Season Two, Episode 1: Linking trauma and pain, with Dr Melanie Lee and Dr Alan Bowman, of Trust Pain Management

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.

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So, welcome to today's episode! I'm Dr Shabnam Berry-Khan, and today's topic is a topic that I think will make a lot of sense to a lot of us out there. We are thinking about pain and its relationship with trauma, which I think is going to be an issue that a lot of us can relate to, with the personal injury work that we do with our clients. On a very simple level, trauma and pain have similar impacts on the nervous system, but I feel it as a psychologist and a case manager working in personal injury, I do know that it's far more complicated than that, and very, very complex and how it presents. And understanding and managing pain can be one of the single biggest game-changers for our clients, particularly those with chronic circumstances. So today, I just wanted to think a little further about that with two psychologists who do work specifically in pain: Dr Melanie Lee and Dr Alan Bowman. Hello, welcome to the podcast! Thank you so much for joining us.

Mel 1:34

Well, thank you very much for the invitation. It's good to talk about a topic that we talk about a lot, Alan, don't we?

Alan 1:41

We do, yeah. Very excited to be able to have the time today.

Shabnam 1:45

Yeah, well, I know that pain and trauma is something of real interest to you. So each of you, maybe you could just tell us a little bit about your journey into specializing in pain and trauma.

Mel 1:59

Yes, absolutely. So, this is Mel here. Hi, everybody. The journey for me began with a real interest in how all of these wonderful psychological theories that we learned at undergrad, and went on to specialize in clinical psychology and our doctorates, could be applied to situations that maybe weren't that immediately obvious. And for me that was in physical health settings: the idea that you could make somebody's life better, despite their significant injuries or other difficulties that they were experiencing. And as you've already alluded to, the complexity of that presentation often is something that doesn't have a straightforward answer. But, to me, the challenge of that, and where psychology and all of our related theories that we now understand about trauma can feed into that, was a real eye-opener. And when that was applied within the pain services that I started working in, the benefit of working within a team of individuals – so, as many people will be aware with NHS provision in particular, it's very common to have a

multidisciplinary, or (Alan can probably speak more to this) the concept of an *inter*disciplinary team that works very closely together, that all offer a different component part of the story to the help and recovery of the individual. And it was the working together that I learned so much from, and it was such a satisfying experience to be able to contribute in that way across a range of both one-to-one and group interventions. So, Alan, I don't know about your journey, because we met actually in the pain service, didn't we, in the Durham Chesley Street area? So Alan and I crossed over working in together in private practice since about 2018, ever since. It started with Trust Psychology, but with Alan and my our other colleagues' help, we've been developing a specific Trust Pain Management service that offers this interdisciplinary team with quite a different focus.

Shabnam 4:11

Yeah, Alan, tell me about you and how you've been involved. So you've been involved since 2018, with Trust Pain Management?

Alan 4:20

So, I actually met Mel in my very first job as a qualified psychologist. I'd recently qualified from my Clinical Psychology training and got a job in a local pain management service, which is where I met Mel. And I think the thing that really drew me to pain, first off, was an interest just through undergrad really, and learning a bit about the models and the theories. But then in practice, actually, it's an area that really makes you stretch your therapy muscles a lot. You have to draw on every single dimension of your Clinical Psychology training, and learn about how other professions work and work together in that team approach, really, that Mel has just mentioned. And that's just really rewarding. It's never a dull moment.

Mel 5:15

Definitely, and it's making me think as you're talking, Alan, that, I don't know about you, but I was actually warned off applying for my job in pain.

Alan 5:23

Yes, I was as well!

Mel 5:25

Were you? Because it's quite a common experience. And I don't know if you can speak to this Shabnam, with your colleagues, as well. But when it comes to the complexity of chronic pain in particular, and just the sheer distress of being with somebody that is an agony at various different points across their body, or across time, with seemingly no immediate solution, is an area that a lot of people found too difficult to want to spend a lot of time in, or were unsure about the direction. But as Alan's saying, it's the satisfaction of what you *can* offer, to what often feels a hopeless situation at the outset, makes it so rewarding.

Shabnam 6:07

That's really interesting. And yes, I can imagine that you would have to have a particular disposition to be able to support people with extreme and chronic pain presentations, for sure. So I can imagine that, yes, the fact that you went for it regardless, and are still working in it – and now working with people who have a personal injury... I mean, that to me, you talk about kind of working with others. I mean, that's the ultimate setting, in a way: personal injury is a is a very systemic… there's a big system around our clients.

