TRANSCRIPT 1030

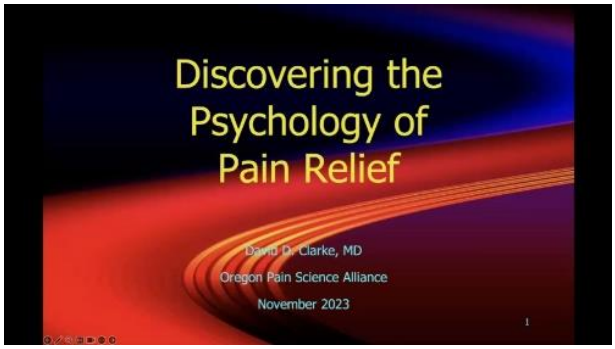
Discovering the Psychology of Pain Relief

November 9, 2023

David D. Clarke MD
Asst Prof. Emeritus of Gastroenterology
Oregon Health Sciences University
President, Psychophysiologic Disorders Association

[00:00:09] Thank you, Rolly. It's a pleasure to be with you and I really appreciate being invited tonight to share my story and share some of what I've learned. Let me go ahead. So tonight we're going to **discover the psychology of pain relief** and it's basically a journey that I started very early in very early in my career.

[00:00:28] I was actually doing pretty well. Early on, I got an award for excellence in medical school. I was passing my board exams with excellent scores. I got into a top training program at Harbor UCLA Medical Center, and **I was seven years into it,** just starting my eighth year, which was the first year of my gastrointestinal specialty training.



[00:00:55] And **I was completely unprepared** to run into a patient that I didn't know the first thing about diagnosing or treating. This was a **37 year old woman** who had been referred to us by another university because they could find nothing wrong with her. The symptom that she had was that she was averaging **one bowel movement per month**.

[00:01:17] And I'm sorry about that symptom, but, you know, if you invite a gastroenterologist to come and speak to you, this is the kind of stuff you're going to hear about. And she was taking 4 different laxatives at double the recommended doses. And it

wasn't helping her at all. **All the tests had been normal** from a regular doctor from the other university.

[00:01:39] And she was coming to us for some **very specialized testing** of the neuromuscular contractions of the large intestine. And my department chair and I were absolutely certain that that test would show what was wrong because no other explanation for her condition was possible. Or so we thought.

[00:02:00] Because that **test also** turned out to be **entirely normal**, which completely perplexed both my department chair and I, but at that point, we had nothing more to offer her and it was **left to me to do the exit interview** and tell her that she basically was just going to have to live with this. But I asked her, you know, just to make the conversation not be too abrupt and final with her.

[00:02:26] **I asked her about stress in her life**, knowing full well that all her other doctors had asked her about stress in her life, and she didn't have any. She was happily married. She had two kids whom she adored. She loved her job as a bank manager. There really wasn't anything. So again, not wanting the conversation to end too abruptly, I asked her about stress earlier in her life, thinking, well, maybe something happened two years before at the time her illness began, and she interpreted my question to mean the more remote past and began telling me about her having been **molested by her father**.

[00:03:11] And I had **never heard anything like that** from a patient before, even after 7 years of training. I had no information about how to respond when a patient says something like that to me. So, I was very worried, that if I asked her too much about this, that it would have all kinds of difficult emotional repercussions. So **I was reluctant**, but at the same time, she seemed fairly calm about the whole thing, and I thought, well, you know, this is for the best.

[00:03:43] Kind of a surprise that she's mentioning this. There's no way it has anything to do with her bowels, but I might as well **at least get the story** because that's what I've been trained to do. You get the history. You find out what happened. When and where did things occur? When did it start? How frequently did things happen? I asked her all of that, and it turned out that Her father had **molested her hundreds of times** up to the age of 12. But nobody, including him, had touched her after that.

[00:04:15] Nobody had touched her against her will for the last 25 years. So **it seemed completely improbable** that this terrible suffering that she had endured could in any way be linked to her gastrointestinal problem. But, it **gave me an idea** for passing the buck, which was that there was a psychiatrist at UCLA named **Harriet Kaplan**, who was also

board certified in medicine as well as psychiatry, and whom I had heard might be **interested in these unusual mind and body problems.**

[00:04:50] So I thought, great, I've got something positive I can do. At the very worst, it might help her live with her condition a little better. So I made the appointment and forgot all about her until about **2.5 months later**, I ran into **Dr. Kaplan in an elevator**. I barely knew who she was, but I did know, so I asked her, what, whatever happened to that patient that I referred to you? Did, you know, were you able to help her at all?

[00:05:22] And she replied, well, Dave, I haven't seen her in a few weeks. And my first reaction on hearing that was, oh, you know, it didn't work out. It wasn't helpful. It was a waste of time as I expected. But then she goes on to say**, she's cured now**. She's fine. Her bowels are back to normal. She's not taking the laxatives anymore.

[00:05:45] And I was absolutely thunderstruck that you could alleviate a horrible, serious, physical condition. Just by talking to somebody because that's all she did. She didn't prescribe any medication. She saw her **once a week for an hour for about 8 or 10 week**s. And at the end of that time, she didn't have a problem anymore.

[00:06:09] There was nothing in my 7 plus years of education that even hinted that such a thing was possible. So, as I got off the elevator, I turned around and I said**, Harriet, how did you do that?** And I thought, you know, if I'm going to be a complete gastroenterologist, I should know how to take care of a situation like this because if it's happened in my practice once it'll probably happen, you know, maybe even a couple times a year that I'll see a patient like this. **I should know what to do**.

[00:06:42] So I prevailed on Dr. Kaplan to sit in with us in the outpatient GI clinic at Harbor UCLA Medical Center. And give us the benefit of her perspective on this condition, how she thought about it, **what was her framework for evaluating and treating patients**. And I gradually absorbed a basic set of concepts about what to do, never thinking I was going to use most of it.

[00:07:11] **My plan** was that if I didn't find anything wrong with a patient, I would ask him a few questions about stress, **send them off to mental health**. and whoever the Dr. Kaplan was in Portland would take care of the problem. Well, I was wrong again and again in my early years of working with this, and **I was wrong that there would be Dr. Kaplan's in Portland**. There weren't any.

