Season Two, Episode 6: The Neuroscience of Pain, with Dr Romy Sherlock, Director of Retraining Pain

Shabnam 0:05

Welcome to the Psychology of Case Management podcast: the show that helps you use psychological ideas to strengthen your relationship with your catastrophically injured clients and their professional networks, so you can achieve more for your clients and feel more fulfilled in your role.

0:19

Hello, and welcome to today's podcast, we are going to be talking – or revisiting – the idea of pain and the relevance, I suppose, of pain in the medico-legal context. I don't know about you, but it seems to be an area that is becoming more and more prominent, I think, in the work we do as case managers and as legal professionals, therapists… in the personal injury world. And I think for the right reason. It's massively complicated. It has links with lots and lots of the work we do, and it has a huge implications for the rehabilitation that we are so desperately trying to maximize for our clients. It's also really interesting, I think, how it relates to us as practitioners – which, I know I would say this – and if you do follow me, you will know that how we, as practitioners, hold ourselves in the space with our clients is massively important. And these ideas come together, and it makes a lot of sense for our next guest, on today's podcast, who really gets what I mean by all of this. And she will come from that massive expertise of understanding pain, and particularly with clients in the medico-legal context, and thinking about the neuroscience of it all. And so today we have Romy Sherlock from Retraining Pain, whose service is a multidisciplinary service around pain assessments and interventions for clients who are experiencing persistent and chronic pain in the personal injury context. And so… welcome, Romy Sherlock!

Romy 2:05

Hi, Shabnam. Thank you for having me.

Shabnam 2:07

Oh, thank you for your time, because I know you are massively enthusiastic about pain and how you can support our clients, and in a way that really connects with what I understand, as well. So I'm really excited to share your perspective with personal injury colleagues, really. But, before we do, and the way we tend to start off our episodes is: tell us a little bit about Romy, and why pain? What brought you to this trajectory in your career?

Romy 2:40

Yeah, great question. Well, because I think, pain… I don't think anyone else who works in pain would disagree that a lot of the time it's not the most popular area to work in. So sometimes, yes, it can be a bit of a journey to get there. But I've worked in pain for kind of most of my qualified career as a clinical psychologist, and honestly it was kind of opportunistic, the job that I took – I had a role in an NHS pain management service for a lot of years – and, honestly, I had mixed feelings, initially, about whether that was an area I wanted to go into. Because I think as health professionals, we do kind of get trained, whatever your background, to alleviate distress, don't we? And there's just something about chronic pain that can just feel so hopeless, sometimes, and so entrenched that, you know, I think that's maybe why lots

of people sometimes think it's not the area for them. And, interestingly, the interview presentation that I had to do for that job was something like 'Working with people with chronic pain: heart-sink patients, or heaven-sent opportunities?' And so it really just laid that on the table straight away for the mixed feelings, maybe, that carry that. But I just fell in love with working in this area, because you will know that sometimes, as a clinical psychologist, we get trained to work in a really broad way. So, not just as therapists but as people who want to work in teams, who want to formulate, and conceptualize cases, who want to train other professionals, and supervise and do research… and I think working in pain is so akin to working in a team, and working with a team of people who all also are really enthusiastic about the changes that we can help people to make whilst experiencing a long-term pain problem. So that was kind of… it wasn't a well-thought-out journey, but it was just where I landed it, and happened to meet lots of other people who shared that enthusiasm, really.

Shabnam 5:02

Yeah. And I do find that those people who do work in pain are massively enthusiastic: like, way more than many other areas! But I wonder whether that is linked to the fact that it is multidisciplinary. And not all of you can be wrong, right? There's got to be something in it… obviously you don't connect so much with the 'sinking ship' aspect… But it's actually a very hopeful, I think, place to work?

Romy 5:35

Yeah. And I think in terms of our journey into Retraining Pain, it was around – you know, I don't work in the NHS any longer – but worked in the medico-legal field for a number of years, and we see that people with pain, often it's really difficult for them to have the right rehabilitation, at the right time, and from the right professionals with the right skills. So often that's really frustrating as well, when you're trying to do your little bit as a psychologist, but it's not joined up with anybody else in a team, thinking that this person needs an occupational therapist or a physio or just something more than what we can do. But we know that if we were actually working in a really integrated way, that we could probably make a really big difference. So it was born of a knowledge that we could do this way better.

Shabnam 6:35

Yeah, that's amazing. And actually of massive relevance in the personal injury world. I believe a big part of your client cohort is actually from the medico-legal… is that right? Yeah. So there is that understanding of the context as much as the intervention aspect of it?