Mel 6:43

Absolutely, there is. And so the need to be able to bring us a relationship understanding of these team dynamics, we found to be really important. And it is interesting, as you say, that there seems to be a certain type of person that gets drawn to this work. But we, Alan and I, seem to find that when we speak to colleagues or when people have joined our team, the ones that are passionate about the pain are really passionate, and the ones that don't want to work in that field or are specialists in other areas are quite clear in their desire not to work with pain. So it really is owning where your interest in that comes from. And there's a point I wonder if a lot of case managers and solicitors might be able to relate to: that when you're with someone in pain, because it's such an unbearable experience for everybody, it is very tempting to turn away from it, or jump to a conclusion or solution very quickly, get treatment underway… because we hate seeing people in that much distress. And every single one of us has been in acute pain. And I think this statistics are, from certain levels of auditing, about 30% of men and 37% of women across England, experience persistent, chronic pain. But it's a very common problem that people put up with, particularly if you think about neck and back injuries or headaches… And we know enough now; the therapies are there; the team working is there to really make a difference and alleviate that suffering. But you have to, as a clinician, be prepared to sit with pain and be in touch, I have to say, with your own level of pain – be that the combination of the psychological and the physical, and the spiritual and the social elements to that…

Shabnam 8:44

A holistic approach, for sure.

Mel 8:46

Yeah, because to be able to do that is to offer the client the greatest part of yourself, as well, and to be able to acknowledge and validate is such an important first step in that relationship-building phase.

Shabnam 9:00

Absolutely. And coming back to that statistic: I'm blown away by that. 30-ish, 35% on average of the general public experience chronic pain, or is that personal injury, specifically?

Mel 9:15

No, it is more of a general population statistic. This comes from a study from Bridges in 2011, suggesting that in England, when they do a survey, 14 million people report some level of persistent pain. Now, we have to think about what that means, because the definition of chronic pain can vary, but it tends to be a pain that, once the initial injury has healed, is still causing significant suffering at least 12 weeks after the injury has been sustained. And the healing you would have hoped would have led to a level of biological improvement by that point. Alan, you might be able to chip in there about the definition of pain.

Alan 9:57

Yeah, I think the International Association of the Study of Pain have got a fairly recent definition that speaks to what you've said there, Mel, but includes this idea of it's kind of existential, in a way, as well. It includes some aspect of existential threat, and the person can't perform or do what they maybe did in the past, in some ways. The 30% number is perhaps an underestimate, as well. I think it's probably bigger than that. I know there has been some data in recent years that suggests up to half of the UK population experience long-term pain. And if we look at personal injury or traumatic injury in particular, there's some data from Canada – so, over the water, but suggesting that about 15% of people who have a traumatic injury will go on to develop chronic pain. So if we think of it like that, in terms of, what case managers might be dealing with in their career, they're going to encounter this at some point.

Shabnam 11:03

That's so interesting, because you're right, personal injury: there has been a trauma. That's the reason people are in the situations that they are in. And, clearly, there is a big link between trauma and pain. In the introduction, I suggested that the nervous system responds similarly. As a pain expert, as you both are, is that true? Is that a mechanism by which pain and trauma can respond similarly?

Alan 11:40

How long have you got?

Shabnam 11:44

Yeah, silly question to ask experts, in some ways, when we're on a time budget!

Mel 11:49

Yeah, Alan might want to jump in here as well, but what it makes me think about as we're talking about these statistics of pain is we're making some assumptions here, aren't we? When surveys like this are undertaken, and people talk about pain, our automatic reaction, for the vast majority of us, is to think of that as a sensation in the body that hurts. Now, even when you think about that in relation to movement that hurts, emotional pain, or pain that has been triggered by a perceived threat or difficulty within our relationships or social context, equally hurts. I mean, who has not been in a place of heartache, or grief, when you feel like your stomach has been ripped apart? Or you're so overwhelmed by stress that your head is exploding? We talk about this in our general vernacular, don't we: that he or she is a 'pain in the neck' or something else just 'getting on my back'. So the tendency that we have to split the physical and the mental is actually a problem in treatment of pain, because we need to look at it so much more holistically. And why an integrated team working together have real expertise and being able to apply a different lens of understanding to what the client is saying and feeling, and what their movements and body language and facial expressions show, as well. But going back to that question of trauma, we do know the fundamental impact on the brain and the nervous system, that trauma – when we talk about trauma, we're talking about any significant event that brings perceived harm to an individual. Now, that could be a car accident, from a personal injury perspective. But all of us have had moments in time in relationships, or in early life experiences, where we've experienced something very distressing within the context of a relationship. And for us to feel full, integrated individuals, we have to feel safe and connection with others. And we know that trauma fundamentally disrupts that safety. So the parts of the brain that detect threat and danger – because, of course, we're designed to survive, and we're designed that our nervous system has to pay incredibly close attention to anything that might threaten the system – then due to that perceived threat, the signals coming into us will be interpreted through those lenses. Hence why the more trauma that we've had, the perception will shift in what's coming in now is whether this is a threat that needs to be actioned upon. And, as you said, personal injury and accidents are traumas in and of themselves. So at this moment in time, the pain that's coming from my back, or leg, or arm is a threat to my system and my sense of safety and ability to be who I want to be in the world. Therefore, that is going to hurt on multiple levels.

