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The Painful Truth

The stories and science behind our most fascinating feeling

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I don’t think I can do much about ‘sorting out’ pain but I am going to tell you a four stories which I use in my upcoming book and will I hope generate some discussion. I am looking forward to learning more from you than you will from me.

I am a junior doctor and I have spent a lot of the past year on Covid wards, and I am also an Academic Clinical Fellow in Oxford. Three quarters of my time is clinical work in psychiatry training and the rest is in research. My particular interest is in mind-body medicine and the relationship between the immune system and the mind. I have written a book about skin (*The Remarkable Life of the Skin)* because of my interest in the immune system but also of human nature so I wrote about psychological and social aspects of the skin as well. But it is only recently that I fell upon pain and discovered that everything I had been taught about pain at medical school, and the ways that most of us in society think about it, is fundamentally wrong and is having a hugely detrimental impact on individuals as well as society. It was this that led me to write my new book, *The Painful Truth.* I am not a pain expert but I see myself rather as a journalist; and I have been able to interview some fascinating people, both experts and people living with persistent pain, including some with a very unusual relationship with it

Paul

I came across the first case, which I have pseudonymised, before I started writing the book; and I obtained permission to interview the others. So let’s meet Paul. This is the moment I first became interested in pain: I was a first-year junior doctor on an acute medical unit, where patients are admitted after assessment in A&E. At the end of each shift the consultant goes round and decides whether each patient can either go home, needs to be seen by another specialty or go to a ward. It’s a bit like a low-end department store on black Friday – chaotic and stressful, you’re running to and fro to a background of groans and bleeps. I was chasing the consultant, who was very good, from patient to patient, and as soon as I had written his instructions he shot off to the next bay, and I tried to follow him without knocking over one of the forest of drip stands and trolleys. Out of the corner of my eye I saw him draw the curtains around the next patient who was Paul. He was an IT consultant in his late forties. For about five or six months he had had pain on the right side of his lower back which he said had started with a conked-out office chair. The pain had got worse, constant, and had spread across his lower back. He had stopped playing golf and for the last month had stopped going out at all and was essentially bedbound. During this period he had been going through a messy divorce which was finalised a couple of weeks before his admission. On the day of admission he had had such agonising pain that instead of his GP he had gone straight to A&E. The doctors wanted to check that there wasn’t some serious spinal pathology so as well as the usual blood tests he had an MRI scan. The consultant told him that “… as you can see, all of your tests are plumb normal, so the good news is that there is nothing physically wrong with you.” So Paul demanded, clutching his back in agony with the sweat pouring down his face: “so are you saying its all in my head?”

In the coming months when I thought about Paul and the medical model that I had been brought up in: that his pain could only be in his body, caused by ongoing damage that could not be detected or treated by medical technology, or in his mind and created by a thought disorder for which he would need some form of therapy. Most of society, including me at that time, are implicit believers in what I call The Great Painful Untruth: that pain is an accurate measure of injury. So one of the questions we can perhaps dwell on is: how as a society have we got to this stage of mind-body dualism and what can we do to change it?

Evan

I interviewed Evan for the book. He is a fun, affable, stereotypical Australian bloke. The first ten minutes of our conversation was taken up with his advising me on the best beer cooler to buy.

 He could never have imagined that he would have gone through such hell. In 2006, in his twenties, he had achieved a lifelong dream by managing to get into the most elite crack force of the Australian army, the SAS. Out of 140 very competent and fit applicants only 19 were accepted. At that time the Australian army were preparing to go into Afghanistan. Most of the army were going to be working with the locals building hospitals and bridges, but the SAS were going to be carrying out missions behind enemy lines. Before they went out they had to undergo ‘resistance to interrogation’ (R to I) training, which is not meant to actually be torture but a stressful situation simulating what it might be like if they were caught by the enemy. At that time the army hadn’t done much of this and the trainers themselves lacked training, so the situation was, to say the least, chaotic. When the day came for Evan to start his R to I training, he was blindfolded, bundled into the back of a truck and taken to the interrogation centre. Here he was stripped naked, covered in cold water and placed in a cold damp room in a stress position for hours. Overall he was tortured for about one hundred hours. Every couple of hours he would be dragged out of his cell and interrogated, each time demanding his “name, number, rank, date of birth … name, number, rank, date of birth …” over and over again, in essence trying to get him into a hypnotic state so that he would give them the information that he was supposed to withhold. Every few hours he was actually beaten and once he was kicked so savagely in his backside that he sustained an anal tear and was bleeding profusely; as he was blindfolded he didn’t know where it was coming from. There was blaring music in the background. After about 95 hours he passed out.

