

GUEST EDITORIAL

**Part II: Certified Somatosensory Therapist of Pain and Master of Science in Occupational Therapy**

To medical doctors  
To patients

To neuroscientists  
To therapists

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We had the privilege of writing the Guesteditorial in the previous tome (Sogomonian & Hoang, 2023) in which we describe our initial reflections and learnings after two weeks immersed in the method of Somatosensory Pain Rehabilitation (SPR). After eight weeks of being thrown into this world, we walked out of the Somatosensory Rehabilitation Centre in Fribourg, as Certified Somatosensory Therapists of Pain (CSTP<sup>®</sup>) and graduates of the Master of Science (Applied) in Occupational Therapy. Our learnings (and unlearnings) and reflections only deepened and complexified during our clinical placement, resembling a **melting pot of knowledge** that continues to brew in our minds. In this guesteditorial, we hope to present these knowledges as a continuation of Part I: Basic Course about the method of Somatosensory Pain Rehabilitation - Montreal 2023 (Sogomonian & Hoang, 2023).

**Tuesday, December 19, 2023**

**Completion of MSc(A) OT, CSTP<sup>®</sup> - Tamara's Rendition**

**Home Montréal, Qc, Canada**

Encounters over the past months have shaken me so deeply that I have yet to understand and make sense of such an experience. As tempting as it is to pretend like my experience at this clinic was smooth sailing, I shall choose the honest route and say that it has been a **bumpy road** that no safety belt could have spared me from feeling. One would expect people who go to a pain clinic are not doing so well, in all spheres of life imaginable.

What I can affirm is that I had the **privilege** of living high highs and low lows with patients and colleagues. What a profession I am in.

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While at the clinic, I took the liberty to snoop into one of many of Claude's bookshelves and found a few **novels** in-between large textbooks. Some books shed light on the experiential knowledge of healthcare practitioners and their patients. Some themes

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discussed in these writings described challenges that emerged from patient sessions I have had and still reflect on.

**Theme #1 – Health outcomes following overexertion for others**

*“How would you repress your dissatisfaction? Do you ever get angry about it? Do you ever feel angry about it?”*

*“It’s hard to relate because now I get angry all the time. We talk about it a lot more now.”*

*“What happened to the anger before you were diagnosed with [chronic medical condition]?”*

*“I don’t know. I see what you’re getting at, and it’s probably true.”*

*“Where did you learn to repress anger?”*

*“That’s a good one – I don’t think I’ve analyzed this quite enough. I think it comes from a desire to be liked. If you’re angry, people don’t like you.*

(Maté, 2004)

*« Comment exprimiez-vous votre insatisfaction ? Vous arrivait-il de vous fâcher ? Vous arrive-t-il d’éprouver de la colère en y repensant ? »*

*- C’est difficile à dire parce qu’en ce moment je me fâche tout le temps. Nous en parlons beaucoup plus maintenant.*

*- Que faisiez-vous de votre colère avant que votre cancer ne soit diagnostiqué ?*

*- Je ne sais pas. Je vois où vous voulez en venir et je crois que vous avez probablement raison.*

*- Où avez-vous appris à refouler votre colère ?*

*- Voilà une bonne question : je ne crois pas avoir suffisamment analysé les choses. Je crois que cela me vient d’un désir d’être aimé. On n’est pas aimable quand on est en colère. »*

(Maté, [2017])

Patients expressing their anger or resentment towards me always felt intimidating, especially as a student. Often, I was not sure what to make of it other than to blame myself for providing care that was not good enough. I then learned to appreciate the emotional intimacy within expressed anger and resentment, appreciate the comfort of showing the ugly within the relationship. I learned that it is a step in addressing and navigating something that was left neglected, intentionally, or not. There is desire to change something, **vitality to fight** the current condition, in whatever shape or form with the risk of open fire between two individuals of different realities. Patients who overexert themselves for others, from what was witnessed, display a level of agreeableness with their loved ones, healthcare providers, out of fear of being disliked

or discarded as not good enough. This level of agreeableness manifests itself through the inability to say no because then they believe they would not be “good enough” to others.