[00:07:36] When they went to mental health, these patients got **cognitive behavioral therapy**, which for most of them, just **simply isn't good enough**. And I was also shocked

that the **patients that didn't have anything wrong** on diagnostic testing ended up being five or six a week, 250 or **300 a year**, over 7,000 in the course of my career.

[00:08:05] And when **I asked them the questions that Dr. Kaplan had taught me** to ask, even, you know, though most of them did not appear any different in terms of their mental health than anybody else you might know or meet, **they had serious stresses** that they were struggling with. Sometimes shockingly serious stresses like my first patient with the hundreds of episodes of molestation.

[00:08:32] But it turned out that **if you could uncover these issu**es and related impacts from those issues, there was usually **a fairly straightforward method for treating them** for alleviating the stresses for bringing the stress level down. And when you did that, people got better. And even as a **bumbling beginner** back in the 80s, I was getting better outcomes with these patients than they were getting from the rest of the health care system.

[00:09:04] And that encouraged me to keep going. And I got better and better at it. I was climbing a **pretty steep learning curve**, but with every additional patient, I was learning more. And after four or five years, I had reached a pretty decent level of proficiency. And I was working for Kaiser at that time. And about a year after I felt like, okay, I've, I feel like I've really learned how to do this.

[00:09:31] About a year after that I unexpectedly **won the doctor of the year award** for this work which was, you know, I was much younger than most people who won that award. So that was, you know, additional confirmation that I was on the right track basically.

[00:09:49] So I kept going with it, ended up writing **my first book** in 2007 called "They Can't Find Anything Wrong". And when that came out, I started getting **a lot of invitations** to give speeches and to be on television and radio. I did over a hundred radio and television broadcasts. I was giving speeches. All over North America and Europe including in the UK at the Royal Society of Medicine and a famous psychotherapy institute called the Bowlby Institute.

[00:10:22] And that has just accelerated. I became a **Co-founder and President** of the **Psychophysiologic Disorders Association** in 2011. I've been the president ever since. We've written two textbooks. We've got an online webinar based course in this for professionals that patients can also take because it's jargon free.

[00:10:45] We have a really nice **self-assessment quiz** for people. It's only 12 questions, but it's set up so that the more questions to which you answer yes, the more likely it is

that a psychophysiologic disorder is responsible for your symptoms. I've been a producer of three documentary films in this field.

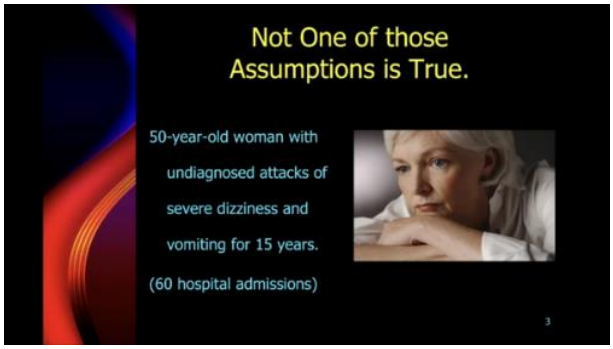
[00:11:06] We have a new even **more advanced course** coming out in **January (2024)** that's going to be on the **endchronicpain.org** website. We have held four international conferences, the last two of them online. The most recent was just two weeks ago and it's all recorded so that you can view the course.

[00:11:27] And most of it is a **jargon free** and for professionals, they can get up to 12 continuing education credits for it. We have a new membership program at the PPD Association where people can get substantial price advantages and discounts for all of these resources that I've been mentioning and more that are offered by our allies.

[00:11:52] And we have **monthly meetings** that are international that are open to all of the people who are members to come and ask questions of experienced experts in the field. Starting in January, we're having **monthly Zoom webinars** just for professionals where they can ask questions of people who've been doing this for decades.

[00:12:14] So lots and lots going on and it's, it's accelerating. 15 years ago, we had almost nothing in this field that reflected the science. And now we've got more and more and more that are **resources for both patients and professionals**. So, with that is a long-winded introduction. Let's go on to the slides.

[00:12:37] And this one goes back to what I was taught in those first seven years of my medical education and training. These are the **assumptions that are taught** to health care professionals and mental health professionals for that matter, both implicitly and explicitly, even to this day **about pain or illness that is not found to be due to disease or injury**: that it doesn't affect many patients; that the symptoms are largely imagined and not real; that the patients themselves are neurotic, they just can't handle their own normal daily stresses; that diagnosing a cause of this condition is not possible; that the best achievable outcome is living with the; and that it's not really manageable by physicians; that when the physician has done their job of looking for organ diseases and structural damage and not found any, then doctor's job is done, and there's really not much more they can offer.



[00:13:41] It turns out and this was what I learned in the early years after first meeting Dr. Kaplan, that **not a single one of these assumptions is true**. Let me give you **one example**. This is a **50-year-old-woman** with undiagnosed attacks of **severe dizziness and vomiting** for 15 years. The attacks would last anywhere from 1 to 4 days.

[00:14:05] She would have between 6 and 10 of these attacks every single year. She was having them severely enough to put her in the hospital four times a year. So about half of the attacks **over the 15 years**, she was in the **hospital 60 times**. And the hospital she was in was **Stanford University Medical Center** because she happened to live in Palo Alto.

[00:14:31] So she got very good care from a dozen different specialists who put her through every test you can think of and did **not find why she was having this condition**. So in the third year of her illness, they had a **psychiatrist evaluator** and he was confident that **she did not have any sort of mental health condition**.

[00:14:53] And he sent her back to the doctors and said, keep looking. Well, **she ended up in my hospital here in Portland** and she was in such despair that she said, doctor, **don't waste your time with me**. You'd be better off seeing your other patients. And she had very good reason to say that after all that diagnostic evaluation.