 In the weeks and months following this he simply couldn’t process what had happened to him. He found out that some of his interrogators, for various reasons, were out to get him. Every time he went to the toilet or some dark, damp place, he would hear a voice echoing again and again in his head : ” name, number, rank, date of birth … name, number, rank, date of birth …” This was the first of a number of symptoms of PTSD: flashbacks, hypervigilance etc. But the worst thing was the terrible whole body pain. He couldn’t put on boots or go into water like a bath or a swimming pool. He ended up taking some very heavy duty painkillers that didn’t touch it. This went on for about seven years. During this time he took the army to court and he eventually won, had his rank reinstated and his extensive legal costs covered.

 There were two ways in which he recovered from his pain. He had tried a lot of psychological therapies and medications which didn’t help at all, but  Eye Movement Desensitization and Reprocessing (EMDR) therapy which is used specifically for PTSD helped quite a bit. But the thing which helped him most was when his case was won and the burden of the Australian army being on it was lifted, and his pain lifted soon after.

 Apart from the thing I mentioned earlier he didn’t have tissue damage that led to his pain but his pain system seemed to be trying to protect him at all costs and was itself causing pain without any physical stimulus, and his story suggests that pain can be a protector, and not necessarily an accurate detector of tissue damage. There is evidence that immigrants have higher rates of persistent pain and painful conditions regardless of ethnicity, which seems to suggest the idea of their brain and body ‘feeling’, for various reasons such as oppression, that they are threatened.

So something we might discuss is the question: how can one individual’s torture, involving the experience of fear, oppression, isolation, humiliation, unfairness and alienation, explain the psychological and social elements of persistent pain?

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It seems that there are lots of different psychological therapies of varying effectiveness in different people, but the ones that help people to process information, increase their confidence, and their understanding of their pain are the ones that work; often in conjunction with other things.

Joe Cameron

The third person I want to introduce you to is Joe Cameron. She is a lady from Inverness in her 70’s. At the age of 65 she went to her GP because she had been walking ‘a bit funny’: her legs were giving way and she found she was leaning to her right. Her X-rays showed severe osteoarthritis but her medical attendants were surprised to learn that she had experienced no pain whatsoever, just this slightly odd movement. She had a hip replacement and thought nothing of it. Her GP noticed that both of her hands were significantly deformed, which she hadn’t really noticed, and these were also severely arthritic. She had a trapeziectomy, a notoriously painful operation which involves removing some of the bones of the hand, for which required no anaesthetic [?analgesic] and had no pain. Her anaesthetist referred her to James Cox and his team of pain geneticists at UCL who found that she had congenital insensitivity to pain. She averred that she didn’t know what pain was as she had never experienced it. There are a few families around the world with genetic configurations which mean that they have no pain detection or nociception. These individuals often die in their teens because they have no alarm system to warn them of injury and damage such as a broken bone or a burst appendix. Joe told me she only knew that she had burnt her hand when she smelt it. It helped that she was a vegan! Yet she had gone through life relatively unscathed. They did a genetic test on her and it turned out that she had a mutation in a pseudogene, a bit of DNA that regulates genes called FAAH OUT. Essentially this regulates an enzyme that breaks down endogenous cannabinoid. We all have cannabinoid molecules created in our bodies but usually these break down fairly quickly. Joe couldn’t do this, and she said she was a lifelong stoner! And as well as not feeling pain she had quite a happy-go-lucky outlook on life. The only negative aspect of this was that she is very forgetful and never knows where her keys are.

Another interesting feature is that her wound healing processes are faster than the average person which might be why she has been able to get away with some of her past injuries. But she has had a fairly sheltered life.