Shabnam 14:57

And that's different to psychosomaticism, or is that technically the same thing?

Alan 15:03

It's a really good question. Because if you think about how people come to have chronic pain, you know, for some people, there might be a really clear-cut explanation. They might have been in an accident where

they have nerve damage, and they've got neuropathic pain. And that answer is really clear. Or somebody who might have a diagnosis of let's say, rheumatoid arthritis, and they've got chronic pain related to that. So that's very clear-cut. But there is a big chunk of people who don't have the luxury of that clear answer. So they might have chronic pain, but they're not quite sure why, and the tests, or the scans, the assessments don't show things that show physical changes to the body. So there is, if you think of it in DSM-5 terms – which I know as psychologists… well I steer away from a little bit, in terms of pigeonholing people – but things like *somatic symptom disorder* come to mind, where there are physical symptoms, but they don't have that kind of medical diagnostic evidence underpinning them. I think we could spend another podcast just talking about that, but I think it comes back to trauma, in my mind, and this idea: actually, trauma is not a psychological thing. It's not a biological thing. It's both. If we think about even down the immune level, people who've had significant trauma, their immune system can change its behaviour. So there's just so many things that are mind and body, and they're both: they're not one or the other. And I think that's true for all chronic pain presentations, however they've ended up getting it.

Mel 17:00

You're raising such an important point, Alan, about pain in general, because it's possible for us to think about pain in the context of trauma. But there was a fantastic article called 'The Psychology of Pain', written by a psychologist that a lot of the audience may have heard of before called Stephen Morley, based in Leeds around… I think it was 2008 time, where he just talks about the normal reaction that a person who experiences acute pain will have – and of course, we talked about how that can go on to develop to be chronic pain. But effectively, he had a really interesting theory that there are three main problems that pain causes to human beings. The first is that it interrupts what you do. So all of us have had a niggle for a few days, or a more significant injury that's lasted a long time, that may have fully resolved or maybe partially resolved, or they're still living with. We know that it interrupts what you're doing on a day-to-day basis. So you're in the middle of a task or an activity, or your attention's on something, and you cannot complete what you're doing. Because pain interrupts that attentional process. And because pain comes from that point of threat to the system, we have no choice but to attend to it. These ideas that you can distract yourself from pain are really not thinking about the primary need that the brain has to attend to this level of threat. Now, you can absolutely turn that volume down. And there's ways that you can retrain the system. However, it's not just a case of simple distraction. The second point that Morley made was that pain interferes: so as well as interrupting, you then can't plan for things. You can't make the usual social events, attendance, or be clear with your boss at work about how this is going to impact upon you, because it interferes with the usual activities and routines. And that really shifts things for most people. And then the third point he made is that it changes our identity. And for a lot of clients with chronic pain – I'd be interested in Alan's thoughts on this – but it's the identity shifts that we do a lot of the work with, in terms of readjusting back to what feels useful and purposeful in life, what activities are meaningful again. So pain interrupts, it interferes and it changes who you believe you are. You move from a place of "I am a productive worker in society," or "I'm a busy mother, or an active father," to "That is not who I am anymore." And that's a real catastrophic situation for psychological wellbeing and needs a lot of careful thinking-through. And that's not even when you're thinking about this becoming chronic: that's just in response to pain in general.

Alan 19:55

Yeah. That last point, Mel, about the identity, is just such an important one, I think, to really hold in mind: that when somebody is managing long-term pain, and particularly in a case management context, I guess, if they're going through a legal process as well, everything becomes about their symptoms, sometimes. You know, they're dealing with the pain every day, maybe medication, maybe interventions from a team like us, maybe a litigation process, and emails from a solicitor. And I hear this a lot in the early stages of work: you know, "I feel like I've lost myself, I don't feel like me, everything is about this pain." And I think some of the best outcomes, and it's the area that I find the most rewarding, really, to see happen in therapy work, is when the person feels like them again. And that that might involve some grieving for some stuff that they

have lost. Or it might involve reclaiming areas of their life that they thought they'd lost, but maybe they can get back in some way. But just as important is the growth area, and actually, what can I do that's completely new, that is still true to my values?

Shabnam 21:10

That's really interesting. And I think from a case management perspective, that can be one of the trickiest areas to think about: Who are you now? And how can we work with this extra part of you that has developed as a result of this injury?