[00:15:14] It wasn't likely that any tests I would order would show anything different. But I said, you know, I've kind of **been making lost causes a specialty of mine** here in the last few years. This patient is someone I saw when I was still early in my experience, probably around 1987. And I said, if you'll give me 30 or 40 minutes to tell me your story one more time, we might be able to come up with something.

[00:15:42] And sure enough, we did. **I found the stress that was responsible** for her attacks. We talked about it. We brought the stress into her conscious awareness because like so many patients, the stress is unrecognized the magnitude of it, even the nature of it is not part of the patient's awareness.

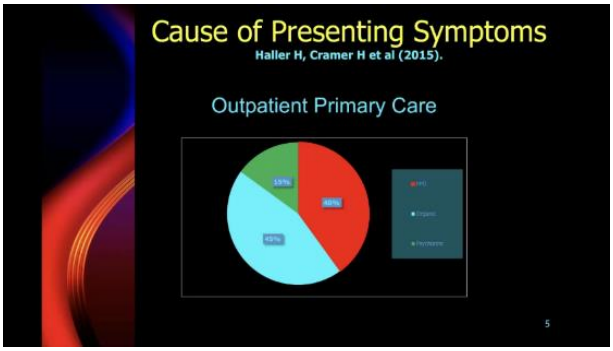
[00:16:04] So if you can find it and help the patient to see it. That starts their healing journey. And in this patient's case, **she was cured on the spot**. She went home from the hospital the next day. She called me a year later when she was back in Portland to say she'd gone the entire year with no episodes.

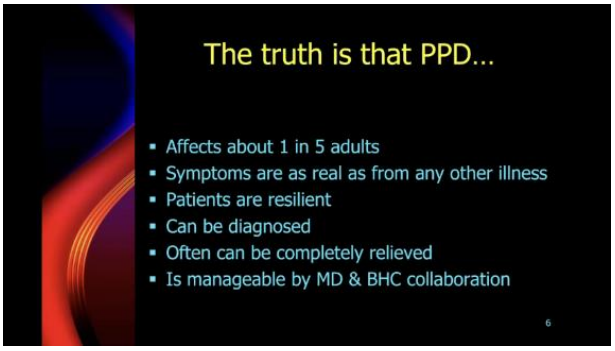
[00:16:22] We'll talk about her a little later about exactly how she was diagnosed after I go through the process. But as usual with my talks, I put way too many slides. But we'll get there. My colleagues and I

like to call this **psychophysiologic disorder**. We drop the A L at the end of psychophysiological because it's already got enough syllables to it.

[00:16:44] The abbreviation for this is even better**. We call it PPD**. And that is, you know, obviously a lot easier to say. This is just, this term is a blend of psychology, the processes of the mind, and physiology, the processes of the body, because that's exactly what's going on in this condition. It's a blend of the two, and it's defined as pain or **illness caused by past or present psychosocial stress, not associated with abnormal organs or structures**.

[00:17:12] There are millions of people who suffer from this. This is a review article of 32 different scientific papers from 24 countries, showing that on the average, **40 percent** of people that present to outpatient primary care **are suffering from PPD**. It's approximately **20 percent of the adult population** or 50 million people in the United States alone.



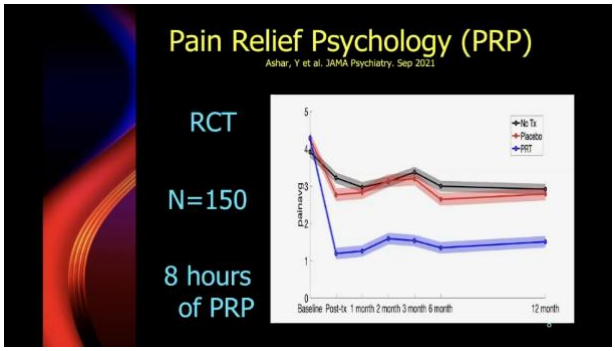


[00:17:36] This is **not rare**. This is 80 percent larger than the diabetic population for comparison. So the truth is that **PPD affects about one in five adults**. The **symptoms are absolutely as real as from any other form of illness**. The patients are actually quite resilient. They're just carrying levels of stress that would bring any of us to our knees.

[00:17:59] **It absolutely can be diagnosed** if you know what stress to look for. It often can be completely relieved by treating those stresses. People don't have to live with this. And the **best outcomes** are when a physician and a behavioral health consultant collaborate with each other, ideally in the course of the same office visit.

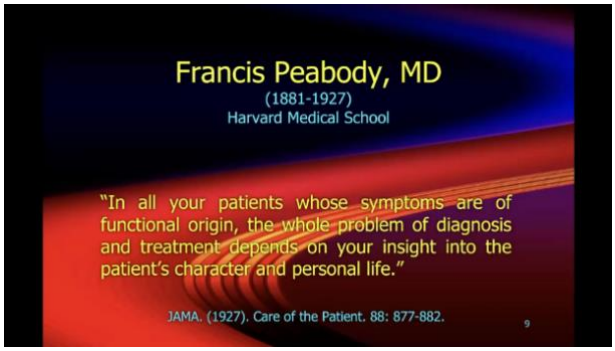
[00:18:22] So it's complete turnaround from how I was originally trained, these patients can get symptoms literally from head to toe, certainly pain anywhere, but **also non-pain symptoms** like: ringing in the ears or dizziness or visual disturbances or non-epileptic seizures, trouble swallowing, trouble breathing, trouble coughing, certain rashes, bladder spasms, genital symptoms numbness and tingling in the extremities complex regional pain syndrome, fibromyalgia, irritable bowel, migraines, the list just goes on and on and on.

[00:19:02] The **only common denominator** is that patients **tend to have more than one symptom at a time;** they don't always, but they tend to. And not only do we have **my 7, 000 patient experience** to share with you, but today we have **randomized controlled trials, gold standard science** that is showing that these outcomes are extraordinarily good.



[00:19:29] This is a study that was done at the University of Colorado in Boulder of **150 patients with chronic back pain for an average of 10 years**. Their pain scores are on the vertical axis and the 1 year duration of the study is on the horizontal axis. And you can see that the **pain scores plummeted** during the first month of the study, which was when they got their pain relief psychotherapy.