Romy 6:56

Absolutely.

Shabnam 6:58

And tell me a little bit. So I'm going to ask you to take us 'back to basics', then, a little bit. Well, not really 'basics', in some sense. But you mentioned when we were talking earlier, there's a huge neuroscience behind pain. And it just occurred to me that I'm not sure that *I* know what that's all about. I think I can hazard a guess. And I'm sure many of the people listening in today might be able to hazard a guess. But wondering if you could share what you meant by that.

Romy 7:29

Absolutely. Well, many 'pain geeks' who unite in their love of pain will be familiar with people like Lorimer Moseley and David Butler, and I think they've been leading the way, really, in helping us to think about

pain, and what the neuroscience can tell us about it. Because obviously we've all worked with people where… we often say to people, it's more than 'issues in the tissues'. You know, sometimes there aren't any… we can't make sense of why people have pain. And then obviously that can be particularly tricky in the medico-legal world, because it's then like, "Well, what does that mean?" Or sometimes, people have had these really catastrophic injuries, and perhaps they don't recover as we might have expected them to, or perhaps we would never expect them to make a really full recovery. And it's helping people to understand – and I guess we know, as well, that the more people know about what's going on on the inside – actually, that can be a really helpful tool for their toolbox, for their pain management. Because, you know, once we understand that, actually, pain is really complicated. So I suppose, first of all, we really want people to know that on the whole, people's pain is real. And even though we might not understand it, always from that kind of organic perspective, we know that it's there. So Lorimer Moseley and David Butler, they've written some, they've got kind of some fantastic materials out there and books and trainings and things. But I suppose in a nutshell, we're thinking about… if our nervous system is constantly watching, isn't it, it's constantly taking information in from the environment and from our own bodies. And we need to think about what kinds of stimuli present 'danger' in our system, and what kind of stimuli present 'safety'. So I will often say to people that I'm working with, that we don't really think about pain as 'pain pathways' or 'pain centres', we really think about when the body detects enough danger from various different things, then that's going to send all of those 'danger' messages up to the brain, and the brain is going to put all of that together. And if there's enough of it, it's going to say, "You know what, let's make some pain. We don't know what's going on here. But we know there's a lot of danger." So we know that's really helpful, if you've just broken your ankle, all of those 'danger' messages are going to be going up to the brain. And we're going to get that really useful pain. But, unfortunately, sometimes what happens when people have had pain for a long time, or there's various other factors, is that perhaps those 'danger' messages continue. So it's like it becomes like a super-overprotective system. And not only might that pain be coming from the site of an injury, but then it might start coming from other places in the body, too, that haven't had any kind of obvious injury. So we start to think about yes, there are even more of those 'danger' signals coming up. And that can be not just around damage that may have occurred, but it might be about people in your life, your relationships, your solicitor phoning up and telling you things about your case, or the doctor's office and them showing you a scan of what your back looks like, or the things that you think and believe about yourself in relation to what's going on, or some of the things you do. So all of the danger, all that safety can come from lots of different places. So I guess our job is often educating people around: for *you* – because mine will be different, and yours will be different – but for *this* person sitting in front of us, what is setting off your danger system? And also how do we help you create safety in your nervous system? So that, obviously, when when the body is detecting lots and lots of safety, then that's predominantly what are the message is that the brain is receiving. And, consequently, how does that help you reduce or manage the pain that you've got?

Shabnam 11:59

A really helpful description, actually! That really felt like I was following, in my mind, the kind of process that someone might go through. And actually, not once did I sense that it was really rooted in the physical: it really felt like it was much more… that it has a massive psychological component. Yes, there is a neuroscience where you are linking in with the body. And I know a lot of people do talk about this. We do have another podcast discussion about the mind-body connect. But, traditionally, historically it has really been a physical understanding.

Romy 12:48

Yeah. And then obviously often people's first line response, is one that we would use for acute injury, which will be a medicalized approach. But if you think about all of those different elements of detecting danger, then it's not surprising, really, that sometimes people have injections, medication, surgeries even. And they aren't the magic answer for their pain. And then, unfortunately, what can happen is definitely what happens in the NHS is, eventually they go "God, we don't know, go and see the psychologist." And

obviously, the message people get then is "Oh, so I'm crazy. You think you're making pain up. You think it's all in my head, you think…" Or people, unfortunately, sometimes do get told: "We think this pain is *emotional* pain." And I always say to people that I think that's really unhelpful, but also, *all* pain is physical and emotional, you know? If you stub your toe, you probably have previous experiences where that's happened to you, or "Who's left that thing on the floor? What's my anger response doing? What are my beliefs around what's going to happen with that injury? Is it going to stop me from doing anything?" So, of course, we carry physical and psychological responses to even the simplest of things.