Mel 21:28

This raises such an important point about treatment focus and the role of formulation, which I think you may have spoken about before in your podcasting, Shabnam. About the role of formulation from a psychology perspective, in coming up with the answers to the questions about: how did this start?; what's maintaining it?; what's being a predisposing factor, or a protective factor here? If we do our comprehensive assessments, and that's so much easier to do when you've got a team around you that are focusing on different elements about presentation, as well, and you really hear the impact on the life of the client's story and what's happened since – and before – their injury that's led to the pain difficulties, then the formulation can help drive the treatment protocol and goals, because you're identifying not only what is possible here, or what's the priority to this individual – and it's going to be individual for everybody; every formulation is bespoke, of course – but we're also then focusing on and naming, from the very beginning: what's going to make this challenging for you?; what are the barriers? And one thing we can absolutely speak to is that previous traumas, or situations where the injury itself has *been* a trauma, that in itself will create a certain level of barriers in the mind, and in the body, that need looking at. And we need to remember that some of the interventions that seem to be the case for a pain service to offer might be quite surprising to some solicitors and case managers, when we think about a lot of the focus of the work, particularly when you bring in occupational therapy roles and physiotherapy roles, is about changing as much of the sensation and volume of the pain as you possibly can, through the right combination of fatigue and sleep management, of all of the symptomology and getting the medication balance right… but also looking at the wider impact. So there's lots of relationship working, activity-building… Sometimes the biggest change I've seen in people was when they start communicating really effectively with their family members. And you wouldn't automatically – well, I wouldn't anyway have thought this when I started working in pain – that some of the things that make the biggest difference are not direct manipulation of the physical sensations. It's speaks to the biopsychosocial model, doesn't it? And looking at it in the context of what that person needs at this point in their life.

Shabnam 24:04

Yes, definitely. And, ultimately, no one clinician will be able to effectively address this issue for our clients. So what are the strategies, then? What should we as personal injury professionals be looking at, if we're thinking about it being multifaceted, we're talking about the mind/body connect, rather than a divide? So it's not looking at it as a mental/emotional thing, or a physical thing. We're talking about something that is *real*. It's not malingering… these are real symptoms, that people truly feel. But unless we tackle it and manage it well, we are left, potentially, with someone who is going to continue to struggle in their life. And that's the exact opposite of what we're trying to achieve, of course, for our clients.

Mel 25:06

Absolutely, isn't it? And I think you're speaking to something really important about how – we hear this all the time – how people are made to feel, once they've reached the point of actually getting the treatment through, say, a medico-legal claim. There have been so many different places that people may have gone

to, or mixed messages – and that's not necessarily been done deliberately, of course. People might be going to different specialists to get their own opinion on what's needed for where their injury or pain is at that point in time. But we see it time and time again, that it's not coordinated care. And, because the services are so overwhelmed and busy, that they will do what they need to do for that particular client in that particular outpatient appointment, for example. And there may be letters and correspondence sent across, but really who's holding the bigger picture? And, again, going back to understanding what the client needs at this point in time – so, I'm sure Alan can come up with some other focused ideas – but the number one priority, it feels, when getting to know somebody who's been referred to our service, is *acknowledgement* of what they've been through, and giving time and space to hearing the details of what their narrative and understanding is. Because by hearing that, and asking appropriate follow-up questions, and there's a lot more clarifying needed, or we can often jump to assumptions as clinicians that "Well, okay, this part of you hurts, we can go on and ask the next question now. But there's a huge amount of detail needed around how and when that injury shows up. I spoke to a client just yesterday that said: "One day is so different to the next, it's so hard to give an average picture. And ask me to fill out this questionnaire one day, and I'll give you a different answer on the next day." So acknowledgement and validation is something that we can mention as throw-away concepts as clinicians, because we all hope that we do it extremely well. But to really validate, we need to look someone in the eye and have an appropriate response in terms of the facial expression that mirrors that level of hurt, to feel that "You've really got where I'm coming from here." And then to feed back and have these reflective summaries. So, starting from that pace of acknowledgement and validation. The amount of times that someone has come through a pain programme, and said, "I just felt listened to, understood and believed, and then we could start doing the work. But that was such a big part of it."

Alan 27:53

Yeah, I totally agree with that, Mel. I think there's something about the legitimacy of someone's pain, the validation of their pain. And I wonder, Shabnam, you might have some thoughts on this, too. But just in the the personal injury domain, there is that adversarialism, isn't there about: What's the person's injuries? What's the extent of the damage? And can there be some minimization of that happen in the system?

Shabnam 28:22

Yes, absolutely. And having the evidence for that, and having something that we can pin the symptoms and the experiences of our clients on, is just so important… and sometimes really absent: it's really hard to know what that is. But it sounds like you guys have got a potential answer to that conundrum, when you talk about formulation; when you talk about, well, you say *multi*disciplinary, but you've also used the term *inter*disciplinary, and I feel like you're going to tell me what the difference is! Am I on the right lines? Am I am I thinking that this is Trust Pain Management's answer to some of these issues that we face?