[00:19:56] The other two groups were the **control groups**. One got an injection into the spine of a **placebo** and the other got their **usual care**, nothing special. This is a huge drop in pain score. You have to imagine these are patients who'd been in pain for a decade on the average. So imagine the timeline, the horizontal axis extending for 10 years to the left before they get this 1 month of pain relief psychotherapy, just 2 sessions a week for 4 weeks. And the **pain score is plummeted**. This is by far the biggest drop in pain from a psychological treatment that had ever been published up to that point.



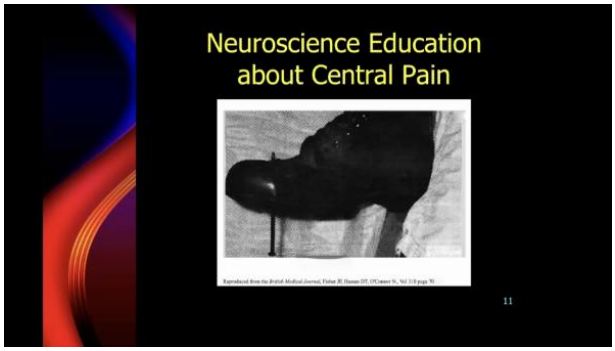
[00:20:35] Alright, **how do we diagnose this condition?** We've known how to do this for a hundred years. This is one of the most famous speeches in American medicine. Francis Peabody, professor at Harvard, speaking in 1925. "In all your patients

whose symptoms are of functional origin, the whole problem of diagnosis and treatment depends on your insight into the patient's character and personal life." The approach that I take is just a rigorous, systematic form of exactly what he's saying here.

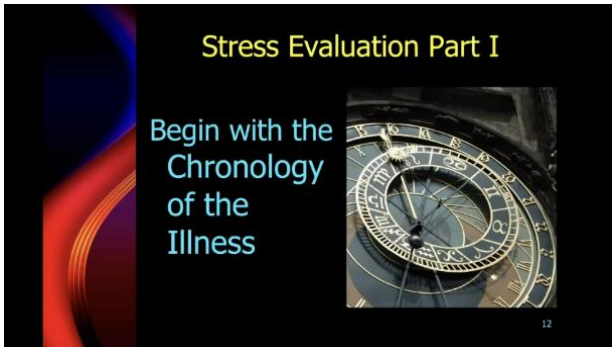
[00:21:05] When he talks about functional origin, he means no organ disease or stress. Or structural damage. So, the **first step is to address the skepticism** that everybody has, myself included back in the day, "merely stress could make people physically ill". And so we clarify that symptoms can originate in the brain.

[00:21:24] Anybody who's ever **blushed with embarrassment** has had a psychophysiologic symptom. Anybody who's ever felt a **knot in their abdomen** when they were in a tense situation has had a psychophysiologic symptom. And this is just a more severe and long lasting form of those normal, common, everyday human experiences.

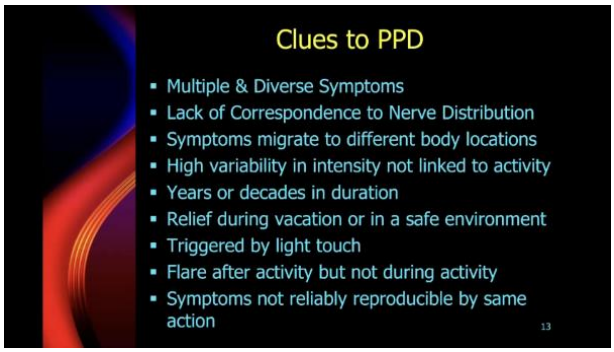
[00:21:45] Another example is **phantom limb pain** in which someone who's had an amputation feels pain at the place where their limb used to be. Obviously, the missing limb, whether it's an arm or a leg, can't be doing that because it's no longer there. It's **the brain that is generating that symptom**.



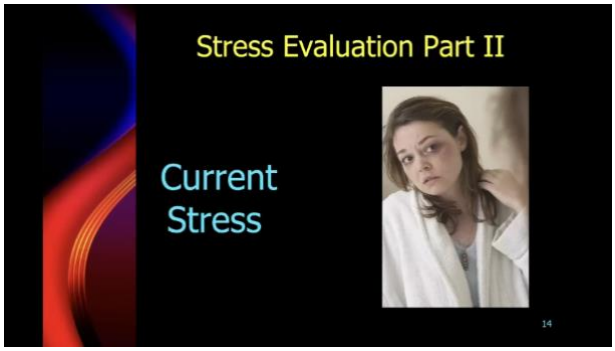
[00:22:02] **Why is the brain doing that?** It's because of stress, and we just need to find what the stress is in each patient's life. Here's another example from the British Medical Journal in the mid-1990s. A **construction worker who impaled his boot on a nail**, and as you can imagine, was instantly in agonizing pain, rushed to the emergency room, given morphine intravenously to alleviate the pain. And then the boot was carefully cut away only to reveal that the nail had passed neatly between his toes and didn't cause a scratch. And as soon as he saw that, the pain was gone. It's a great example of how the pain can be generated in the brain.



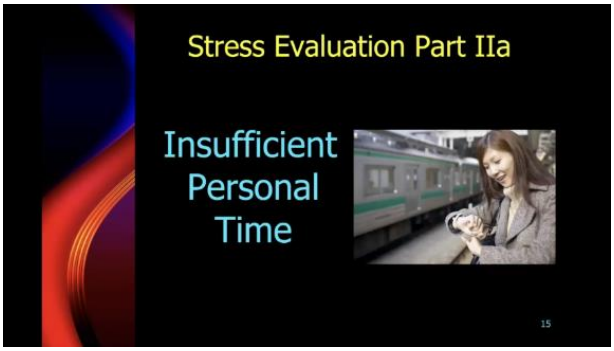
[00:22:40] So in evaluating the patients, **I go through a six-step process**, which may take several office visits to complete, but that's okay. There's no law that says you need to do all of this in one visit.



