



Chronic Pain – Myths and Treatment

Why current treatments are so ineffective, and how to get results in spite of your pain specialist

Introduction

In Australia the treatment cost per annum of chronic, unrelieved physical pain is over \$12 billion. In the USA it is more than double that. Lost productivity and other costs skyrocket these figures into the hundreds of billions. Not only is this a huge burden on the economy and the health system, but it represents an enormity of human suffering that is both appalling and terrifying.

Most of us have experienced terrible pain. The thought of living with that agony every second of every day is luckily, for most of us, unimaginable.

It is my hope that the methods described here will replace those currently being used which have little or inadequate effect. Based on our own clinical research, we know that we can achieve almost immediate relief for at least 75 per cent of people with chronic pain. The majority of those people will achieve total elimination of their chronic pain, even where they have suffered for many years.

Immediate results in our first clinical trial group showed 100 per cent elimination of pain for 4 out of the 8 in the group, more than 50 per cent pain decrease for another 2 of them, and zero change for the remaining 2. At 2 week follow-up the results held. At 2-year follow-up we were able to contact only 4 of the original 8. 2 of those had no chronic pain at all in the intervening time. 1 had minor “niggling” chronic pain, and the other had increased pain, however this could be explained by her chiropractor’s high-velocity manipulations of her cervical spine, which she persisted in having even though it clearly and severely worsened her pain after every visit.

Over the past 2 years our clinical experience has demonstrated that better results are obtained when the patient continues with the program over some months, even where the pain has been dramatically reduced. It does appear that for most people the nervous system requires “training” over a period of time in order to permanently cease over-reactivity to sensory signals, even where 100% of pain relief is initially achieved. Over those months most people will experience ups and downs of pain and flaring, however the general trend will be strong decrease in pain, reduced episodes of flaring (and lower spikes) and greater return to role, until there is no more pain despite the person once again leading a full and normal life.

Our research is ongoing, and you can read more about the available research in Section 4 of this book.

We hope that this report will help you to:

- ☑ Understand the development of a theory of pain so that you fully understand the facts and fictions of pain treatment
- ☑ Get up to date on some of the more modern approaches to chronic pain, including some which are in common use but which research does not support

- ☑ Understand the importance of physical exercise in avoiding development of chronic pain, including a safe, staged program that can be designed by your specialist physiotherapist
- ☑ Understand the psychological, social, and emotional components of chronic pain and learn how to address those issues
- ☑ Learn a whole new approach to treating chronic pain so you have an excellent chance of living life pain free, with no or little medication, and no or little flaring, and no need for surgical intervention in most cases.

The techniques outlined in this report do not in any way replace the need for thorough investigation and treatment of chronic pain. Rather, they are presented as an adjunct to such treatment, and also as a stepped alternative to more invasive treatment measures such as surgery, where such surgery is of significant risk.

On no account should you self-diagnose any condition, and all unexplained pain should be investigated. If you choose to do the chronic pain program, whether solely through the application of what you learn in this book, or through the on-line program on www.realhelpforchronicpain.com, you should do so only under the supervision of your qualified medical specialist.

Warning: If you are on prescribed medication for pain, do not alter your dosage without first checking with your doctor. Because of withdrawal effects or complications, some pain medications can only be varied with great care, often with only very slight changes at one time. Even though you may start feeling better almost immediately, this does not mean that it is safe to simply stop your pain medication. Always check with your doctor first!

The Theory of Pain - How we got it wrong

In times past we used to have beliefs and ideas about pain that in the light of current knowledge seem ignorant or even bizarre. Even now, with the benefit of a more evidence-based approach to the development and provision of interventions for pain, and even though we have made enormous progress in the treatment of acute pain (in most cases), conventional treatments for chronic physical pain still seem woefully inadequate in terms of satisfactory outcomes for patients.

It is now clear that **acute pain** and **chronic pain** are very different in nature, and in fact these 2 pain types even utilise different nerve paths, as you will soon see.

It is only very recently that this was clearly understood and better interventions have begun to be developed. (For a better understanding of the benefits and shortcomings of the variety of current chronic pain treatments, please see the following section.)

The main area in which we “got it wrong” when it came to the treatment of chronic pain was that we did not (and most interventions still don’t) understand the crucial role played by seemingly non-physical factors such as the patient’s social, family, emotional, psychological, financial and occupational issues.