 So this is another example of pain being a protector. Joe wasn’t a typical example of congenital insensitivity to pain like the people who tend to die very young.

Joel

Joel is a Neurologist. I interviewed him on Zoom before the Covid pandemic and before it became fashionable. He was in his office in Boston. I stroked the side of my own face and asked “can you feel this?”. He looked surprised and replied: ”no-one has asked me this before! Yes, I can feel it on the same side of my face – or the opposite side as though I am looking at a mirror.” Joel has something called Mirror Touch Synaesthesia (MTS), which means that whenever he sees someone touched he feels that on his body, or how he imagines that touch to feel. Synaesthesia is not that uncommon; some people associate certain numbers with certain colours, but this remarkable example is much rarer. It was as well Joel didn’t become a trauma surgeon because he had had some traumatic experiences seeing other people in pain. This is an excerpt from his memoirs about when he was a junior doctor watching a cardiac arrest.

“As the doctors continued chest compression I felt my back firmly pressed against the floor, my limp body buckling under each compression, my chest swelling with each artificial breath squeezed into me with a tube, a hollow sickening sensation …. I was dying, but I was not”

After this he runs into the toilet and throws up, and has to convince himself that he is still alive. He feels as if he has fallen into the sensations of the other person.

 He says that this condition in some senses actually gives him gives him hyper-empathy and he feels that this helps with the diagnosis in some patients: he literally feels their pain.

This condition comes with huge drawbacks: there are some people who genuinely can’t leave the house in case they see someone in pain and will feel it themselves. I read about one person who can’t eat with anyone else as if she watches them she feels that food in being thrust down her own throat.

There is very interesting evidence that we are all ‘mirrors’ to some extent, in the way that we can ‘catch’ pain from other people. There is also evidence that people with MTS have heightened empathy, which raises the question of the relationship between physical pain

and empathy. There was study at UCLA in 2015 in which subjects in an MRI scanner were subjected to a painful stimulus. They were given a placebo analgesic which reduced their pain. They were also shown pictures of people in pain and the placebo reduced their empathy for them. When they were given Naloxone not only did it reduce the placebo analgesia but it restored their empathy for people in pain.

This is known as neural resonance: the way that we can feed off other people and in some sense feel their pain. To illustrate this I want you to meet Tyrone Magnusson who is a YouTube star. *[Video showing his reactions to a video of two young women arm-wrestling in which one had her arm broken]* You can see at the moment this happened he grabbed the same place in his arm as though it was broken, appeared to be in pain. This has been attributed to so-called mirror neurons, but may not be associated with any particular neurons in the brain. Perhaps from an evolutionary point of view it’s better to *feel* that someone else is in pain instead of just *knowing* it. [or perhaps evolved before the emergence of conscious cognition? Ed.]

So a question for discussion might be: how does this help us to help people in pain? From a philosophical standpoint we might also ask: what is the link between empathy and compassion? Because what we should want is not just to feel we have participated in someone’s suffering but also to feel compelled to do something about it, and translate empathy into compassion.

Discussion

*Regarding witnessing pain: female friends of mine can’t bear watching violence on film or TV because they feel sympathy and compassion for the victim, and some men I know feel they identify with the aggressor.*

There was a study done on Schadenfreude which looked at reactions to pain in people who were deemed unfair when playing an online game. Participants could guess when other people were cheating or not. On average, whenever women saw people in pain who they thought were not cheating, they felt empathy for them and areas of the brain associated with pain lit up. When they saw people who they thought had cheated in pain they didn’t feel empathy for them. When men saw the people who had played fairly in pain they felt a little empathy for them, but when they saw the people who had cheated in pain the pleasure centres lit up!

*I think I was more aware of this after I had my son. I couldn’t bear to see violence on TV but I could when I was younger.*

Joel felt that he was in more pain when he saw someone who looked like him in pain. There are studies that tend to show more empathy to people in pain who look like us. A study from Australia found that if people are more exposed to or have more experience of people who look different from them , in terms of race, for instance, they are more likely to feel empathy for them.