[00:22:52] I start with the **chronology**. When and where did the symptoms begin and what's been their pattern over time. Later on, I'm looking at the **stresses in the patient's life** and looking for any chronological links between when and where stress was happening and when and where the symptoms were happening. **I'm going to skip this, but**, people can pause the recording and look at it. **It's particularly for physicians** who are interested in what some of the clues are to the presence of psychophysiologic disorders.



[00:23:22] **Second part**, very simple. Are you under any stress at the moment? Is there anything going on in your life right now? Or did anything of a significant stress happen right before your cannot symptoms began that might have triggered them? Or have the symptoms, stresses in your life been fluctuating up and down and your physical symptoms fluctuating in parallel with those stresses? All kinds of things we're looking for there. Another one is, **do your symptoms go away when you are in a less stressful situation**, such as being on vacation or being in a safe place? That's another clue.



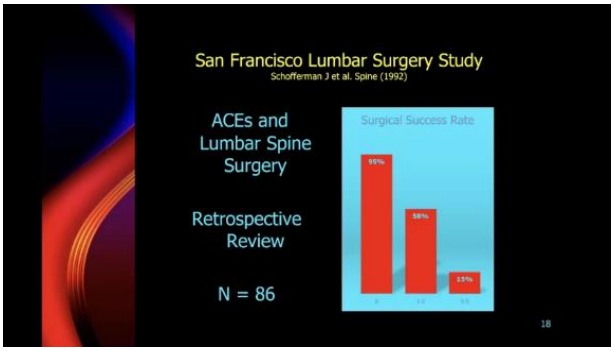
[00:24:01] A subset of the **stresses in your life right now** is a very common one, not having enough personal time, spending your days, taking care of everybody else in your world, but not having the time or the inclination even to put yourself on the list of people you take care of.

[00:24:20] If you do that for too long, it's going to catch up with you and **your body can start to protest in the form of symptoms**. Many people with this issue grew up in difficult home circumstances as children where they **didn't get sufficient opportunities to play**. They had to instead pay attention to whatever difficulty was going on around them.

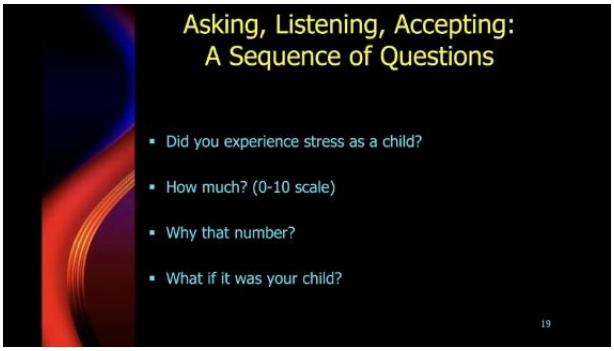
[00:24:43] And if you don't learn to play as a kid, the outcome from that can be you don't know how to play as an adult and **you're on that treadmill**. This was **the biggest shock of my medical education**, finding out that stress when you were a child could make you ill. as an adult. That was what happened to that very first patient with the severe constipation.

[00:25:03] There's research now, **a lot of research**, that shows the association between what are called ACEs, **Adverse Childhood Experiences**, and symptoms later on in life. This is one of those studies. I won't go into detail, just to say that in the pelvic pain group, The incidence of childhood sexual abuse was three times higher than it was in the group that did not have pelvic pain.

[00:25:30] This is a study of the **outcomes of lumbar spine surgery**, basically surgery on the low back. And it shows that in the group that had no adverse childhood experiences, that surgery was 95 percent successful. But if you had, up to five adverse childhood experiences, three, four, or five out of five in the categories that they used, the success rate of the surgery plummeted to 15%. Why? Because the **ACEs can cause stress**, which can cause your brain to generate back pain. And if you operate on the spine for back pain that is generated by the brain, It's not likely to help.



[00:26:12] When I'm asking a patient about these issues. I start with a very general open ended question. **Did you experience stress as a child?** And we start the conversation there. And I find that patients are quite willing to discuss it, even though I might be only the first or second person they've ever shared it with.



[00:26:31] At the same time, many of **my patients will minimize** what they went through, they'll tell me about something very bad they went through and then at the same time they'll be saying it wasn't that bad. Or they'll tell me that I know other people have been through worse, or they'll tell me "I think I'm pretty well over that right now".

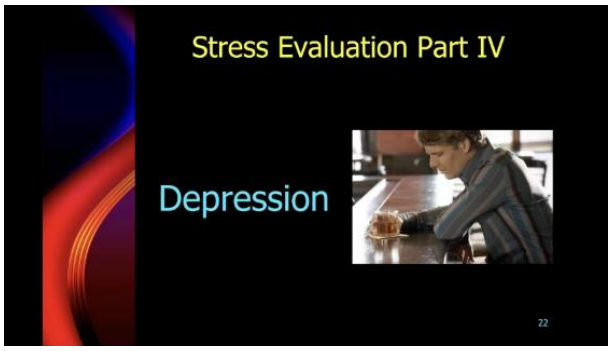
[00:26:49] So my response to that is to ask them to **imagine their own child growing up exactly the same way**, or to imagine **being a butterfly on the wa**ll of their childhood home. And having to watch a child of their own or another child whom they care for enduring that same childhood experience, how are they going to feel about doing that?

[00:27:09] I asked this in my written screening questionnaire. We have it as one of the 12 questions in the self-assessment quiz on our website. On my written screening questionnaires, I give people **four choices**: you'd be **happy** if you watched a kid growing up the way you did; you'd be **neutral** about it; you'd be **sad** or angry; or you'd be **very sad** or very angry. And **I correlated that with a standard 10 item adverse childhood experience questionnaire,** and you can see the results here that people who said they'd be **happy** to watch a kid growing up the way they did, they had an ACE score of only a little over **1 out of 10.**

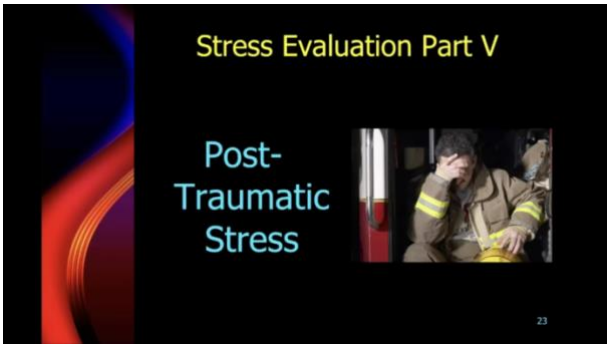
[00:27:49] But when you get to the **very sad** and very angry end of the spectrum, the average ACE score was over **7 out of 10**. So with just this one question, we're capturing a huge amount of information.