As you will read in the next section, the experience of chronic pain is absolutely dependent upon these things, not because chronic pain is “all in the head”, not at all! Rather these factors are absolutely complicit in the body’s pain response. Through not understanding these factors, treatment was directed at the patient’s physical activity only, and the patient was (and often still is) told to “push through the pain” to complete excruciating exercise regimes, often causing the patient enormous physical and emotional distress.

The other area in which we “got it wrong” was that we blamed the patient for his pain, accusing him of “bringing on the pain” or “creating the pain” by his thoughts and attitudes. Several current approaches still do this. We now know that those thoughts and attitudes certainly do help produce pain, but that they in turn are produced by unconscious emotional responses, over which the patient does not have direct control! So insisting that the patient use willpower and basically try to ignore their pain, could be seen as

blatantly cruel. A far more humane and effective approach (which is what you will learn about here) is to identify and deal with those emotional factors and permanently resolve them, **not** to try to make changes through willpower.

The third area where we didn't so much "get it wrong" as much as just didn't know, because the scientific tools to demonstrate this weren't yet developed, was how the brain actually processes chronic pain. Brain imaging techniques have clearly demonstrated that the brain activity that typifies chronic pain signalling is almost identical to that created by emotional pain such as fear, anger or other emotional distress. It seems amazing to us that until now no-one has linked this with learning theory and memory studies. If they had, they would discover that the same processes which modulate conditioned responses and memory, also appear to modulate chronic pain.

Sadly, the outcome of our past and current misunderstanding of the nature of chronic pain has led to a proliferation of programs which have the intention of "helping the patient to live with his pain", rather than the reduction or even elimination of that pain altogether.

In short, there is a whole easier, far more effective way to help people with chronic pain, which does not blame the patient for his thinking, which does not treat the patient as a body without a brain, and which accurately targets the real cause of the chronic pain: conditioned activity of the brain and nervous system. Unlike almost every other program, this program has the full intention of dramatically reducing or eliminating your chronic pain, by working with the actual mechanisms which produce the perception of chronic pain the first place, literally "switching off" your chronic pain.

The neuro-psycho-physiology of pain

In fact you are starting your chronic pain program right now, as you read these very words. Studies show that merely believing one understands how chronic pain arises (even if that understanding is incorrect) leads to a reduction in reported pain levels. It is thought that the reason this is so is that we human beings find "not knowing" to be a very stressful experience. When we believe we "know" or can label something, our stress levels reduce and our nervous system becomes less reactive, in many cases causing less pain. This is a small start!

Our beliefs about chronic pain have come a long way since ancient times, when we thought that there was some kind of string or tube along which pain signals travelled, either by "pulling" the string, or "opening" the tube. Modern studies in anatomy, neurology and chemistry allow us to understand the workings of the nervous system in intricate detail, and yet there is still more to discover, with so many new and exciting studies revealing more and more on an almost daily basis.

One of the most exciting things we've discovered is that the level of injury does not necessarily match with pain levels. Almost everyone has had the experience of receiving an injury which at the time did not cause pain. Usually it is because there was something else going on at the time that produced much higher sensory stimulation. It would be disadvantageous to feel pain when the survival needs dictate that one should fight or flee, for example. So even in cases of acute pain we know that it is not simply a matter of "x" injury = "y" pain.

In cases of chronic pain this is even more so. For example in cases of chronic pain due to spinal damage, or due to compressed or otherwise injured nerves, there is no correlation with pain levels. What I mean by this is that a person could have no damage whatsoever and yet feel the most severe pain, or a person could have major damage and report no pain, and even report no disability.

So while it's obvious that pain signals operate via the nervous system, it should also be obvious that it takes a lot more than nerve signalling for you to feel pain. Let's look at the pain sensors themselves to see how even *they* are modified by YOU.

Your Pain Sensors

You have millions of nerve sensors all through your body, whose job it is to report changes to tissue which could represent damage or danger. These sensors are sensitive to mechanical stimulation (eg pressure), temperature stimulation (eg heat) and chemical stimulation (eg the lactic acid produced in your muscles during a workout).