*Thinking of the doctor who felt others’ pain and people like him, I wondered about the threat to their own wellbeing because of it. When I ran a number of groups for people in pain before Covid I had to be mindful of my own wellbeing. I wasn’t actually feeling their pain but I was aware of something – perhaps their suffering?*

 *I had a very interesting experience along those lines when our daughter was running the London marathon and when we picked her up at the finish I was surrounded by thousands of people in with painful legs and knees. And I actually felt pain in my knees although I don’t have any problem with my knees and my daughter asked why I was walking strangely! It was a weird sensation but I think it was because there were so many people in pain there.*

*Regarding injury and the idea that pain is a protector and not a detector: There are people in the philosophical literature that argue against that - I have a horrible feeling they may be right – but to press the other side, rather than saying it is not a detector perhaps it could be suggested that it is an imperfect detector. For instance, if you have a fall but on the face of it with no injury nor even any hidden injury – I guess we can’t know that – that doesn’t show that it is not the role of pain to detect injury, but if that is its role, in that particular case the pain has failed. These maladaptive cases … to infer that the role of a sensation, if it is maladaptive, has gone wrong … it’s like a telling a blind person saying that the role of the eye isn’t to see. I worry that this is too quick a stab. It kind of came up too when you talked about the pain insensitives who tend to die young because they miss injury which makes you think it is a detector and not always an accurate detector. There is still space for saying that. A footnote on that: when you told us about Joe Cameron and what has fascinated me about her was that a year or two ago she was in all the newspapers and she is alive, and for that reason not a good example of an insensitive. So can we explain why she is alive and in relatively good health?*

I massively simplified the issue on my slide about the ‘great untruth’ that pain is an accurate measure of injury. In most cases of pain the detection of pain has played an important part as the beginning of central sensitisation. The issue I was trying to take down was the assumption that it can *only* be an accurate representation of the level of injury and only present when there is injury; which doesn’t make sense at all when you look at pain generally. But that is something that I believed as a junior doctor and lots of people believe it implicitly

 Your second point … one thing about Joe is that she is never worried about anything. Recently she overturned her car and didn’t seem at all worried at the time or afterwards. She got stuck on a zipwire over a ravine in Montenegro for a long time and it didn’t bother her at all. Perhaps it was just a combination of never having had a very serious injury and good medical support.

*There will be some that go further than regarding pain as an imperfect detector, and empiricists who will say that the function of pain is not to register injury even imperfectly, but to motivate and produce a reaction, often in the context of injury. So unlike vision its role is motivational, not informational.*

 *On the second point, some people make a distinction between pain insensitivity and pain asymbolia; they do feel pain but it isn’t unpleasant. Is there any suggestion of that with Joe?*

I didn’t get that impression that she knew what pain was, unlike someone with asymbolia after a stroke who know that they are in pain but it has lost its emotional content.

*I was interested in a couple of cases in people going through a divorce. There are lots of studies showing that women who have been abused and victims of child abuse are all associated with family history and work issues, and chronic pain. I wonder if a psychiatrist can trace the links … and that sort of thing. I’m a sociologist; I always think the precipitants of chronic pain are sociological … it’s complex because they might have had an acute injury to begin with that is sustained by social factors, or which turn acute pain into chronic pain, such as abuse of one sort or another; or people that don’t like their jobs or don’t get along with their co-workers. We know about the underlying biological mechanisms, and I am wondering if a psychiatrist can trace those mechanisms that physicians like so much from the social issues.*

… I am a psychiatric trainee but not speaking as an expert psychiatrist …

*… there is literature from over 100 years ago during the great depression showing how much people were in pain having lost their job.*

Paul was someone who had serious emotional and social stressors, having lost his job. I firmly believe that that played a very strong role in the development of his persistent pain, and the association of ACE’s etc with chronic pain is well documented. As to mechanisms, I don’t really know the answer. One strand of it -I’m not trying to be biologically reductionist - is the role of brain inflammation which may be primed early in life and make people more likely to have chronic pain syndromes. The literature would suggest that with a number of things like fatigue, in a subset of people with depression, it seems to have a longitudinal effect as well. But it is complex and this is just one strand of past experience that can build up to reach a threshold to make someone more vulnerable to long-term pain.