[00:28:01] The **ACES themselves can't be changed**. We can't, as much as we would like to, go back and change the past. But what we **can** do is **have a therapeutic benefit** to the long-term **ACES impact**, which comes in **three major categories**: **stressful personality trai**ts that have resulted from the ACES; **repressed emotio**ns; and triggers which are people, situations, or events that are in the present day.

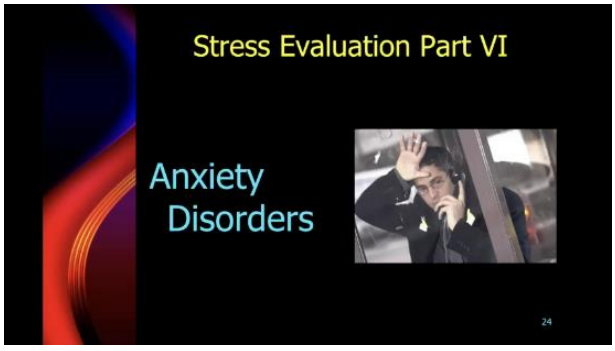
[00:28:31] But they are **in some way linked** or reminiscent of the **ACES of the past**. But all three of these are subject to therapeutic interventions that can make a huge difference. And when **we make that difference, physical symptoms, whether pain or otherwise, improve.**



[00:28:49] The **last three parts of the stress evaluation** are mental health conditions. They are: **depression**; **post-traumatic stress**; and the **anxiety disorders**. And here the key is to evaluate those in detail because they don't always manifest in an obvious way. The majority of patients with these conditions actually present to the health care system with physical symptoms rather than mental health symptoms.



[00:29:17] So you have to ask detailed questions about the patient's, situation and about secondary symptoms of these conditions to make sure that they are not present or to confirm that the y are present. For my medical colleagues, a **very useful technique**, but also for patients is to make a list of all the stresses you've had in your life, both at the present time and in the past .



[00:29:41] For patients who want to tell the doctor their life story for the next 2 hours, this is a great way to **honor the patient's willingness to disclose** this information. But also to let them know that you don't have time in a 15 minute office visit to give this issue the attention it deserves. But patients will go to work on these lists.

[00:30:02] They'll bring them back for their follow up visit. And in many cases, they'll actually start working on some of the stresses on the list, which will have potential benefit to their symptoms. And that makes it clearer to everybody what's going on. For **patients that are working hard on behalf of everybody else** in their life, but don't know how to put themselves on

the list of people they take care of they **need to learn self-care skills**.

[00:30:28] They need to take a regular block of time with no purpose, but their own joy. They need to use that time for trial and error, and they need to find a way not to be guilty about doing it. And if they can **learn this essential human skill of self-care time**, they will have that skill for the rest of their lives so that whenever their stress level gets up to the point where they're starting to have physical symptoms, they will now have something enjoyable that they can do that will bring the stress level back down.

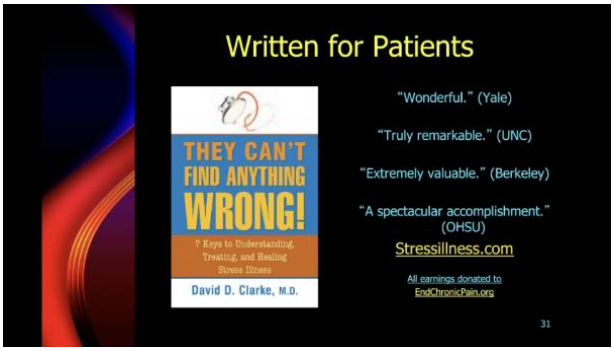
[00:31:03] For my **patients who've survived childhood stress**, I like to point out that that experience is analogous to being born on the far side of Mount Everest or in a dangerous jungle. And they **deserve tremendous credit for the heroic perseverance** that was needed to endure those situations. And they should give themselves that credit.

[00:31:25] They should think of themselves as heroic. They should recognize that what happened to them was through **no fault of their own**. And when they do that, it gives them a foundation for further healing.

[00:31:37] **Another good exercise is writing**. We won't go into a lot of detail because I know I'm already running short of time, but a great technique here is to write a letter, not to mail it, just to write it to anybody who mistreated you as a child.

[00:31:52] Put down all your thoughts about that person, which may be some good thoughts, but **all the thoughts and feelings** that you have, to put them into words. Because if, if they go into words, **they may not have to be expressed via your body** quite so much.

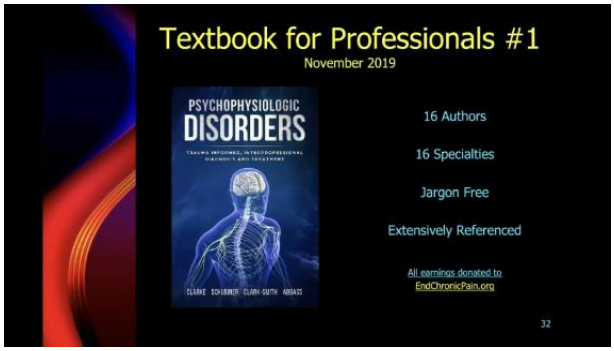
[00:32:07] This is my screen for the, whether the patient can read or not. I just ask them, do you like to read? If they say no, we move on. If they say yes, there are today a lot of **evidence-based books** that can help patients to recover from this.