However your pain sensors have a very brief lifespan: they live only for a few days, and are constantly being replaced according to the recipe held within your DNA. But neither the number of sensor cells, nor their sensitivity, is fixed, because if you are experiencing stress or other issues which your brain and nervous system regard as “survival issues” the DNA can consequently direct the production of *more* sensors which are each even *more sensitive* to mechanical, heat or chemical stimuli.

This alone is a very good reason to identify and resolve issues that “jangle your nerves”! For instance you may be angry, or fearful, about certain things and those are on your mind a lot. You must find a way of resolving these, and BMSA is probably the fastest known way to achieve that.

I sometimes have clients who simply do not want to know that their anger is maintaining inappropriate responses in their CNS (central nervous system). It is important to them to “maintain the rage”. It is very, very difficult to help these people, and the sad thing is that they are often having no effect on the object of their blame, but are certainly hurting themselves. If you have anger toward people, places or situations, and suffer from chronic pain, I seriously ask you to consider treating those. To do otherwise is to let them win, again, and again, and again. Seek to identify things that make you angry, fearful, sad, or any other unhelpful emotional response, and work to resolve those so they no longer create an over-sensitised nervous system.

Of course, sometimes fear can relate to real-life problems which seem unsolvable. It might seem outrageous to say that in fact there are always options, even though it might not be possible to consider them, or even see them, when you’re in distress. This is a job for your pain team, which should provide not only the appropriate health professional, but also perhaps a social worker, psychologist, financial adviser, etc. More than most people, chronic pain patients need that attention to detail on their quality of life issues in order to help quieten that over-reactive nervous system!

Even though there may be one or several solutions to problems which stress you, I realise some of these may at first seem completely unpalatable. For instance we know that people with chronic pain NEED to re-engage socially. However many say they can’t, not necessarily because of the pain, but because of their ***embarrassment***.

Before you discount ANY solution, ask yourself what are the emotional reasons for saying no. These need to be brought out into the cold hard light of day and examined for what they are – illusory beliefs that are actually doing you harm.

In your Chronic Pain Program we will look at a whole range of neuro-psycho-physiological factors which influence pain production and pain perception, learn to permanently resolve those factors, and ***switch that pain off for good***.

Commonly used drugs, flawed or compromised research

Research in chronic pain is not very advanced, and many treatment methods being utilised today are far from satisfactory in their outcomes. Even worse, methods are being used not because of any evidence of their efficacy, but simply because “that’s the way we’ve always done it”, or worse still, the health practitioner recommending the method has nothing but his/her own belief that it works.

Almost every health practitioner, unless he/she has studied critical thinking and research methodology, will tend to presume that if their client doesn’t return, that their methods have worked. It may seem

alarming, but it is true that without even short-term follow-up, professionals, being human, make some pretty outrageous assumptions about the value of their methods.

This is how it happens that you so often see people with “MD” after their names touting what amounts to snake oil. Mostly they’re not dishonest, and seriously believe in the product. And mostly they couldn’t be more wrong.

Much more research needs to be done, because as you can see from the notes below, very little that has been developed so far, is actually effective in any significant way.

TENS

The TENS (transcutaneous nerve stimulation) machine was invented by Wall and Sweet after they realised that stimulation of certain nerve cells diminished firing of pain signals. It was really the first breakthrough in the control of chronic pain. It could be managed by the patient himself, it allowed reduction or even elimination of drugs, and seemed to have no unwanted side effects.

However studies showed that not everyone benefited (and the previous chapter explains exactly why) and even people who did initially respond, became less and less responsive to it over time.

It did not treat the cause of the pain, and did not prevent the re-occurrence of pain, but tried to “dampen down” pain when it occurred. TENS has been shown in 15 out of 17 randomised controlled trials to have no benefit compared to placebo.

Currently there is an advance on the TENS machine which is surgically implanted at a cost of around \$AU40,000. There is no evidence that this invasive alternative is much better.

So TENS and its successor are no panacea, but they do work, in a very limited way, for some people.

Hydrotherapy

Hydrotherapy can be thought of as water-based physio-therapy. Studies into the efficacy of hydrotherapy have been confined to cases of lower back pain (the most common of all chronic pain) and showed short-term effect in the range of a 50% reduction in reported pain.

However, it does not resolve the cause of the pain. These studies showed a complete return of pre-program pain levels just 3 months later.

