to do to get better - or for the lawyers in the room, to get their case resolved.

What happens is that your clients come back the next week and ask the same question. Then they come back two months from now and they ask the same question again. This is happening because your patients want explanations, but they also want reassurance. Although they may not be aware of it, your clients also want help accepting their injuries and limitations, as well as help accepting how their continuing symptoms are affecting their life. Your clients are asking everyone, even their lawyers and insurance adjusters, for help with their sadness and grief.

With long-term painful injuries and illnesses, people are grieving the forced changes to their health, their reduced sense of control over their lives and are grieving the many losses that have been caused by their chronic pain and limitations. People in pain are suffering and want help from anyone that will listen to them. If their pain levels are high and their losses significant, they need even more help and support.

The key here is to plan for many smaller explanations with your clients, including a repetition of the most important points. They will need frequent explanations about why flare-ups happen, reassurance that the extra pain they experience is not dangerous and encouragement to keep them moving forward. Your patience and kindness, as well as your expertise, can help your patients heal physically and emotionally. And as I have been repeating over and over today, people’s physical and emotional heath are closely linked and are continuously affecting each other. Your words and compassionate tone can them heal and recover.

**Number 4** is what I call *resistance is futile* (for all of you Star Trek fans out there). What I mean by this is that you do not want to fight a patient’s resistance with resistance of your own. Head to head conflict is not how you get, and keep, people moving forward. When you are working with people you want to pay attention to the flow of the conversation between you and attend to any patterns of resistance. If you are trying to explain something to someone and you are getting repeated objections and resistance, the onus is on you to try to take a different tact. Sometimes, we get frustrated and caught up doing more of the same, speaking louder, speaking in a more detailed manner, and offering more examples.

If that resistance is still coming, you want to pick up on this as early as possible and look for a side step. I remember one patient telling me quite directly. She said, *In Greece, we don’t believe in exercise and rehabilitation*. She felt that all of her doctors and therapists were pushing exercise and the gym on her and she was not going to have any of it. The professionals were emphasizing an increase in function for her and thought that exercise was the best way forward. This is understandable – exercise is a key component for the rehabilitation of physical injuries.

What she did believe in was becoming more active and working hard to help her family. So, that became our way in, our way to increase her functioning. More outings into the community, more shopping on her own and more conversational walks with her children and grandchildren. She was quite open to these simple ways of increasing her functioning. Our working relationship became more productive with much less resistance from both of us - and she improved.

**Number 5** is the why trap. Asking why after injury, illness or trauma is totally legitimate. We all try to make sense of the things that happen to us and this is especially true when bad things happen. But, trying to answer this question can be very time consuming. And it can be tricky to answer. Sometimes when people ask why, they don’t really want you to give them a literal answer. Sometimes, they just need to talk and be listened to.

Listening and supporting your clients is very important, but clients will rarely ask you directly to be quiet and just listen. Imagine you are at a funeral, somebody has died, a person is heavily grieving and they ask you, *why did this happen?* Sometimes this person wants to know the answer to their question. For example, you might say that the person died because she had had a stroke. But, sometimes the person’s question means something bigger and more related to their grief, such as why do such bad things always happen? The key word here is always and it often indicates a bigger, more emotion laden question, coming from the person’s grief rather than their need to know specific information.

Psychologists have the luxury of spending a lot of time with people. So sometimes we can indulge that question and help with the person’s grieving and suffering. Many professionals, though, don’t have all this time to talk things out with each of their clients. You don’t want to be insensitive or rude, as this can be even more time consuming to try and turn around. Sometimes, repeating a simple phrase, such as, *I wish I knew or I wish things were not so unfair* works. The key is to have a very kind and compassionate tone to your voice as you respond and then try to move them back to the task at hand. The basic idea is that you want to side step this question, with a compassionate tone, and keep your focus on the practical steps necessary to help people move forward.

**Number 6** is my favorite. Most people go into health care or legal professions because they want to help people. Yet, caring for other people is tough work. It is even harder when you are trying to help people who suffer from complicated incurable problems. And harder still when the people you are trying to help are frequently knocked down and made worse by stresses related to the legal and insurance system. Sometimes it is a wonder anyone improves.