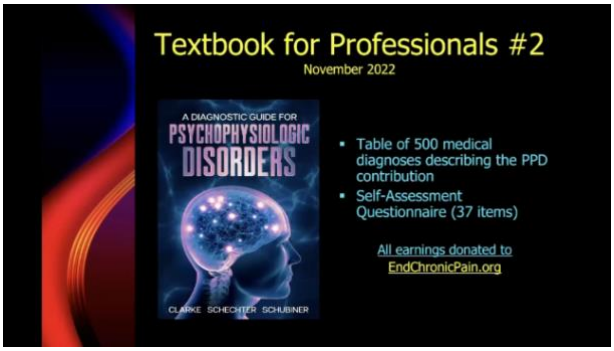
[00:32:23] This is **my book** it's been out for a number of years now, it has approximately **four dozen stories** in it about my patients that illustrate the very broad spectrum of different kinds of stresses that can make people physically ill. And most people with a psychophysiologic disorder will find **at least one and often more stories that resonate** for them personally and can start their healing.

[00:32:49] I donate all the royalties from this to the nonprofit. In fact, **I donate all the earnings that I have from any connection to this work to the nonprofit**, because I don't want even the appearance of a financial conflict of interest.

[00:33:04] There are just too darn **many companies** out there that are **exploiting PPD patients by selling them supplements or device**s that have no better than placebo benefit. And we can do way better than placebo for people who have this condition. This is the textbook that Rolly mentioned earlier but it's written without jargon.



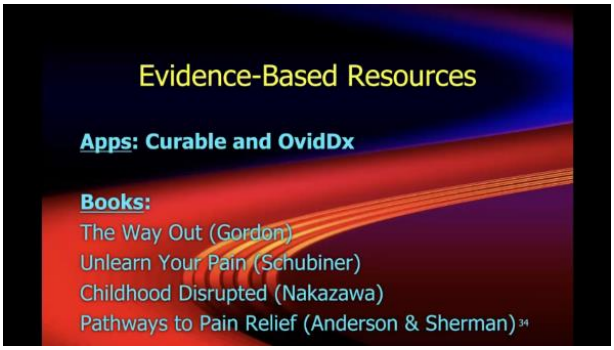
[00:33:27] We wanted it **so the medical professionals could read the mental health material** and vice versa. And a nice fringe benefit from that is that people who aren't healthcare professionals at all, if they're interested in the science, they can get a lot out of this. And I know a number of psychotherapists who are prescribing this book for their PPD patients.



[00:33:48] Once again, all the royalties are donated. Same with this book. This one's more for professionals. It's got a table of almost **500 different diagnoses in it and describes the contribution of PPD to those diagnoses**. The

diagnoses were selected because they're common in PPD patients.

[00:34:07] There's also a longer version of our 12 item online **self-assessment questionnaire that's a full 37 items**. Same structure, the more questions to which you answer yes, the more likely it is that you have PPD.

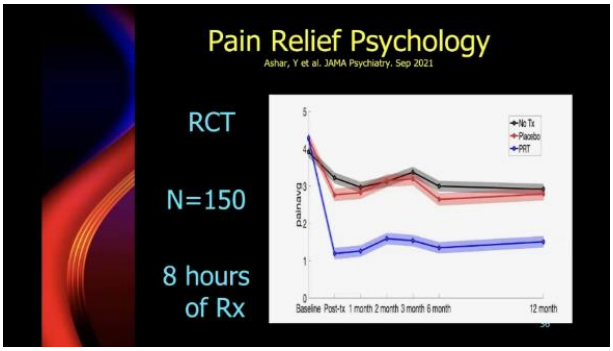


[00:34:22] More **evidence based resources**. I'll point you particularly to the **App: Curable**. They charge for it, you know. About the same amount you'd pay for a half hour of psychotherapy, for a year subscription.

[00:34:34] The founders of that company took the best ideas from my colleagues and myself and put it into a wonderful user interface. The other app up there is to teach healthcare professionals these ideas. **Several other books**, evidence-based, that I can recommend, each one has something to contribute.

[00:34:53] **Pain relief psychology, there are several subtypes**, but they're all closely related. And what they share is that they **focus on brain generated pain**. Their goal is relief of pain or illness, not merely helping people to cope with it. And they address, most of them address adverse childhood experiences or ACEs, trauma, and emotions.

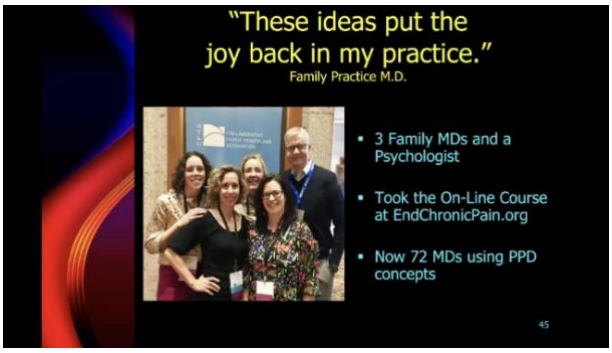
[00:35:14] And when they do that, they get these kind of results **huge changes in pain scores in fairly short spaces of time**. This was the **Boulder Back Pain Study**.



[00:35:24] This was a **West Los Angeles VA study** of older male veterans with chronic pain. Two groups, one got cognitive behavioral therapy, which I mentioned earlier, the other got pain relief psychology of a specific type, happens to be **the one that I practice the most**, and you can see the huge difference in achieving their goal of at least 30 percent pain relief.

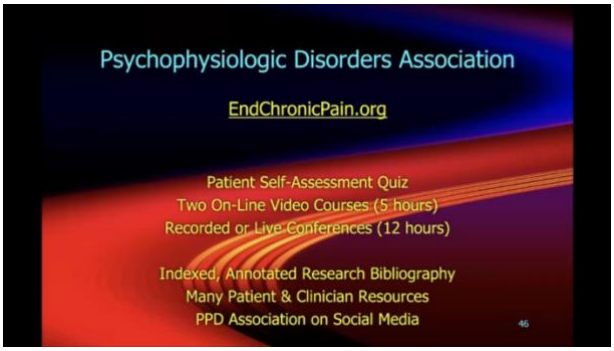
[00:35:47] **Nothing like this has ever been seen before in pain relief literature** to have an eightfold higher success rate.