Exercise programs

Inactivity is one of the leading direct causes of death in the Western world. Let me put this very bluntly. Lack of activity makes people physically and mentally sick, and kills them. You might think this is an extreme statement to make, but no health department would disagree with a single word, so universal is the agreement on this basic truth.

So without doubt **everyone** needs to be active, meaning that we have around 1 hour of aerobic activity at least 4 times each week, and around 20 minutes of resistance (weight bearing) activity at least 3 times each week.

The problem is that people with pain have an instinctive desire to withdraw from activity and tend to be very fearful of even normal aches and pains from being active. A chest pain that a regular runner almost disregards because to him/her it is so insignificant, might be a traumatic event to someone with chronic pain.

Carefully graded exercise programs are associated with reduced levels of pain, but there is little evidence that it is the exercise itself that is helping to gain that reduction. It is more likely that

1 The social aspects of exercise help to lessen the patient's anxiety and thereby serve to quieten the nervous system.

2 The well-known health benefits (mental and physical) of exercise create greater wellbeing and greatly reduce the impact of pain perception.

One way that regular resistance exercise certainly does impact on pain is that good muscle mass and strength provides better support to joints that are under pressure from injury or disease.

Surgical interventions

As a last-ditch effort to eliminate chronic pain, surgeons sometimes resort to actually cutting a nerve branch. Initially this can (not always) achieve a seemingly miraculous result, although often at the cost of reduced mobility.

Studies show that the nerve regenerates, though unfortunately in a less differentiated way, and that pain can be greater at that time than before surgery.

Compounding this is the fact that trials of this method show "fake" surgery to be just as effective. (Are you getting the idea that it's not really about nerve paths anyway?)

Cognitive Behaviour Therapy (CBT)

Cognitive Behaviour Therapy has been used for some years to treat a whole range of problems, such as anxiety and depression, for example. In recent years it has also been used to treat chronic pain.

It is based on the belief that our thoughts and behaviours feed back into our nervous system and help to maintain problem states. It then seeks to identify the sorts of unhelpful thoughts and behaviours that we have, and to stop them, by willpower.

It's not surprising that there is a high drop-out rate, not only among patients but also among therapists, because CBT is certainly "doing it the hard way" and in any case the results are fairly unsatisfactory. After all, its aim is not to switch the pain off, but to help people to "live with their pain".

Even though studies now show that CBT produces results no better than placebo, and therefore should not be used as a therapy treatment, there is a CBT principle which is correct. Studies do show that where people engage in avoidant thoughts or behaviours, their distress levels are higher. This is true. But as you will see, there is a much easier, gentler, and more effective way to resolve these issues than CBT.

Acupuncture

While there is strong evidence for achievement of short-term analgesia for acute pain, there is no such evidence for long-term control of chronic pain. Needling seems to produce a stab of pain, followed by relaxation of the taut muscle band, which is followed by general soreness and then temporary relief. No studies suggest that acupuncture provides a cure for chronic pain.

Osteopathy and Chiropractic

As difficult as it is to design randomised, double-blind, controlled studies of these treatments, there is no validated evidence that they make any significant difference to chronic pain levels.

The only clear assumption which can be made from these studies is that the more "fanfare" which accompanied treatment (this includes all of the actions which accompany the procedure, as well as the

way the clinician dresses), and the more hospital-based the treatment, and the longer the treatment sessions (even where the treatment was a placebo) the better the improvement of the patient.

In other words, it was not the treatment itself which determined whether the patient gained improvement. What did determine improvement were things like whether or not the clinician wore a white coat!

Medications

Pharmacology plays a vital role in pain control. Compared to all of the therapies above, it is the only treatment that in randomised, controlled, double-blind trials actually produces significant outcomes.

All drugs have side effects, and different people, and different types of pain, respond differently to different preparations or combinations. Here are a few of the most common types.

Antidepressants

There is considerable evidence that people with depression feel pain more acutely, but as well as targeting depression, anti-depressants can also decrease the incoming signals from the spinal cord to the brain and improve pain relief. They tend to be used only where nerve damage has inactivated receptors that narcotics could target (eg in cases of shingles), but the effect is regarded as fairly weak and even insufficiently significant.

Anti-inflammatories

There are not yet available safe, tested anti-inflammatory medications. This does not mean that they should not be used because of fears of addiction, dependency or side effects. With help from their supervising doctor, a treatment can be found that absolutely minimises these risks at the same time as maximising comfort and wellbeing.