Shabnam 14:12

And it just makes me think, gosh, at the point at which you start talking about it being multidisciplinary or psychological, can make a massive difference in how that pain is experienced, in the sense that if you just leave it purely within that medical model, and then it becomes, recognized by someone down the line, potentially – not necessarily always, but potentially – you're actually presumably coming through the doors of the psychologist, where we're talking about a much more traumatized, therefore, in pain person. Where this could have actually been completely avoided or to some degree mitigated or just acknowledging that this is a mind/body issue rather than purely a body issue or purely a mind issue.

Romy 15:01

And sometimes people – you're right – people are then coming through the door who may have PTSD from an accident or an injury. And that may be a big part of the jigsaw. But then there's also the 'post-trauma trauma' of the pain experiences that they've had, and the interventions that they've had, the messages they've been told… And sometimes they're what we consider like hopeful messages, like "I can't see anything on your scan that's explaining why your knee is so painful." And that's actually incredibly threatening to that person, because they're saying, "But then I don't know what to do with that, that doesn't explain why I'm having all of this pain." So yeah, I love talking to people about why psychologists work in pain, because their first impression might be "Oh, it's because people don't believe me, or I'm malingering," and it's like, nothing could be further from the truth. It's because we just have a different skill set. And I think once you understand that 'danger in me' or 'safety in me' (or DIMs and SIMs), then you think, "Oh, yeah, okay, so that does make sense to come at this from lots of different angles: how does my mood affect my pain? How does my previous experiences affect my pain? How do my current relationships affect my pain?" Okay, well, they're all the domain of psychology. But, crucially, alongside the other people in the team who have their part to play, because if we don't do all of that at the same time, often what will happen is you can only get so far. And I think have seen this a lot, where I might be working with somebody who's really complex, and I think I really need to… maybe they're not even having any physio, or OT, or they're having some, but it's definitely not the kind of… it's maybe not evidence-based, sometimes, unfortunately, and it's hard to… but we really need to be working in this joined-up way. So, if there's barriers to movement because there's so much fear, and it's creating so much danger, then there's also trauma symptoms, and then there's lots of other barriers in the way, how do we have a really joined-up treatment plan? So that we can be doing that at the same time, to give people the best chance of rehabilitating, whatever that looks like.

Shabnam 17:32

Definitely. Well, exactly. And I think that whole case conceptualization idea, I think it has relevance in many aspects of the personal injury work different disciplines do, including case management, but that's another story for another time. But to me, what you're saying, there's something about language and how we use language and how that can be triggering, or calming, for clients. And actually, as you say, other professionals in the fold, really. And that, to me is… any medicalized language, I think, is scary. As soon as someone says, I think you mentioned scans in procedures, and I just think "Oh, no! That just sounds… hard." I mean, is that is language part of the wider sense of the intervention, assessment and intervention?

Romy 18:29

Yeah, hugely, hugely important. And I think just taking that example of something like scans, thank goodness you don't really hear people talking about 'crumbling spines' and things any more. But in the not-too-distant past that was a much more frequently heard expression. But people will often often… I've certainly worked with people where they've been quite traumatized about what they've been told is on their scan, and it might be things like degenerative changes, or degenerative spinal disease or whatever, and they're like, "Oh, my goodness!" – and just trying to help people to understand it: that it's wear and tear, it's wrinkles and grey hair on the inside, you know…

Shabnam 19:13

Frightening! It's not frightening... it doesn't have to be.

Romy 19:16

No, it's not, and we would probably all have that, if we had a good look on a scan. But yeah, absolutely. And again, as we've touched on, the psychological language, as well, about that validation of people's symptoms and how much we can understand that, I think that's going to create a sense of safety in me, if I went to see somebody and they said, "Look, this is what this says, but often they're a part of the jigsaw puzzle, but they're not the whole jigsaw puzzle. So they can be important, but there's other things that are important too," that would set my mind at ease and think, okay, and actually pave the way – like you say – for a more multidisciplinary approach. I guess we do often live in a world, don't we, that's very medicalized for lots of difficulties. And it's really more about being 'done to' than 'done with'. So, yeah, I think it's really hard to try and… and that's why I think it's really important, actually, that… if you're working in personal injury, how can you avoid working with people with pain? And actually just being a bit familiar and confortable with some of these ideas is really, really helpful. Because it's going to help your relationship with those clients as well, around: this is the position we're coming from, it's not a sort of threatening, non-believing position, it's just knowing that pain is really strange, and really painful.