 It is very difficult to ‘measure’ the contribution of sociological and psychological factors over time; but I agree that this would be interesting and important.

*You have answered the question I was going to ask, which was whether people like Joe can feel* something *but don’t find it unpleasant. Presumably people with congenital pain insensitivity can feel other sensations: touch, pressure, heat cold etc. ?*

 *But I wanted to bring Maureen into this bit of the conversation because she is a hypnotherapist, and I understand that one of the techniques hypnotherapists use is to help people to kind of suggest to themselves that what they are feeling is something different from pain. Have I got that right?*

*You can use imagery and metaphor to reduce pain, the sort of metaphors like reducing the ‘size’ of the pain and changing it from blue to green, or making it fluffy rather than hard; you can use all sorts of imagery. And people will indeed sometimes say that they still feel the pain but it is not so bothersome. Nociception sort of improves. That is a rather mysterious thing, but there may be some crossover with congenital insensitivity. One thing you can use hypnosis for is procedural pain such as from dental implants, and even abdominal operations without anaesthesia. It’s a fascinating field.*

I have had quite severe IBS as long as I can remember but it has recently been cured by hypnotherapy.

[ I had some difficulty in making sense of some of the following contribution which I have therefore transcribed verbatim including the two words in brackets that I couldn’t make out, and hope the reader will do better! Ed.]

*I’m not sure, Monty, that you aren’t proposing quite a dualistic model when you describe those different dimensions. Is that your intention? Do you associate yourself as a dualist? Because much of the message does appear like that. I’m obviously not using that in any way to attack you . A lot of the discussion has gone down in a very dualistic framework. As a card-carrying [?anathropist?] I am someone with a particular interest in picture pain processing and research in that area. If we look at someone like Joe and if you do interview her more carefully she did actually have a very early life experience of pain almost [primalistic?] where we have some genetic predisposition to have some feeling, but with time she doesn’t see the normal regularities forming which we would associate with the normal maturation of the nervous system so she doesn’t lay down to the models which then predict the particular things she engages in life or the particular impacts of life have any real need to produce this thing that we call pain. A lot of the discussion we have had is about setting pain up as an object I’m a bit confused where you sit with all of this? I am somebody with a background in physical therapy as a clinician but also in neuroimaging and I did my PhD in immunology and a second one in the philosophy of pain seeing elements of all those things coming out in your work but I don’t know where you sit and that is intriguing me.*

I’m not a dualist in terms of the way you are trying to explain things. I too find processing very interesting but that wasn’t really within the scope of my talk. Was there anything in particular? …

*All four cases you probably dealt with there and the way that you interpreted it, to me, there was a very dualistic undertone in your use of descriptors there about pain, nociception and mind and body being separated at times. That’s how it came across in my hearing.*

*I think we all discover that as a medical student you are not taught about the kind of conditions you are going to meet 50% of your time. Speaking as a past GP and psychiatrist you will understand that functional disorders is my favourite topic. I spent a lot of my career not knowing about hypnotic things. Someone asked earlier about whether the psychiatrists could unearth trauma. One of the fascinating things about your lovely Australian guy Evan was that he did well with NMDR which is basically a hypnotic technique. I was taught in my psychiatry training to take a full psychiatric history with tick boxes all over the page which was very ungratifying! But when I discovered hypnotic techniques I discovered that the problem wasn’t what was cognitively thought; it was usually something else very deep. I would say to people: if you have a symptom and it goes away does it matter if you don’t know why? Most people don’t mind. Most of the problems are very deep and often you don’t want to tell your conscious mind what the problem is as long as you can find the solution for that, whatever it is. As to other functional disorders: you can have functional blindness, functional stress or functional anything which is why these are 50% of our work. So it’s great that at this stage of your career you are exploring this area and I hope that you will go on to do great things. It’s multifactorial: [?] might play a part – I’m not dismissing that but a huge part is played by the unconscious mind and we really need to be addressing that. Do come to our conferences [on hypnosis] at the RSM - they are brilliant!*