[00:35:54] This is a **study from Harvard** showing similar striking results.



[00:35:58] I will skip over since we're so short, telling you the stories of some of these patients. But I will say that the **doctors** who have learned how to do this **have seen their practices transformed.** One of these doctors who learned it a few years ago, took me aside at a conference and said, these ideas and **put the joy back into my practice**, and they were so enthusiastic about it that it spread from these 3 doctors to now a full 72 doctors in their community, which is a medium sized city. **They took the online course at endchronicpain.org.**

[00:36:30] Here's the information about the nonprofit and we've got lots of resources on there that are growing all the time. **I'm very enthusiastic about the advanced course** that's coming. It's going to be jargon free. It's got actors in it. It's got graphics in it. It was filmed here in Portland with a video production company that I'm very excited about. And that's going to be released in January. So I'll stop there.



[Question period begins]

[00:36:58] Yeah, that's great. Thank you. so much. Kathleen, go ahead.

(Kathleen) You know, in the pain science group, we discuss all **different methodologies**, and there's so many different answers, it seems, but it sounds like you've found the secret sauce on that. Can you explain that a little bit more on why mindfulness, there's just so many options that pain sufferers go through and trial and error. So, do you suggest all of those or do you have, a little bit more of a state straightforward path?

(Clarke) Let me, let me show you mindfulness.

[00:37:38] Here it is. This is **this study from Harvard** with the vertical axis showing the percent of their subjects who were completely pain free and the horizontal axis shows the 6 month or 26-week duration of the study. In the pain relief psychology group, which is the brown line, they all start off with zero are completely pain free.

[00:38:07] Six months later the pain **relief psychology group has 64 percent** are completely pain free. And the reason I'm showing this slide is that the magenta line there is **mindfulness, which achieved, 25%,** pain relief after six months. So it was better than nothing, but not much. If this was a football game, the score would be 64 to 25.

[00:38:38] And so that's why I didn't talk, and you didn't hear me talk about mindfulness tonight because it's a little better than placebo, but not a lot. And if you're going to be working on this, you should **devote your energy to the technique that's the most effective**. it took me years to, I mean, I was on a relentless pursuit of the root causes of what was going on because I had seen Dr. Kaplan cure this profoundly ill woman, with just talking to her. So, I knew it could be done. And I was determined to find what was necessary to achieve those kinds of outcomes with everybody who came my way that had this problem. It took me five years of almost 300 patients a year before the pieces of the puzzle finally came together.

[00:39:35] You know patients who have this condition, when I, when they don't know anything about it, and I first see them in the office, and they're telling me their story, it is as if they are randomly throwing **jigsaw puzzle pieces** at me, and I don't have the box to show me what the picture is supposed to look like.

[00:39:54] And sometimes a piece that they throw at me in the first five minutes, and a piece that they throw at me after 35 minutes, fit together and it makes sense, it just, took me a long time. And like I say, probably close to **1500 of these interviews**, before I could, make these pictures happen on a regular basis.

[00:40:18] You'll see some of the results of that if you take the advanced course in January. In that course, I am teaching the **most advanced stuff** that I possibly can.

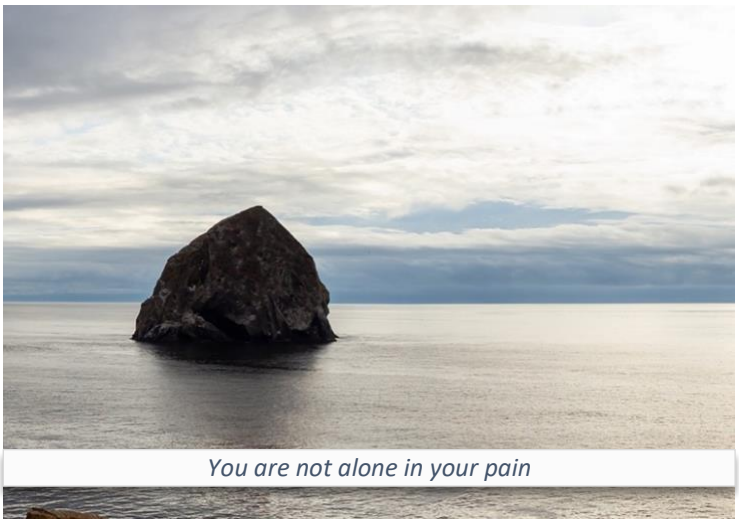
(Maureen) Wow! What was the **brown line** again, doctor?

(Clarke) That was the form of **pain relief psychology**. Okay. They had a fancy term for it, but that's basically what it was, is everything. They called it **psychophysiologic symptom relief therapy.**

About Pain Science Life Stories

Formed in 2018, the Oregon Pain Science Alliance (the Alliance) is an all-volunteer nonprofit 501(c)3 corporation. Our members come from the health care community, their patients, and others who follow pain science research.

We seek to share current information on how pain experiences are formed in the brain and influenced by biological, psychological, and/or social factors. Through community education events, health care workers describe how pain-science-based practices have changed their interaction with and care for patients, and patients tell stories about their experience with learned pain science tools used to help master chronic pain. We can now share these collected and curated stories, and other unique features, through the Alliance "story website" launched in early fall of 2022.



You are not alone in your pain

How to get involved?

Do new Pain Science insights and practices resonate with you?

We welcome anyone interested in collaborating to find or produce good stories and insights, then curating them to display on our website. Sharing in our discoveries and making them broadly available is both personally positive, and mutually satisfying.

The phone number or email address below will get you more information about us; then use the website link to the Member page for the steps to become an Alliance member, if that makes sense to you.

If you have a story using pain science tools and practices, and would like to share it with the larger community through our website, please send us an email. We would love to hear from you.

Phone: **541-224.8378**
Email: opsa@painsciencelifestories.com