Alan 29:10

Yeah, it's interesting. You might hear those two words and think, well, it's just semantics, really, it's all teamwork. But it's more than that, I think. And I do feel quite passionately about this. You know, we all hear the term MDT, don't we? I'm sure we're all familiar with it, this idea of a multidisciplinary team. But one of the big names in in pain management, Dennis Turk, talks about this. This was back in the '80s, actually, but it's still being talked about today. This idea that actually an MDT isn't necessarily the most effective set-up for a team in the context of pain management. And when he talks about an MDT he refers to this idea of all the professionals involved in a person's care; yes, be under one roof, but despite that being disconnected, either in their philosophy of care, or their beliefs about what causes pain, or how they intervene, or how they communicate, if at all they do. And actually, this alternative model of interdisciplinary teams is discussed. And in this kind of team, yes, we're all under one roof – or maybe not in a pandemic: we're all on Zoom. But we share a coherent set of beliefs about what pain is, how to help it; we trust each other, because we know each other and work together well; we know where the boundaries

of each other's work are, and we're not afraid to challenge each other, either. And when you have that, you have a much more joined-up experience for everybody, on both sides of the clinical encounter. And the client gets better treatment. They feel held, they feel listened to; they don't feel passed from pillar to post, which is one of the biggest complaints I hear from patients for the NHS. You know, who've got many long-term health problems: I've been to see a GP, I've been to see a consultant, I've been to see a specialist, and they're all from different places, and no one's holding the thread.

Mel 31:26

That's such an important point, actually. If I think back to the sort of the team cases that we've done to date, there's something so lovely about being… it's hard as a clinician working with complexity, of course, isn't it? We get to places in our own therapeutic interactions where you can feel the frustration and the agony that the client's feeling, and you want to make it better, and rescue as soon as you can. But you know that there are steps to that process. So to have one another to communicate with and pass information to and fro in an informed-consent, flowing way, so the client knows, when they've told you, that it *will* be passed on to the physiotherapist for the next appointment, for example. Or the times when we do co-joint-working appointments as part of our pain interventions, you're giving the same messages from two different perspectives, often. And it's really helpful, we've heard from our physio and OT colleagues, to pick up on a relational aspect of the interaction, such as the explaining of the core pain management principle, perhaps, but that doesn't get followed through on. And there's a way, by having a psychologist as a core part of that team, that that can be understood and – better yet – predicted from the outset, because we've got good formulation. So, with a particular client I've got in mind now, the importance of the ending was absolutely crucial. But because we were aware of that, and this client's history from the beginning, we were able to feed that into the various points of review during the treatment. And this goes back to what Alan was saying about processing losses. One really key principle I'd recommend to case managers and solicitors working with clients with chronic pain, is to have some very good explicit discussions about expectations, and talk about what the ending of a particular period of input should mean, or may involve. Because we can have some very understandable but unrealistic expectations. And this goes back to core early life experiences, as well: you just want someone to make it all better for you! Of course you do!

Shabnam 33:38

I'm thinking attachment, as well.

Mel 33:42

Oh, all attachment! And we're not even starting to think about how our own parents reacted to pain, or to health problems. It might be that pain has such resonance in someone's life if it was part of a parent's presentation, for example. Did you get told to "get on with it" as a child? Were you taken to hospital? Were you given medication? All of that will feed into what you believe should happen with your care and treatment in the here and now. So, to be able to pre-empt the fact that we're not going to be pain-free at the end of treatment, because nobody is pain-free: we all will have situations in life where we will encounter niggles of pains or aches again, but what we do is understand and allow the body and mind to talk to one another, hear what the body's communication is through that pain and respond to that need appropriately. And Alan and I and the team have been having discussions more recently about: how do you ensure that follow-up care happens into the community? Because that was often the problem that we experienced in NHS services: that even if someone had had quite an intense period of input, it would come to an end, and if that hasn't been discussed and pre-empted, people can feel very lost and left again. Because the pain might be better, but it's certainly not gone away, and other aspects of their life are still no better. So, thinking about how you can keep connections going, update and maintain improvements… That's all to be thought about at relapse prevention follow-up stage.

Shabnam 35:22

That's really interesting. And it's really interesting that how you've described managing expectations actually, interestingly, mirrors sometimes the litigation process of how it can feel. A lot of our clients describe feeling like they're just left out into effectively sort of living 'real life,' or living life now without litigation, and how abandoning that can often feel. And I'm just thinking, if trauma is linked to pain, as you've described it, then surely, actually, that's something that can link in with the concept of not actually being pain-free in the future. But it's about trying to think about all the different factors that can contribute to being in a better position than you would have been otherwise.