There are a range of pharmaceuticals which qualify as anti-inflammatory and most of these are descendents of aspirin, which has risks relating to bleeding because of its blood thinning properties. These drugs are also notorious for causing gastrointestinal problems.

The COX-2 inhibitors are a very new class of drugs (NSAIDs -nonsteroidal anti-inflammatory drugs) which selectively inhibit COX-2, an enzyme involved in the inflammation pathway, while sparing COX-1, thereby reducing gastrointestinal toxicity. Vioxx was an example of a COX-2 inhibitor which was subsequently withdrawn from the market after reports of associated heart attacks, strokes and blood clotting.

Narcotics

These tend to be opium or cannabis derivatives (the latter politically unpopular because of widespread abusive use), and they work by acting on the central nervous system itself. A drug which is effective as a narcotic always has unwanted side effects, for example constipation and respiratory depression.

When pain doesn't respond to one of the aspirin-like drugs, it's common to combine those with a weak narcotic. A lot of research has taken place to optimise the desired effect and minimise the risks.

Anti-epileptics

During an epileptic fit groups of nerve cells in the cerebral cortex (brain) become very excitable and "gang up" to fire in unison. Anti-epileptic drugs prevent this simultaneous firing. In some pain, for example trigeminal neuralgia, it is thought that cells in the brainstem which receive sensory nerves from the face, fire in unison, causing that awful but familiar stab of pain. Anti-epileptic drugs can be very effective in these types of pain.

NeuroStim

NeuroStim is one of the BMSA's (Brief Multi-Sensory Activation). When used by or under the supervision of a qualified, trained professional, it can be highly effective in identifying and actually switching off a range of pain responses.

Its theoretical basis is that chronic pain consists of conditioned responses of the brain and central nervous system, and that these conditioned responses can be extinguished.

The few clinical trials that have run have not been randomised, controlled, or double-blind, but consisted of treatment groups where patients were taught to self-treat. Approximately 50% of the groups eliminated pain entirely within 3 days, and a further 25-50% were able to reduce their pain very significantly.

Subsequent studies have shown the importance of continuing treatment until flaring no longer occurs and the patient has resumed a completely normal life. The treatment does seem to be successful in actually switching the pain off, not just masking it, and unlike drugs, it is not something people need to do for the rest of their lives, or even for very long. NeuroStim is generally a *rapid* treatment compared to other interventions.

NeuroStim was developed by clinical researcher Christine Sutherland, and forms the core treatment for the BMSA Chronic Pain Program.

For more information on the Program, including some interesting case studies, please visit <http://www.realhelpforchronicpain.com>.

How to Access Your Chronic Pain Program

Because clients differ in the type of program that is most suitable for them, we've made it possible for you to access the program through 3 different options:

1 On-line group treatment program.

This program includes your manual and provides up to 12 months' one-on-one support in an on-line group environment which is forum-based and closed to the general public. The cost of this program is simply a one-off payment \$US67.

To join the on-line treatment program, visit <http://www.realhelpforchronicpain.com/program.html> and purchase the manual "The Pain Train: Time to Get Off". This book is in electronic format so that you can download it immediately. You'll also immediately receive an email with easy instructions for registering on the client-only treatment forum.

2 Private consultation via telephone or Skype.

This method delivers private, one-on-one treatment during a number of one-hour sessions. Clients initially commit to three sessions over three weeks, and then decide whether they will continue weekly, or on an as-needs basis, dependent upon their own particular condition.

The cost of this program is \$US480 in advance for the initial three sessions. If you decide to continue with further sessions, these are charged in advance at \$AU160 per session. The manual is included at no extra charge.

To commence this treatment program, visit <http://www.realhelpforchronicpain.com/program.html> and select this treatment option. You'll be taken to the payment page and will have almost instant access to the manual, as well as instructions for setting your initial three appointments.

3 Private face-to-face consultation.

This method delivers private, one-on-one treatment face-to-face during a number of one-hour sessions. Clients may attend the clinic, in Perth Western Australia, or in some cases we are able to travel.

The cost is \$AU160 per one-hour session. (Fees for travel vary dependent upon distance, as well as travel and accommodation expenses.)

To book for face-to-face consultation, please email info@realhelpforchronicpain.com.

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