*You said that the guy Evan got better when the case was completed. We as GP’s recognise this all the time. In family care we call it litigation neurosis. So until a case was settled the symptoms persist; I am not suggesting that people are using them deliberately to influence the outcome – well that might occasionally be the case – but mostly it seemed completely genuine to me that once it was all over, whether they had won or lost, it went.*

… not knowing how things work but they do work …

I am reading a book by Matthew Cobb called the Story of the Brain about our inability to understand what is going on. Do these constructs … that’s what machine learning is trying to do to find groups of people who will respond best to certain diseases; but still not knowing the kind of mechanisms behind that, and for a lot of these things it will be a long time before we can understand what happens mechanistically …

*We are getting there; there are neuroscientists researching phenomenological control and calling it that rather than hypnosis …*

*It troubles me - we have a couple philosophers on here - I do a lot of fieldwork in China; (China, Asia and Africa are most of the world apart from the 20% affluent part, but China is the only place I have experience of) and one thing I have noticed is that philosophically their conception of pain is different. In some ways they think that pain is healing. For example I was surprised to hear acupuncture patients say: yes it hurts and immediately they felt better. It’s not associated with tissue damage … you can see it with coughing or scraping. But I have a troubled notion that pain is necessarily associated with tissue damage. Do the philosophers have any comment on that? I don’t know what pain would be … but the acupuncture patients felt they could go home and do things – they were healed phenomenologically as well. . Of course they were to break a leg they would be in pain but it is not but not necessarily associated with tissue damage.*

*Of course it goes without saying that philosophers will disagree with each other but some, and I am one of them, will try to persist with the idea that the pain is a perceptual experience whose role is the detection of tissue damage. But of course this is wrong a lot of the time, as I was pressing Monty on at the beginning. But I have to admit that I am completely convinced by the other side – perhaps this is what you were getting at, Ernie; you really want to push the conception that its role is not the detection of tissue damage. Maybe one bit of evidence, other than that the two can come apart ( and pain which doesn’t settle for reasons we can talk about which are simply inaccurate,) is just how cognitively impenetrable for some people their pain is. As with Evan, when his legal case is resolved his pain goes away.*

 *Taking vision as an example It’s not clear that our visual experiences are not affected by our beliefs. In some cases they are: if you see something the shape of a banana there are psychological tests that can show that it looks yellower than at yellow circle – the association with bananas makes it a more vivid yellow – but vision is relatively immune to the rest of your psychological states. Whereas pain is notoriously influenceable by it and by nocebo and placebo etc. There are lots of cases like this; when things are going badly and someone is depressed , that will sort itself out when they are not in pain. So I confess that if you try to push the other side it is quite hard to reconcile with the idea that pain’s primary role is to register injury even if it sometimes gets it wrong. So I am sitting on the fence!*

*I think you are almost stuck in an inherent teleology of pain, that it serves a purpose; which it undoubtedly does, but does this have to imply some sort of intention? We have all these factors, both psychological and physical , that happen to a person who is trying to make sense of their sensory world all the time, and in certain situations the best sense, which is not always accurate, is to have the experience of pain. And that makes the most sense of their sensory experience at that particular point in time. So in a way pain is associated with all of those things but it doesn’t have this teleological function of protection of tissue damage. It may arise with this but as you say it may arise without it. This idea that pain is there for a particular function rather than that it just makes the best sense of what is happening, and that can account for whether there is a stressful situation which does or does not involve tissue damage; it’s just the best possible way of explaining what is happening to you at that point in time.*

*I was encouraged at one stage to think of that as pain being an answer rather than the problem. In many situations in life … if the toddler has fallen over and is seeking attention or someone avoiding a painful psychological issue in their life or perhaps seeking compensation for a perceived injustice, pain is a very powerful social thing to exhibit. It’s very difficult to ignore someone in pain because of our social norms and empathy. It serves me well as a clinician to think of … , a patient with a difficult pain problem, to ask if this is providing a helpful answer in life. It comes back to Monty’s concept of protection, and this evening I have certainly thought differently about that: whether it’s protecting you from the heat of a fire, or a difficult interpersonal relationship, or a memory. The more I think about that, and the more helpful it is as a clinician, to realise that trying to get rid of the pain can be counterproductive: it doesn’t work and can lead to more problems. I see clinical negligence cases; people who have been damaged by procedures intended to get rid of the pain. In the past we have done amputations and nerve blocks and people have been seriously harmed by those procedures when perhaps there may have been an alternative explanation for their pain.*