Mel 36:12

Yeah, absolutely. And moving towards a place of health and wellbeing, which is about connection and integration and just trying to repair the potential damage that has been caused from fragmentation. So, one of the key findings from a lot of the trauma research, and the way that the therapies have developed, is at the point of trauma, the right and left hemisphere stop talking to each other: we remember the sensations and the feelings attached to what happened, but we maybe don't have the language for it. So there's a huge amount of narrative and meaning-making needed. And you have to respect the fact that everyone's interpretation and the meaning of their pain will be individual to them. And I think, as clinicians, because we maybe have heard about injuries before, we can be quite quick to jump in. So giving the person that time to really explain how it affects them… and again, going back to core basics with, although we're talking about very complex situations, sometimes focusing on the necessities of life, like: let's just get you sleeping well, first; let's just think about, do you really need to be walking up that flight of stairs every day, or doing school the pickup when nobody else is helping you, let's really look at what's going to make a biggest difference to your life immediately, that will just ease things, before we get into something more historical, deep. I think *episodes of care* are important to think about here, and that's why a really comprehensive, thorough assessment process is needed. Because Alan was talking earlier with me about sometimes the thorough examination with some clients is really missed, until much further down the line.

Shabnam 38:02

Yeah. It's interesting how amongst my colleagues, I'm not sure that pain and trauma – and I know I'm coming from a psychological perspective – is as well recognized, or as deeply recognized as they should be, given the the impact it can have on people's lives. I think that there can be a bit more of a focus on maybe the more practical physical progress and advances that people can make. And that often doesn't result in the outcomes that people are wanting, because it's seen in quite a uni-faceted way, in a sort of single-discipline sort of way. I think it may be something to do with not really understanding what it is that is the pain, what it is that's going to fix it. A bit like what you were saying earlier, it is quite hard to sit with all of that, because it's unclear what to do with it. And the same with trauma, actually, as well. So it almost is a double overseen issue, if you like, that feeds into each other, resulting in quite a lot to have to deal with. But it just feels almost safer to just focus on something that is more physical, something that is more, I suppose, friendly to litigation, if you will.

Alan 39:29

That's so interesting, Shabnam, and it makes me think of this cognitive bias referred to as 'commission bias' where we feel like we've got to give somebody something, or there's this idea of – I think it's called 'gift exchange theory' – where your client comes to us, and the gift they give is their attention and commitment to the clinical encounter. But then we're left on the other side of that interaction, but what gift do we give? And, you know, if it's heart surgery, then the surgeon can give the gift of fixing the heart valves, or whatever it may be. But in chronic pain, it's a much more difficult thing to do. And I think it's understandable, and I've seen it a lot in my time, where a clinician will revert to the concrete and revert to

the practical, because that feels like a gift they can give. Oh, well, you've turned up; you've showed up, you're committed, and I can give you this drug, or I can give you this set of exercises. I'm not dismissing those particular things, because they are part of it for many people. But I think we need to get – across the board, you know: as psychologists, case managers, visual therapists, GPs, everybody – we need to get more comfortable with the uncertainty that chronic pain brings.

Shabnam 40:46

Yeah, and is that what you do at Trust Pain Management? That's obviously something that you have built into the model that you use. Tell us a little bit about how you do things that Trust.

Mel 40:59

Yeah, absolutely. So, what – as you were talking there, as well – I was thinking about is there are things that we know help pain management in general. So as soon as you can get that information across, that can be really important. So these might be things people have heard about in general. So we often talk about it with 'the four Ps'. And this can be part of a lot of group pain management programmes that people might be familiar with in NHS settings. If people, at the end of their chronic pain treatment journey, are *pacing* themselves, are having appropriate rest periods – doing what their body can tolerate, but resting in between, or meeting the needs as they're listening to it, and they're *prioritizing* what matters to them (and this is where Alan's got a lot of experience in the Acceptance and Commitment Therapy, and I know some of your previous podcasts, Shabnam, talked about ACT a lot). I do some ACT work but I'm also in Cognitive Analytic Therapy territory, and love looking at the mapping processes of what's happening in the room, as well, and the influence of the past on the present. But the prioritizing based on your values, and what's meaningful, being able to *plan* activities: just pre-think through. And have had that really excellent communication with others around you. So much can be achieved just from these really quite straightforward concepts, including the idea of the core ability to just say what you need, and ask for help from others and get that support, because so many of us are ashamed to do that. And shame is a very debilitating emotion, that will mean that we will not ask for help: because I *should* be able to change my bed without hurting my back, or I *should* be able to drive the car without getting a crick in my neck or it really aggravating stuff. So to be able to help people get to those strategies, and there is a lot of really helpful information out there – I'm thinking off the top of my head about the Pain Toolkitm and the work of Peter Moore, that Alan's been in contact with. There's a lot of resources online, and that, that case managers and solicitors and other professionals can point clients in the direction of that can get them a long way there: there are these generic strategies that can make a difference. Where I feel Trust Pain Management can really make a difference is when case managers have tried those strategies, or have suggested things, but the blocks, or the barriers or the difficulties seem to be really insurmountable. What that is speaking to is there's some unnamed process, or there's sort of a repeating pattern happening in the dynamic there, that's not being addressed. And that's something that we can certainly assess for and bring in, through making sure that the assessment process… because our model, as it works currently, is when we do our initial assessments, we have the physiotherapist, the occupational therapist, and the psychologist together. When that's possible, with face-to-face, we will do so, but also on Zoom: the idea of having multiple eyes and and hearing the story from different perspectives, is crucial. And then once that report, and the recommendations have been made on what we've heard from the initial assessment, we share that with the client and make sure that that narrative is consistent with what they understand it to be, and that they put their voice heard throughout the way that the report is written, then we're able to offer something bespoke to their needs. We've almost got a lot of strategies that work very well: a menu of options that classic pain management programmes are able to deliver. But the difference being it's formulation-driven, so we will decide with the clients what they would like to prioritise and why, and be able to name early on where we might get into challenges or difficulties, and promote a certain order of things. And the greater the complexity, the more it is that we're going to have to work on relationship- and trust-building before we can look at technique delivery.