During this struggle to help people, it is easy to feel defeated and inadequate at times. It doesn’t help when we get criticized by patients, lawyers and not so independent experts. To survive in this field, we need to pull together. I saw an interview with Michelle Obama a few years ago and still remember it. An interviewer asked her how things were going at home with two teenagers. She laughed in a kind of self-effacing way and said, *Yes, we have two teenagers at home. Barak and I are used to feeling inadequate.*

I thought that if it is okay for Michelle and Barak Obama to feel inadequate, it should be okay for us, less accomplished, regular people to feel this way. I am sure that all of us feel helpless, frustrated and inadequate, at times, when we are doing this very difficult work. It is very had on our pride and self-esteem. I think we should own up to feeling this way when it happens. We all go through it. Don’t be embarrassed by the struggles and support each other in this important work.

**Number 7** is to focus on function. This is the best overall measure of improvement and a useful guide for patients and professionals. You will often find, with this population, that no matter how many years you work with them, they are not necessarily going to end up with less pain. But hopefully, over time, they will be able to do more, take less medication, recover some of their losses and be able to participate more in their own and their families’ lives.

When you think about it, you don’t really want your patients to have less pain. I know this sounds very twisted and a bit sadistic. And it is kind of hard to explain. So, let me try with a personal experience.

I like to play a lot of hockey. I am sure that the more I play, the more fit I become. But often it doesn’t feel this way. After each game, I seem to be just as tired. And that is because any fitness I gain by playing more is used up by playing harder. The true test of whether I am fitter is not how much fatigue I feel after each game. It is how fast I can skate, how much endurance I have and how my game improves (hopefully).

Although there are many factors at play, it is generally true that when people in pain do more they experience more pain. So, over time, if their pain levels decrease you hope that they will increase their activity level, which will increase their pain once again. You want them to use up every decrease in pain by being more active and more functional. You want them to regain as much of their lost life as possible. You want to see increases in function, leading to a more active and more fulfilling life.

A focus on function is the best overall long-term goal. In the short-term though, including times of flare-up, it is sometimes necessary to help reduce the person’s pain severity. When pain is uncontrollable, overwhelming and leading to serious depression, pain control is the best immediate option. Pain medication, anti-depressant medication, pain and stress management, relaxation and mindfulness strategies, rehab therapies, pain education and much support are some of the many useful approaches for the short-term, until it is time to return to a focus on function.

**Number 8** is a plea for simple, clear and definitive communication. Writing reports can be onerous and for some people the worse part of their job. So why not make it productive and worth your while.

The best reports are short, to the point and with a minimum of jargon. We all like our professional jargon and it is often easier to write this way. But while it may appeal to those within the same profession, it can be off-putting and intimidating to other readers within your rehab community. For most of us, our reports will be read by a wide variety of professionals, as well as lay people such as our clients.

After many years, I still remember a quote from a talk I went to in graduate school. Tom Jackson, a vocational expert and author of *Guerrilla tactics in the job market*, said the following: ***Good communication means taking responsibility for what is being heard***. This means tuning in to your audience(s), walking in their shoes and tailoring your words to their ability to understand what it is you want them to know. His quote has helped me a lot in my career.

For me, working in the rehab field, good communication also means relevant communication. Yes, I want to know the specifics of your findings and plan of action. But, I also want to know a bit about the person you are treating. *Is treatment progressing as expected? Are there setbacks, maybe repeated ones? Are they struggling to stay at work? Do you suspect there are other things interfering with your rehab therapies – maybe financial stresses, funding cutbacks for treatment or wage loss, or family stresses, as examples?* You do not have to have all the answers to these kinds of questions, but your observations can be helpful. And please make sure to explain to your clients how such observations can help them and the other professionals they are currently working with.

**Number 9** - we are all psychologists. In all of our professions, we have to listen, learn, explain, support and motivate our clients. That is an important part of our day to day work. When obstacles or setbacks come up, we all use these skills to help our clients get back on track.