**Theme #2 – The inability to say “no”**

*“Let me ask you something right away,” I begin.*

*“Sure.”*

*“(…) How easy has it been in your life to say no to things that were actually more of a pain in the ass than a benefit to you?”*

*“I don’t really say no. I try to help people all the time.”*

*“Even if it’s a pain?”*

*“Yeah. Even if it’s not the greatest time for me, or I should be doing other things that are more important for me. I like to help people out.”*

*“What happens if you don’t?”*

*“I feel bad about it. Guilty.”*

(Maté, 2004)

*« - Permettez-moi de vous demander quelque chose tout de suite, lui-ai-je dit.*

*- Bien sûr.*

*- (...) Avez-vous jamais réussi dans votre vie à dire non à des choses qui vous emmerdaient plutôt que de vous faire plaisir ?*

*- Je ne dis pas vraiment non. J’essaie tout le temps d’aider les autres.*

*- Même si cela vous emmerde ?*

*- Oui, même si cela ne tombe pas au meilleur moment ou si je devais faire des choses qui sont plus importantes pour moi. J’aime donner un coup de main.*

*- Et si vous ne le faites pas ?*

*- Je me sens mal à l’aise. Je me sens coupable. »*

(Maté, [2017])

I witnessed that the absence of expressed anger or resentment may be an indication of defeat, the grief or even death of a **Future Self** the person is working towards. While at the clinic, I crossed my fingers and hoped that such defeat was temporary, and a spark of some sort would eventually ignite. A spark to say “no”, “I disagree”, “I can’t take this anymore”, “I hate all of this”, “Can we do something differently”.

Absence of expressed anger could also be an indication of other things, of the infinite variables within a **therapeutic relationship**. I often wondered if when I contributed to such defeat.

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### **Further reflections on those two themes**

I have always had mixed feelings about wearing a white coat, scrubs, or any professional attire representing a provider of care holding **authority** (over a patient's therapeutic journey). On one hand, it can create a healthy distance allowing us to represent the role and expertise we have in providing care. On the other hand, such symbolism conveys the power dynamic to a patient who is more inclined to say "yes, I agree, let us keep going, I am okay with what we are doing" with the professional, even when the patient is not fully consenting.

What is so interesting about this Somatosensory Rehab method, is that it **REQUIRES** patients who have touch-evoked pain, to say **STOP**... to the therapist.

The therapist with the therapeutic touch: not when it is unbearable, not when they cannot take it anymore, but to an **agreed upon boundary** from both the patient and therapist. Eventually this "STOP" to the therapist, translates to "no", to things outside of the clinical context. "No" to overexertion at home, at work, in romantic relationships... "No" to an abusive partner, to a passive family member, to an overbearing boss.

I suppose saying "no" does not mean being disliked, it does not mean not being good enough. No is a full, stand-alone sentence, of **assertion** and affirming one's own capability to determine when one has had enough and is enough.

Many patients first start their **therapeutic journey** incapable of saying no, in multiple aspects of their lives, let alone to the therapist. Perhaps in some cases, I speculate that being unable to say no has led them to exacerbated states of pain.

The difficulty with saying no represents potentially the greatest challenge some may face when in therapy, especially when saying no to (pain-inducing) "therapeutic touch". I have witnessed that beginning to say no is liberating, expressive, honest, and allows one to let go of anger and frustration stemming from overexerting oneself to others. I wonder if learning to say "no" is one of many ways of unlocking the **prison of pain**.

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**Wednesday, January 24, 2024**

**Completion of MSc(A) OT, CSTP<sup>®</sup> - Marie-An's Rendition Montréal, Qc, Canada**

**Home**

When taking the Basic Course about the method of SPR and its plentitude of theory, I had expected the course, the manual, and the Atlas to provide me with most, if not all, the answers to complete the clinical placement at the clinic in Fribourg, Switzerland. On the first day at the clinic, Claude warned us that our plans for our patients' sessions must remain flexible. I was confronted with this warning on my very first patient session during

which I quickly learnt that pain is so unique and unpredictable that one must continue to learn and unlearn to be able to adjust to patients' needs. The method of SPR along with its course, manual, and Atlas provide a base that allows therapists to lay upon their treatment and assessment. Yet, the method excels with its flexibility and the room it gives therapists to adjust assessment and evaluation to the fluctuating nature of neuropathic pain. This clinical placement encouraged me to continue to work on and improve my patient-centered care and reinforced the importance of being a **life-long learner**.

### **Theme – Alternating co-therapy as a tool of positionality**

In the first Guesteditorial that we wrote, we discuss about our initial reflections on how to position ourselves when working with patients living with neuropathic pain (Sogomonian & Hoang, 2023). We recognized that patients are **experts** of their experiences living with pain.