Shabnam 45:10

And presumably you get referrals, obviously, from personal injury referrers, case managers, solicitors and clients themselves, I guess?

Mel 45:19

That's right, Shabnam, we get a variety of different referral routes in. One question, though, I think you were alluding to when we had a conversation earlier, as well, is it can be very difficult for case managers and solicitors to know exactly when a referral is appropriate. And particularly in our NHS experiences, it would be often the case that someone would have been around a lot of different services, and we would see someone at the end of their journey, which is a real tragedy, given how much you can help earlier on. So don't be afraid, as a case manager or a solicitor, to reach out at a very early point. If there are indications that treatment is not indicated at a particular point in time, we can certainly feed that back. But often, if the initial needs assessment is done, and there's an indication that an injury has happened, but might develop into a chronic condition, then we might be able to pre-empt that to a certain degree by giving the right support earlier on. So we would always encourage people to reach out to us just to explore why something's not working, as well. We're very happy to give some case consultation or some training, just to think in general about the approaches and how and when to refer.

Shabnam 46:33

Well, you've probably bridged very nicely onto the question that I ask everyone who guests on the show: three practical things for case managers, solicitors to use in their practice. I guess early intervention – what you've just said is part of that.

Alan 46:52

If I could say one thing it would be to try and unhook from this idea that it's the brain *or* the body, because it's both: pain is a biopsychosocial thing. So to have this dichotomous, black-and-white view, of: well, is it a physical illness? Or is it psychosomatic? It's getting really old hat, that, and quite old-fashioned. And I think if people can start to think about how, actually, these two things are part of the same whole, and we need to support people in a really integrative, holistic way – which case managers are front and centre of, aren't they, because they have to consider the whole client? That will be my request and tip, really, to throw out the black-and-white thinking and acknowledge with the client, that it's both.

Mel 47:41

Yeah. And from a very practical point of view, I think, going back to that point about validation and acknowledgement, it's very easy to hear someone say they hurt and go, "Oh, that's a shame for you," and then move on to the next question. I would really recommend that when you're… especially when you're first engaging with somebody, really connecting with them on the *meaning* of the pain, because we need to be honest with ourselves: a lot of our turning away is because a client's description of their pain is actually very triggering to ourselves. So the other huge benefit of working in a team is if anything is triggering, or if – as Alan said – we can challenge one another, if something is happening, then we're able to catch it and think about what we might need in terms of our own self-care. Because I've seen it, unfortunately, happen in different team scenarios when things get played out, within the system, that is really unfortunate, but it's often just missed, because it's not seen or understood. So, you've really got to just give someone the space, look them in the eye, and to know, and remember the last time you were really hurting, how that felt. And just give that space and time to connect: the person will then move on to the next part of their story when they're ready to. But going back to that idea of being aware that pain interrupts and interferes and changes identity, people are dealing with this multiple times an hour, multiple times a day: it doesn't go away; it's a

constant demander of attention, pain. So it's utterly exhausting. And back to that point of addressing expectations from the beginning, as well, that's such a useful thing to be able to do.

Alan 49:30

Yeah. Mel, you just triggered a thought there that I think just really hit home in terms of what you're saying there: that it is exhausting, isn't it, being in long-term pain? And I'm aware... I've seen this recently, with the medico-legal process, obviously, there's often lengthy meetings or discussions needed with the client there. And I just think, really practically on the ground, being aware of that, making sure that the client has a chance to take breaks and that the duration of these meetings is thought about, where possible. It can be little things like that that can make a big difference.

