GUESTEDITORIAL

Pain: a gift that nobody wants

To MD **To neuroscientist**
To patient **To therapist**

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Five years ago, I read this book written by Dr **Paul Brand** and Philip Yancey. Dr Brand's insight on pain and pain management and his amazing experience as a pioneer leprosy surgeon inspired me greatly in my practice. Pain, that used to be a totally negative concept in my mind, became a more neutral word. Pain defines and protects our existence. In this sense, it really is a gift, but unfortunately, nobody wants it.

Today, I am currently attending a Somatosensory Rehabilitation Method (SRM) class that discusses neuropathic pain, namely, hypoaesthesia, allodynia, and the notorious Complex Regional Pain Syndrome (CRPS). Are they still gifts for us? Should we accept them? Troubled by the mysterious cases of some patients, I am here trying **to find the answer**.

In the first two days, the instructor, Eva Létourneau, guided us to build the bases of SRM. On the third morning, I entered the class, hoping that the founder of this approach, Claude J Spicher, would guide me until I found the answers of those tough cases. Surprisingly, he started the class by challenging us to think about **how we would identify ourselves**, and our patients as well.

How should I identify myself? I was a journalist in China, and now I am an Occupational Therapist (OT) in Quebec, Canada. Fifteen years ago, facing the changing era, all I could do was recording the stories of my interviewees. For my people, pain is not a strange thing, be it physical or psychosocial. Our approach for pain management is **to endure** and accept it, certainly, not as a gift. However, pain and pain management have never been common topics in our daily lives. A painkiller is rarely something that you can find in an office drawer or in a purse.

Moving to Canada, I became an OT in a **totally different culture**. Although pain is the word I speak and hear most often in my daily work, I still am amazed at the different ways people deal with pain, such as when my Canadian colleague approached me to ask if I have painkillers. For her, pain is something she needs to get rid of immediately by medication; for me, pain is something I should bear or expect it to go away. Her approach is active passive; mine, passive passive. One common point: we are all passive. We do *NOT* see pain as a desirable gift.

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Pain is an experience, also a culture, in another sense. We use different terminology to define pain. For certain cultures, there may not be as many specific words to describe pain as the English terms in the McGill pain questionnaire. To be honest, as a native Chinese Mandarin speaker who graduated from the program of Chinese literature and journalism, I find it difficult to translate these terms into Chinese. This cultural difference, combined with personal experience, made the evaluation of pain almost an impossible mission. Quite often, in the clinic setting, the frustration of not well understanding patients'pain leads therapists to a quantitative approach: it is enough to use a scale of one to ten to define the patients'pain. We can all agree that your one is not the same as mine, but in reality, we tend to ignore the difference in order to simplify the situation. The results: sometimes it worked; sometimes, patients argued with us: "But I have no pain, I have numbness"; "The pain is at 3 out of 10, but burning is 10 out of 10". At that moment, as a therapist, I was intrigued: "Are we talking about the same thing?", "How should I evaluate and treat the seemingly indiscernible, untraceable and indescribable pain?" With all these questions, I continued to search the answers in the literature. Eventually, this search brought me into the SRM class (**Fig. 1**).

Figure 1: the thirty participants from nine countries. In the Centre, Eva Létourneau, instructor.

Thirty therapists from Canada and Europe, some excited, some puzzled or even doubting, sat in the class with me. There are also over one thousand other therapists from all over the world being trained for this same approach along with many more to come. Certainly, we brought the

baggage of different cultures and personal experiences; but the same topic connected us: neuropathic pain. Eva came from the same context as most of us: an OT in Quebec Canada. Her challenges, we all had and still have; her experience, offers us inspiration and encouragement. Her teaching style is a typical American way, very structural. Brick by brick, she built the foundation, and led us into the SRM area. Her teaching style is more like a **coach**: she questioned, inquired, re-questioned, and exhorted us to find the solution. After two days of class, our confidence was boosted up. We couldn't wait to try the new approach with our patients. But, hold on, the reality is not that simple. When Claude joined the class on the third day, he hammered our trust badly. It seems that all these just clarified pictures became a bit confusing again. His background in both practice and research made him a professor practitioner: not only did he know how to do, but also the reason to do it. His humble attitude reminds me of what Confucian said: "*If you know, recognize that you know; if you don't know, realize that you don't know. This is knowledge"*. The remarks he made often prompted us to brainstorm in order to find an optimal solution. This process of reflection involves not only specific symptoms of the patient and their evolution but also **the person as a distinctive being** with special inheritance of culture, family, and religion. The way in which Claude and Eva insisted on how important it is to respect the patients' expression in relation to the symptoms, to the extent that the therapist should be able to say the word the patient uses to describe the pain in his/her mother language, emphasizes the critical part of the evaluation of pain for SRM approach. This is to have consensus at the stopping level to avoid triggering the pain.

So what is the approach? As Claude mentioned in the *Handbook for Somatosensory Rehabilitation*, it deals with disorders of the cutaneous sense. The first thing to start the approach is always to reach an agreement with the patient in order to enable him to know when to stop, either during the evaluation, or in the treatment program. The theoretical basis, to put it in a simple way, begins with the SRM motto: "Look for tactile hypoesthesia, because by decreasing hypoesthesia, neuropathic pain decreases". Claude and Eva presented many existing research literatures to establish their biological basis, **adaptive neuroplasticity**. In addition to many promising data gathered from their and other Somatosensory Therapists of Pain' practice all over the world, its effectiveness becomes widely known. The method requires reliable testing tools, for example, the monofilaments and the two-point discriminator, to quantify the pain and precise maps including the aesthesiography, allodynography and rainbow pain scale chart to define the neuropathic pain territory and severity. In this way, the seemingly untraceable pain becomes measurable and visualizable for both therapists and patients. Based on the results of the evaluation, the therapist and the patient agree on a treatment program. Again, the underlying theory: adaptive neuroplasticity.

The goal of the somatosensory rehabilitation approach is to **translate the theory of adaptive neuroplasticity into practice** and to yield solid evidence of treatment efficacy. However, there is always a long way to go from concept to practice. "How to communicate and reach an agreement among team members, including doctors, other therapists, and patients?", "How to motivate patients to adhere to treatment, as it is relatively a long treatment process?", "How to convince the insurer to support the patient's treatment?" They are all predictable obstacles

faced to the therapists. Eva admits that this approach cannot be effective if the therapist only works within her own corner. One of the remarks made during the course: **be an agent of change** echoed in the whole class. With this new approach, what we learn is not only a treatment method; more importantly, it can shape our thoughts about pain.

The discrepancy of the understanding of pain among different cultures, within various individuals, persists. However, open mindedness and awareness of these differences will help us to make pain communicable and measurable. In a **perfect world**, the therapist can take as much time as possible to know his/her patient as a whole; in reality, time constraint is everywhere. The balance between idealism and reality? A heart willing to listen and a modest attitude of respect often open the door for the therapist to enter a patient's life.

I came to the class trying to find the solution for some mysterious cases concerning my patients. For some, I might have found it with SRM. For others, their pain remains a mystery for me. Is pain always a gift that nobody wants? My answer: look for tactile hypoesthesia in our mind and knowledge. The better we understand pain, the more we can accept it as a gift. Pleasant or unpleasant, **it defines our existence**.