

GUEST EDITORIAL**Reflections on Potential Pitfalls in
Clinical Approaches to Persistent Pain**

To MDs
To patients

To neuroscientists
To therapists

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I was motivated to complete pain-related post-professional training by the **discomfort** I experienced treating individuals with persistent symptoms. Such discomfort is often a result of powerlessness in the face of diagnostic and treatment uncertainty. Many of us enter health-related fields to help people, perhaps even “heal” them. Individuals with persistent symptoms and dysfunction, particularly in the absence of a precise and treatable diagnosis, can challenge our ambitions and threaten our identity as successful clinicians.

Thankfully, scientific advances have equipped us with valuable frameworks and tools to co-produce health in these complex situations. A biopsychosocial perspective of pain¹ has primed us for multifactorial assessment and treatment. A self-management support approach² has enabled us to appreciate that our job is not to fix others but empower them to thrive. While perspectives such as these have significant implications for high-value care,³ we need to continuously reflect on our practices to optimize outcomes. For example, while pain neuroscience education was advocated as a keystone intervention for persistent pain,⁴ newer recommendations position the technique as an adjunct intervention.⁵ More broadly, a critical review of the biopsychosocial literature in low back pain problematized discourses that narrowly focus on cognitions and behaviors.⁶ In the following sections, I overview potential pitfalls of modern emphases on perceptions and individual activation in the **context** of clinical approaches to persistent pain.

Perceptions in Pain

Historically, a direct, proportional relationship was assumed between structural pathology (e.g., tissue damage) and pain. Therefore, individuals who reported pain in the absence of physiological signs were believed to have mental illness.⁷ The outdated narrative of hysteria, predominantly associated with the female or “weaker” gender, continues to influence illness experiences in the 21st century.⁸ However, modern conceptualizations of pain emphasize its biopsychosocial nature and legitimize its experience even in the absence of organic disease.

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Pain is positioned as an output of the brain and is distinguished from nociception.⁹ An understanding that pain is more complex than tissue damage may offer **hope** to those with persistent pain in the apparent absence of pathology on traditional imaging. It can pave a way toward recovery through restructuring beliefs about the pain experience.

But are we coming full circle? While biopsychosocial approaches intend to unite the mind and body, the strong emphasis on pain as perception may focus on the mind to the exclusion of the body.⁶ The related clinical emphasis on cognitions implies that anyone can experience decreased pain by “applying mind over matter.” But what about the **individuals** we encounter who have trouble changing their perceptions? Do we perceive such individuals as weaker in some way? Do we risk returning, even implicitly, to narratives of hysteria in the way we think about those with “*persistent persistent pain*”?

But are we pathologizing the normal? When we as clinicians and researchers think, speak, and write about perceptions, do we pathologize understandable and even logical responses to pain? Variables like pain catastrophizing or kinesiophobia may be valuable indicators for risk stratification and personalized care pathways,^{10–12} and we should continue to assess and address them. But are they always inherently maladaptive? Do we explicitly recognize our expert **bias** and appreciate that what we know and understand about expected symptom severity and duration is not common knowledge?¹³ And do we perceive individuals with these yellow flags¹² as weaker in some way? There is acknowledgment that the term “catastrophizing” in particular may carry negative connotations.¹⁴ But do we acknowledge the broader irony that we emphasize restructuring others’ cognitions because of their intolerance of uncertainty while overlooking our own intolerance of uncertainty that challenges our treatment of these individuals?¹⁵

But are we disregarding the biological domain? With the emphasis on perceptions within pain science, I often think about an individual I treated who presented with persistent pain after a motor vehicle accident. Her physician dismissed her concerns and repeatedly referred her to therapy with the implication that there was no medical rationale for her pain. Ultimately, after seeking a second opinion several months post-injury, she was found to have multiple undiagnosed fractures. Were her female gender and culture-related expressiveness reasons her concerns were dismissed as exaggerated? With an understanding that tissue damage is neither necessary nor sufficient for the experience of pain, are we at increased risk of missing pathoanatomy? And are we more likely to pay less comprehensive attention to the biological domain in specific individuals based on age, gender, culture, race, etc.? Furthermore, is our emphasis on perceptions in persistent pain perhaps partially a function of our limited understanding of the complex **physiology** of pain? And do we, therefore, sometimes content ourselves with helping individuals live well *despite* pain instead of helping them live well with *less* pain (e.g., by incorporating methods such as somatosensory rehabilitation of pain¹⁶)?

Individual Activation in Pain

A focus on perceptions also intersects with self-management, which emphasizes the individual's responsibility for their health and active engagement in care.¹⁷ Self-management support involves empowering individuals to engage in this process and often includes cognitive and behavioral elements. Empowerment entails a shift in power dynamics and shared responsibilities. This shift can be difficult for the clinician to embrace but simultaneously can be freeing by removing the burden of obligation to fix another.^{18,19} Self-management approaches align with high-value care through their potential to optimize **health** outcomes while decreasing utilization and costs.²⁰

But are we ignoring individual preferences? Self-management has value, but do we make assumptions about the universality of activation? Active approaches, such as shared decision making, are advocated as incorporating individual preferences.²¹ But we also know that individuals have different preferences for shared decision making.²² Similarly, individuals may have varied preferences for self-management, including the level of desired involvement, communication styles, and methods of support. Should we consider individual preferences when determining what is the right amount of supervised therapy, for example? One minor finding that stood out for me in my dissertation was how some participants spoke about therapy as a means of active **engagement**.²³ While some individuals may view therapy as a place to get "fixed," others may view it as a designated space and time they like to use to "fix" themselves. When emphasizing self-management approaches, do we perhaps overlook the value some individuals place on relational aspects of care, relative to both clinicians and peers? We need to empower individuals, consider individual and societal costs, and minimize unnecessary services. But are there gray areas where we should honor individual preferences for more support without viewing individuals through a lens of decreased activation?

But are we assuming access to resources? When supporting specific behaviors, most of us recognize that individuals may not have access to specialized exercise equipment and recommend what we consider low-tech options (e.g., take a walk around the block). But do we assume access to other resources? Does the individual have a safe place to take the recommended walk? Can they realistically make time to follow our exercise recommendations if working multiple jobs? Do they have access to sufficient nutrition and a stable place to sleep? Do they have adequate literacy, health literacy, and numeracy to understand and incorporate recommendations? Individuals with decreased resources are often the ones who can benefit the most from empowerment and self-management approaches. But simultaneously, they may need increased and extended **support** without being labeled as less activated or non-compliant.

But are we ignoring determinants of health? Beyond individual social needs, an emphasis on individual activation may disregard the broader reality of structural, social, political, and economic determinants of health.²⁴ 2020 has spotlighted health inequities across the globe. How do we position individual responsibility for health within contexts where care is prioritized over health and where social and medical services are fragmented despite shared

implications for well-being? What is our role in addressing inequities within our communities?²⁵ Empowering individuals, as in self-management support, is not incompatible with addressing broader social **disenfranchisement**. But how can we ensure that the focus on individual activation does not overshadow upstream determinants? And how can we move beyond individual care to empowering communities and populations?²⁶

Conclusion

Perspectives of pain and optimal assessment and management strategies continue to evolve. Emphases on perceptions and individual activation in clinical approaches to persistent pain remain key aspects of high-value care. However, we must avoid the dangers of overconfidence in our approaches that can blind us to potential pitfalls. Instead, we must continue to reflect, question, and engage in **dialogue** with each other and those living with pain as we work to co-produce health for individuals and society.

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