Shabnam 50:07

Definitely.

Mel 50:08

That's such a good point, Alan. Just to acknowledge to the client: is there anything that you need for this duration? It might be that people need to take medication at a particular point in time, or need to use the bathroom. And just being held in mind is so important, isn't it? That I have not forgotten throughout this that actually, even as we're meeting, you might need to change posture or position in the chair, because that is setting things off for you. And people are overly polite in these meetings, aren't they? Someone will sit through pain rather than say, “Sorry, I need to stand up and move.” So giving permission for that early on is something we do a lot of, particularly in the kind of assessment and therapy processes.

Shabnam 50:46

Amazing, amazing. And I suppose when you overlay the context of – again – litigation, barristers, solicitors, lots of people in the room, possibly everyone looking at you… despite that, how easy it can be to forget the needs of the client! It becomes a sort of theoretical concept, and they're right there in front of you! It's quite something, as a case manager, I’ve found, to be able to say – that concept of permission-giving, but you can see how it links. Remind me what the four Ps are?

Mel 51:21

Pacing, planning, prioritizing…

Alan 51:29

Is it preparing?

Shabnam 51:35

You mentioned three before. I was thinking: What was the fourth one? Did I miss it?

Mel 51:40

No, I think you're absolutely right. What we used to do in our pain unit, actually, was call it… I’ve not helped myself by calling it the four. It's the three Ps: the pacing, planning, prioritizing. And the fourth P, often I would add, as a CAT therapist, is the *process* and really thinking about… as well as, obviously the *pain* and

thinking about *practical* things that you can do. The process, going back to what you said about the influence of attachment, the way that people move speaks a lot to what is happening internally. So, just to be curious about that. And the transference, I know that's an interesting term. But what we mean by that in such psychotherapeutic terms is the way that you can be left feeling when working with somebody, when you're picking up on what's going on internally for them, can be very physical with chronic pain. So it could be paying attention to your own stomach churning, neck and head tension… Or if you're in pain yourself that day, how that's going to influence the interaction. It's a very interesting thing to be able to debrief and have supervision on.

Shabnam 52:43

And fatigue levels, I think.

Mel 52:45

Oh, yeah, yeah. Again, it's just making me think of very practical things about concentration and attention ability. Just to be able to say to someone, like, have we written down the next appointment date? Or what are you holding in mind at the end of this meeting that you'd like to be able to do? Just being very mindful of what's going in, because I say to a lot of clients that whatever percentage of your attention and brain capacity has actually been taken up by your brain screaming at you to attend to this signal of pain, there's very little left there. Now, mindfulness and various other things can do wonders in terms of creating some additional capacity, by actually attending to the sensation and coming back to your breath. So there's definite things that can be done. But just, again, that permission giving: of course this is going to be difficult for you, so let's think about how we can help facilitate that and offer some foundation structure.

Shabnam 53:47

Well, if I'm not mistaken, you haven't given me three practical steps. I think you've given me seven. Well done! This is an example of "bigger than the sum of our parts."

Mel 54:01

Oh, Shabnam, this is fantastic. You're absolutely right. It's the integration, isn't it, of multiple minds and thoughts coming together? A lovely illustration.

Shabnam 54:13

Yeah, I'm so grateful to you for being able to share some of your thoughts, some of the ideas behind the model that you use, that you've developed, and some strategies, of course, for our listeners to take away with them. If people want to contact you, how can they do it? How do we get hold of Trust Pain Management service? Or you individually, each?

Mel 54:38

You are absolutely welcome to contact us via our website, and we've got a direct phone number of **0191 5805870**, which our administrator Catherine monitors. We are in the process of rebranding and developing our website. So watch this space for some interesting, exciting developments on the horizon. But info@trust-pain-management.co.uk gets directly to Catherine, or you can come through our sister company of Trust Psychology. We do a lot of medico-legal work there too. But the pain division is particularly for this team approach that we've been illustrating today. So, you can get direct contact with myself and Alan but I'm on melanie.lee@trustpsychology.co.uk. And we're on LinkedIn now, and we'll be doing some more posting there. That's a good place to connect with people.

Shabnam 55:39

Ooh, yes! I was going to ask about your social media presence. But LinkedIn is a good place to be for personal injury. Ah, brilliant! And, Dr Melanie Lee, Dr Alan Bowman, thank you so much for your time, for your insights, and your thoughts around two – but one in particular: pain – very crucial aspects of our clients' experiences. So, should anyone need to contact you, we know how to do that. But for now, thank you so much for your time, and we will see you next time. Bye-bye for now!

Mel and Alan 56:16

Thanks, Shabnam! Bye!

56:23

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.

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