Shabnam 21:02

Yeah, absolutely. I mean, because that's what we're trying to do, at the end of the day, is maintain a therapeutic alliance so we can have those tricky conversations, or clients can bring their – safely – aspects of their experience that perhaps are less easy to understand, because they know that you're going to manage it, and acknowledge it and validate it, as you say, which is so crucial. And it just makes me think, actually, because I'm going to 'out' myself a little bit: I do struggle with seeing someone in pain, it is really hard to experience as an observer. I literally feel it, my knees going wobbly. And while my brain seems to still engage, I do find it really tough. And it's no surprise that some… the vast majority of my clients don't experience pain, actually, which I hadn't actually realized until we were speaking. But I wonder why that is, and how that brings it a little… how that makes me feel, how I can tolerate pain in someone else, because I know what it will do for me is trigger that sense of feeling a bit helpless, not being able to say 'the right thing,' because, frankly, I'm probably freaking out to some degree.

Romy 22:30

And sometimes the right thing, the only thing people want to hear, is: "I can fix this pain, I can take it away. It will go." And when we get to the point where – maybe – we have a sense that we might not be saying that, that can feel really dangerous for us, can't it, as health professionals, or case managers or professionals working in this in this field. And I think… if you don't wince when someone falls off the trampoline on *You've Been Framed*… it's those mirror neurons, isn't it? They're the reason that we can feel

empathy, and actually, yes: sit alongside somebody who's in pain... can be really, really painful. And I think it's about what does that activate in our own nervous systems, as well.

Shabnam 23:19

I mean, obviously, other case managers and Personal Injury professionals aren't necessarily as triggered as I am, because you do get referrals, obviously, to people who understand, can sit with that, can acknowledge that pain and say, "Hey, we need to do something about this. Let's send our client… let's refer our client to Dr Sherlock at Retraining Pain, and she'll help." I'm assuming that that's a fair comment to make. I'm obviously… I know my limitations, in that sense. But I think that's something that… I want to be able to believe that my colleagues are not in that same boat. But also, I'm going to hit you up with a request for… How do you deal with that, if you are someone who's a little bit… not squeamish, but there's a sort of squeamishness about it?

Romy 24:19

Yeah, I think… being able to kind of have that capacity to perhaps know when to refer on, and that sort of thing, is obviously really helpful. And I think a bit of a theme of some of your previous podcasts have been around how do we reflect and recognize what's going on in ourselves?

Shabnam 24:38

Yes, Know thyself!

Romy 24:41

And your 'Vicarious Trauma' episode, around what's rubbing off on us, from other people's experiences. And so I think sometimes… I'm a big fan of Acceptance and Commitment Therapy and thinking about how do we actually sometimes have to respond to that 'righting reflex' of wanting to somebody. It's okay, isn't it… that's maybe why we're in the field: it's about alleviating distress. But if we can't maybe give the answer that people want, how do we sit with that in our own system, sometimes? I mean, we're really privileged as psychologists because we have clinical supervision, so we have lots of opportunities to do that. And I think when you work in a team, as well, it gives you really good opportunities to share that heaviness sometimes, and also the hope, maybe, sometimes: you can share a bit of that as well. But also just… I know we've chatted a bit, previously, about how you can… can you only go as far with that client as you've gone yourself? So how do we befriend our own nervous systems a bit? I'm a big fan of polyvagal theory and bringing that into my work, as well. And in a very small nutshell, really, that's just about thinking about… we all know that we've got a sympathetic and parasympathetic nervous system. So we've got our 'fight or flight', and we've got our 'rest and digest'. But we've also got a couple of different versions of our parasympathetic nervous system. So are we going to shut down and feel overwhelmed, and maybe kind of paralysed by, or numb? And I think maybe that's what compassion fatigue feels a bit like. Or are we going to be in more of that ventral, vagal state where we're like, "Yes, I can – overall – live in that state where I feel safe and connected with the people I'm with." Probably we're all going to dance in and out of those different parts of our nervous system, all the time. But can we have that kind of ventral break over the top? So it's like the umbrella that holds us? So that obviously, you see the difficult client: maybe they're angry, maybe they're disappointed, maybe we're feeling their pain; we feel hopeless. How do we recognize that "Yeah, okay, that's my 'sympathetic activated response' or my shut-down, non-response, but that I'm confident enough in that central system to bring me back online again." Which I guess just comes back to the things that we all probably talk about quite a lot, in terms of how do we look after ourselves, when working in this challenging field? Can we *befriend* the nervous system a bit? Can we say "It's okay that I feel anxious, or hopeless, or sad for this person, right now"? And I can perhaps take that and manage that in my own way, before having to see that person again, and think about how to move forwards with that.