*Ernie was talking about the cultural thing and acupuncture. We had a cohort of Bangladeshi patients in my practice when I was a GP. Most of the middle-aged and elderly women got depressed and they wouldn’t talk about depression or pain but they would complain of ‘burning all over’. It took me a while to work out that it was an emotional cry for help; they didn’t have a word for depression. It didn’t help; that our interpreter was often a 12-year- old grandson! But the way they were describing their distress was incredibly culturally constructed.*

*What you have been saying about a teleological construct is very interesting but the question for me is how best to communicate this to someone with persistent pain. It often seems that trying to fight the pain and treating pathology can often backfire. Perhaps we can say that pain is a protector even when it is ruining your life; it is trying to protect you albeit wrongly.*

*What happens quite often is that we project this third person perspective but actually quite often when we engage with people and develop their first person narrative we discover what the meaning really is for them, and that is the essential point here. It’s one of the luxuries of having been a clinician to have had patients as part of my education and sometimes when I am dealing with more academic aspects of pain as well – I am a professor of pain - I have learnt from people who have different views of pain than myself, and the important thing is to listen to people.*

*To pick up on the protection issue: it may well be a way of the body trying to protect people. One of the functional things we were talking about was prediction error: in other words the brain getting it wrong. It’s trying to protect you and is making is making a really good job of it but then the wires got a bit crossed and it’s all a bit confused. Something I learnt from one of our great hypnosis people, Dabney Ewin, which I found very useful was the notion that word pain comes from the Greek* poena  *which means punishment. It so happened that when l learnt this I had a very difficult patient (people used to send me all their difficult, heartsink patients), just fitted extremely well with that patient. There are all sorts of reasons, never just one, and the protection mechanism is just one, like prediction error … but we will be a while getting there.*

*I very much go along with what has been said about the necessity of listening to the individual’s story. The problem is that doctors don’t have time to listen to that story. One of the benefits of running groups for people with long term pain is that I got to hear their stories and then I would go back to the clinicians with it and often the treatment would change. I remember one lady in particular who described her pain as ‘gut-wrenching’ abdominal pain and was on high doses of opioids. Her story was that she had a daughter with mental health problems who tried to commit suicide at least twice a month. No amount of opioid was going to help that pain. We don’t give people the opportunity to be heard - that story came out over a long period of time- and that needs somehow to be included in the system.*

*This is a very important point. If someone goes to a very busy clinic with sociological problems such as having lost their job or are the victim of abuse, how is that going to be covered in a clinic? I don’t have answer to that. In the US 20% of the time they are prescribed opioids and 70% some sort of pain medication. How are you going to explore that in 15 minutes?*

In general practice here you may not have more than 10 minutes. One of the hardest jobs for a GP is trying to listen to someone and disentangle their problems in ….

*… you just run late! …*

*Another story I remember was that of a lady who had been diagnosed with complex regional pain syndrome in her feet . She didn’t feel that her legs belonged to her. It turned out that the psychologist and the doctor seeing her were men of a certain age and reminded her of the man who had and was still abusing her, and when she was in the company of men like this she used to ‘switch off’ her body from the neck down. All the tests they did on her suggested complex regional pain syndrome. As soon as they knew that story they decided to change the diagnosis and look at her differently. It’s so important that we know the background.*

*Monty: you have engaged us in a fascinating talk, and could you just conclude by telling us where this has taken you and how your study of pain has helped you?*

I haven’t one specific thing to conclude with but I want to thank everybody for such an interesting discussion which has helped me to realise that we have barely started scratching the surface of the problems of chronic pain and how we can help people living with it. The more you look at the psychological factors and social injustices that perpetuate these things the more you see that they are so at odds with the medical model. It’s been great to talk to such a multidisciplinary group of people about this issue; this is the way forward and needs to be pursued much more widely.