Rehab work is difficult for patients and professionals. It requires a lot of energy, determination and perseverance. When rehab is prolonged, which is always the case for any type of chronic injury or illness, it can take everything a person has to give. All people want to get better as fast as they can. And they will need you in their corner, believing in them and encouraging them, every step of the way, on this long-distance journey.

We all like to emphasize the scientific and technical skills we bring to our work. This is exciting and helps us to feel pride in what we do. It is easy to underestimate, though, how important it is to provide encouragement and emotional support for our clients. Our clients cannot be successful without us providing hope, positivity and a firm conviction that all of their hard work and sacrifice will be worth it for them.

I remember a televised interview with an Olympic skier several years ago. This downhill skier had just won an important race after a long recovery from several near fatal ski crashes. Beside the skier was his physiotherapist who had been an essential part of the skier’s rehabilitation. What struck me about the skier’s comments to the interviewer was what he said about his physiotherapist. He said that his successful return to skiing and his recent victory could not have been done without the constant support of his physiotherapist. The skier did not compliment the physiotherapist on his technical physiotherapy skills, although there is no doubt that they played an essential role in the skier’s successful recovery. The skier only mentioned how thankful he was that his physiotherapist never gave up on him. This seemed to be an important contribution, among many, provided to him by his physiotherapist. This really struck home with me.

**Number 10** is that rehab is a team sport. Success comes when we all pull together. I have tried to simplify the many complexities that are part of why chronic pain is such a big problem for so many people, worldwide. Many people with chronic or long-term pain, especially after accidents, come with a mix of physical problems, social problems, emotional problems, medication problems, financial problems, legal problems and insurance problems, to name just a few. And, these many parts of the problem don’t just add together, they interact and magnify each other and your clients’ health problems. All the while, a person’s pain keeps getting aggravated. They are vulnerable to one setback after another.

It would be much easier if these components could be worked on one at a time. But, as I have emphasized over and over today, this is not possible. All the problem areas of the injured person’s life become intermingled, affecting each other, and creating more pain, limitations and loss.

The injured person’s family doctor or medical specialist cannot help on all of these fronts. A rehab team is necessary. Even if we work out of separate offices, we can help each other by talking, collaborating, and sharing reports, as examples. When people improve, we can all know that we played some important part in that.

Working together as a rehab team also helps us to see the bigger picture, the layers and complexities, and that helps us to be more effective with the people we are working with. It also makes our careers more satisfying. I have been doing this work for 30+ years. It is still my passion as my daughter says, and I have to confess that it is true. It has been a great life working with this population and with the many incredible rehab professionals that I have been lucky enough to know.

**A Simplified Summary**

I have talked today about the many layers to this big complex problem of chronic or long-term pain. It seems that, at every turn, I have piled on the ands and the mores. As I review this material, it looks a bit like a jazz improvisation and maybe more complicated than you signed up for. I heard an interview a few years ago with the great Canadian jazz pianist, Oscar Peterson. He offered a simple description of one type of improvisation found in jazz music. He said, *you take the melody, create an improvisation, then add a new development, improvise on that and then bring it all home.* In this analogy, the person’s injuries and pain are the melody. The meanings and interactions are improvisational layers to the core symptoms of pain. The additional stresses that may be going on in a person’s life are the new developments. All of this has even more layers of improvisation as it all gets mixed in together.

Now, I am going to bring it all home with a simple summary of why chronic pain is so overwhelming for so many people? Here, is a simple mnemonic – Pain **And** Loss. Long-term pain and its many associated stresses and losses add together (and interact) to create a big, complex problem experienced by people from all walks of life, all over the world. And if you want regular reminders (or even more detail), please feel free to sign up for my blog/newsletter at [PainAndLoss.org.](http://painandloss.org/)

Thank you very much. It has been my pleasure.

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For those of you who want even more reading, here is a blog devoted to the ideas I have been talking about today. Enjoy and subscribe at PainAndLoss.org.