Shabnam 27:59

Yeah, thank you for bringing that in. As you know, I'm a big fan of us, as professionals, being part of the experience of our clients. And actually, potentially, are we accidentally… given what you said earlier about the assessment around what contributes to pain being so broad? And I think you mentioned, earlier, relationships and how one relates to other people. And we actually may well be part of that. I'm sure I would be, if I had a client who's severely in pain all the time, and I'm freaking out! I'm not going to soothe them! I'm not going to activate their, or my, parasympathetic nervous system, am I? I'm going to be the complete opposite of that. And so that concept of self-care and bringing it back home a little bit – a lot! – is crucial, absolutely crucial.

Romy 28:57

It's a really important point, because one of the things I didn't say, I think, about polyvagal theory is about how, yes, we're self-regulating all the time. But also, we need other people to co-regulate, as well. And so when we're in that ventral system, we're 'safe and social'. And that's probably when we're going to be at our best with our clients, isn't it… we're helping them co-regulate, and to some extent we're co-regulating with them, as well. I suppose the danger, then, is that when you maybe work in a field where you're massively over capacity, you've got incredibly complex people on your caseload, there's a lot of expressed emotion involved, isn't there, in litigation, and there's a lot at stake. I think it could be easy to think, "Oh, God, not that person with chronic pain again that I'm saying this afternoon, I don't know what to do with them." That would be a really natural response, wouldn't it, in the context of just thinking "This just feels overwhelming for them. And it feels overwhelming for me."

Shabnam 30:03

Yeah, it all feeds into the system, doesn't it, and the experience… yeah, that makes so much sense. And it's really helpful to think about pain from that neuroscience perspective. And that polyvagal theory, I think, has massive relevance in the work we do: not just in pain, but generally, but it's really interesting to see how it might work in the pain context, as well. I'm not sure that I've heard it being used, actually, that much in the personal injury context, so… it may be a first! So, tell us… I know you've mentioned loads of really helpful ideas. If I were to say could you pick three ideas that our audience can list here and say, "Do you know what, I can do that: that makes a lot of sense to me, or that's something that I could… I could run with that idea, just to explore pain management, and to think about how to support clients, really, to maximize those goals." What would your top three be?

Romy 31:23

Oh, gosh, that's a really good question… I think – it sounds so obvious, and simple – but just continuing to remind ourselves that pain is so subjective, and that pain is real, even when we don't understand it. It's just it's really strange. But when we do understand it a bit more, often we can see why it's so strange. Thinking about how often pain is just one huge overprotection. So it's actually: how can we befriend this a little bit more? It's like, it's not something that's my enemy. It feels like it, but actually, it's that your body is trying so hard to protect you. And it's doing it a little bit too well. So we need to help it dial down its enthusiasm a little bit. But if we can kind of befriend and understand that, then that can help us go a long way towards that. And… I guess I might think about how do we continue to carry forward our responsibility that sometimes we work in a very medicalized world, and I think even though we know all of this stuff, that sometimes clinical practice is still way behind the times. So how do we… we have a responsibility to know a little bit about what's going on, to know when we need to refer on to specialists, where we need to have a team! We need to have a team around these people, because it's just a joy to work with people in a joined-up way, in a collaborative way, with joint treatment goals… it's actually just *magical* for the rehabilitation process, I think, if that's not too strong a way of putting it.