Student therapists are often taught to work with patients collaboratively to find **solutions** to their occupational disruptions. It is very easy to fall back into this mindset which narrows the spectrum of care that we can provide. Constantly trying to find solutions can hinder the quality of care provided. For example, my encounters with some patients who have been living with neuropathic pain for months, if not years, sometimes resulted in sessions where I felt like we were not able to progress with the treatment. Sometimes it would be difficult to get a word in a session, making it difficult for me to perform follow-up assessments. It was very destabilizing at first and I saw it as problematic to therapeutic intervention. Something that needed to be fixed.

I was **assuming** what patients needed. I was expecting patients would just adhere to treatment. I was assuming I knew the solutions to fix every problem. And this all remains false.

It was only through dialogue with my co-therapists that I came to realize the importance on reflecting why I was feeling discomfort after patient sessions. **Alternating co-therapy** is defined as :

« Deux thérapeutes partageant le même plan d'intervention et la même approche thérapeutique en suivi alterné auprès d'un·e même patient·e » (Murray, Bernardon & Letourneau, 2021)

Two therapists sharing the same intervention plan and therapeutic approach in alternating follow-up with the same patient.

The Somatosensory Rehab Centre actively adopts alternating co-therapy providing us an opportunity to work independently with patients during patient sessions but in **collaboration** with other therapists in the overall treatment plan. In fact, the centre

allocates thirty minutes everyday during which each pair of co-therapists can meet and discuss about their patients. Not only was I able to update my co-therapist with pertinent information about our client but I was also provided with a safe space to discuss about how I felt about the sessions. The team often prompted me with questions that would lead me down reflective paths on how I would position myself with my patients and how this may perpetuate power dynamics between myself and patients.

During our courses at McGill University, we learn about **positionality** as essential to providing quality care. We learn that one must be aware of our social position (e.g., ability, wealth, gender, etc.) and how the inherent biases we hold deriving from these social positions influence the care we provide. I have always found entering a new clinical placement that I tend to position myself as the professional. Although my intentions are to provide safe care, the reality is that by positioning myself as the professional, I do more harm than good. It is very possible that my responses and reactions were invalidating of my patients' experiences and emotions because I was too focused on the treatment itself and getting things done on paper.

It was only through alternating co-therapy and having the opportunity of meeting with my co-therapists regularly and per my needs that I was able to fully be aware of my positionality: a student who does not live with chronic neuropathic pain and who has all the privileges that come with not having pain disrupt my daily life. It was only then I gave more space to my patients and stopped worrying about doing follow-up assessments. I started my sessions by asking my patients what they wanted to work on. If the topic deviated to another part of their life, I would listen and let them be heard. Pain impacts so many aspects of life that it is more than likely that difficulty in one area of my patient's life was associated to living with pain for so long even if it did not seem to be linked at first glance. Patients are experts of their experiences. Pain is unique to each person. Patients are thus experts of their pain. How can I (not the expert) support them in reducing their pain **if I do not let them lead?**

In a field where productivity and efficiency are often valued, I wonder whether health care does more harm than good. Actively positioning ourselves as safe health provider is difficult when the systems we work in perpetuate the idea that we are the most knowledgeable and are the experts. From my experience in this clinical placement, frequent dialogue and feedback between parties of interest (myself, my colleagues, and even my patients) can be a tool to reduce harm inflicted on patients when receiving care. Institutional changes can look like what the clinic currently does: giving regular opportunities to health professionals to enter into this critical reflexive dialogue in a **safe space**.

## Conclusion

In conclusion, the journey through the method of somatosensory pain rehabilitation has been transformative, revealing the intricate dynamics of pain, patient-provider relationships, and the nuances of effective therapy. The ability to say "no" emerges not only as a therapeutic tool within the clinical context but as a liberative life skill that encourages patients to establish **healthy life boundaries**. This, in turn, becomes a pathway to enabling them to say "yes" to the life they truly desire. In parallel, alternating co-therapy is a clinical tool to improve therapeutic rapport, wielding the transformative ability to alter mindsets and consequently reshape the entire healthcare institution. Our experiences not only introduced us to the method of SPR, but also inspired a reevaluation of therapeutic approaches to improve patient outcomes and well-being.

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