Shabnam 33:25

No, I think many people would agree: it does feel a bit like magic. And for me, I just think it's a massive barrier: if we don't deal with the pain, how can we deal with anything else? Because it's so *there*, it's so present; it can be the experience that people have all the time, and I don't think – as someone who's never really experienced other than expected or normal levels of pain – I don't know if I would ever really know what it's like to feel chronic pain all the time. But I know when I have been in pain, it is literally all I can see! How, then, am I expected to layer on top: rehabilitation, dealing with professionals all the time, having care, when everything exacerbates that pain? I just… I'm lucky enough that whenever I've been in pain, I've been able to just stop and it'll go away because your basic paracetamol's going to work – on a very basic level. A couple of days, I get up and crack on again, or whatever: a day, or even hours later. I just think it almost needs to be right at the beginning of our journey in understanding our client, rather than right at the end, or at some point in the middle…

Romy 34:50

Yeah, and I know it can really vary when case managers actually get involved with people. Sometimes they've already been on this journey for quite a while, but I think we're lucky that we've worked with some amazing case managers who really recognized that this isn't like a last-ditch attempt: "Oh, no, we've tried everything else, now let's try this." It's actually right from the beginning: right, pain is really tricky. And we need to be working on this, not in a simplistic… you know, "Let's see if we can find the magic tablet that works." Chances are, that's actually not the case for most people.

Shabnam 35:26

No… Yeah, I take my hat off to those professionals who do refer to you, and get it, because whenever I talk to professionals, particularly those who specialize in pain and have an MDT setup, I just think, wow! I almost *want* to have a client with chronic pain, so I can refer on. For me, it's also helping me address the idea of *why* doesn't my client have pain, because actually they might be on a massive medley of drugs, including morphine, and the impact that has in their life means that they're not able to engage quite in the way that they want to: very sluggish, or they're tired, and actually, that's not pain management then, is it?

Romy 36:16

No, it's not, that's just 'existing' isn't it?

Shabnam 36:17

Existing! It's just *existing*. That's exactly right. And it's an opportunity, I think, to reassess the needs of clients in those positions, actually, into this other model, which might feel scary and uncomfortable. And I'm sure that there would be ways that you and your team would coach case managers and other professionals into sharing how to do that. In fact, I'm pretty sure you mentioned that you will be offering free webinars to the medico-legal personal injury world, to help us do that very thing: to talk to clients about pain, and how it can actually be treated, perhaps, differently.

Romy 37:02

Yeah, absolutely. And I think, in a podcast, you can kind of scratch the surface of some of these ideas. And I think we just thought it could be really useful if people would be interested in… just a free – maybe one-hour – webinar, where we just talk a little bit more about some of these ideas, and – crucially – try and give people some really tangible things that you can take away and say, at the end of that hour, I'm going to

have three, four or five things that I've got in my pocket that, when I'm working with these people with really difficult-to-manage pain, I can try out, I can put into action. That would be great. So, yeah, we're going to be doing that soon after this podcast goes live. So people can reach out if they want...

Shabnam 37:50

Sign me up!

Romy 37:53

Yeah, sign up and come along!

Shabnam 37:55

Yeah, absolutely. And I think it's a really generous thing to do. And I think it's really important, as well, because I know you are massively experienced, and your team is as well. So this is a real golden opportunity as far as I'm concerned. And my whole team will be signing up, by the way. Look out for a barrage of psychologists and case managers, signing up from PsychWorks and SBK Case Management! But no, if people want to get hold of you, Romy, how do people do that? Obviously, presumably, the details of this webinar will be on your website?

Romy 38:34

Yeah, so our website's www.retrainingpain.co.uk or you can reach out to us on info@retrainingpain.co.uk and obviously we will post some details on LinkedIn, too, when that's going to happen.

Shabnam 38:49

Yes, I know you hang out on LinkedIn and – well, I don't really do a lot of the other social media things that much – Instagram, Twitter… I'm learning!

Romy 39:02

No, me neither. Not much. LinkedIn's my home at the moment.

Shabnam 39:04

Yeah, that's definitely where I'm at. So okay, well, we will look out for that and definitely share, and all the rest of it. But for now, if I can say thank you so much, Romy Sherlock, for your time helping us retrain in pain a little bit.

Romy 39:22

Thank you for having me.

Shabnam 39:24

Not at all. And thank you to everyone who's been listening in, do the honours, if you don't mind, to like, comment, and share and we will see you at the next one. All right, bye for now!

39:45

Before you go: if you enjoyed the episode today, I'd really appreciate it if you could rate it on whatever platform you're listening on, and share and like on your social media profiles. Word of mouth is the best way for us to grow and to be a continuous resource for all. And if there's any topic you wish for us to cover, please drop us a line on our website. Thank you so much for all your support.

Guest: Dr Romy Sherlock, Director of Retraining Pain

Presenter: Dr Shabnam Berry-Khan, Director of PsychWorks Associates

Editor: Emily Crosby Media

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