TIL LUCHAU: Hello there! I have the pleasure today of being with Ruth Werner and we are going to talk about her recent attendance at the San Diego pain summit. Ruth is a retired massage therapist and an active writer and educator. Her book “A Massage Therapists Guide to Pathology” is in its sixth edition and it’s used in massage schools around the world. Ruth has a passionate interest in massage therapy research and in the role of massage for people who have health challenges. I am happy to be talking to Ruth today. I knew you at a distance for a long time before we ever meet in person and you had one of those names where you hear “Ruth Werner” and you go "oh yeah, of course I know her, because she’s written and she's you know... one of the people that’s real established in the background information that we are talking about." So, when you were going to the pain summit, and I couldn’t go, I thought how lucky for me that I know you and can invite you to have a conversation about it and really glen from that experience some of your take away. So, we'll do that. We will have a conversation and I am just really glad you are here! I am really looking forward to finding out what you learned and looking at how we can play that.

RUTH WERNER: Thanks Til. It’s a great pleasure for me to be here. I want to tell you I have a small group of friends on Facebook and I told them I was going to be having conversations with Til Luchau and they all went "Ahhhh I wish I could be there!” So, you have a deep and devoted following of people who really love and appreciate your work.

TIL LUCHAU: Lucky me.

RUTH WERNER: So, it is my pleasure to introduce my friend and cohort in this project Til Luchau. Til teaches hands on work around the world and writes a regular column for a leading professional journal. Yeah, I think I write a column for that journal too. He is a Certified Advanced Rolfer® and has been a somatic psychotherapist, resident practitioner at the Esalen Institute, faculty chair of the Rolf Institute's Foundation of Rolfing Structural Integration program and adjunct faculty at Naropa University's Somatic Psychology Degree Program. So, it’s a great honor to be with such a fancy person and I am eager to talk about what I brought away from the San Diego pain summit. I want to emphasis for our listeners that this is just me, and my little pointed headed filter, and I hope everybody who hears this understands there’s much more to what happened at this meeting then what I am bringing in. I’m just sharing these things that are just stuck in my head.

TIL LUCHAU: Thank you. We gave ourselves permission to do the unauthorized version of our own impressions of all this by definition. I’m just asking you what’s stuck in your mind and I’m just going to free associate a little bit and talk about what sticks in my mind as a result.

RUTH WERNER: Sounds great.

TIL LUCHAU: So Ruth, thanks for taking the time to talk. I didn’t get the time to go to the San Diego Pain conference. You did attend and you've agreed to take some time to talk about your takeaways and highlights and I’m going to help us have a conversation on how to apply those things if there is even an application in practice. So, you are at home on the coast of Oregon?

RUTH WERNER: That’s right, the Pacific Ocean is right out the window.

TIL LUCHAU: So cool!

RUTH WERNER: No seals today.

TIL LUCHAU: Yeah and I’m at home right here outside of Bolder. No oceans in site but it’s a great day and it’s just cool to be able to talk to you like this, in spite of all the technical fussing we had to do to even get to this point. We are going to talk about a few things, and I wonder if there is anything overall you want to say about what the conference was like for you, or want to share for the people who weren’t there in the big sense.

RUTH WERNER: Sure. The San Diego pain summit is a meeting that is quite different from most of the other conferences and congresses and conventions, at least that I attend and go to a lot. There are a couple of things that make it really different. One is, it’s essentially the brain child of a single person named Raja Rousse. I’m not sure what the genesis of this meeting is but she has been able over the past three years to create a collection of physical therapists and massage therapists and other kinds of manual therapists. There are osteopaths and

chiropractors and some other who attend from all over the world who come together and talk about latest findings in pain science. But it's not a typical research meeting where researchers will get up and say here is my hypothesis and here are my methods and here are my results and here's what we think it means. There's a little bit of that, but the focus of this meeting is for clinicians and researchers to talk about application. To talk about where the rubber hits the road. As you know, I've been involved in a lot of research meetings and I get really excited to hang around with scientists who like to study things.

But very often there's a big disconnect between what they study and what a person can use in the session room and it becomes the job of people like me you to discern when educators say "well ok, here's this finding it looks a little abstract but really here's how you can bring this into your practice and the purpose or a result." I guess the San Diego pain summit is that simple, where that people are not invited to come and speak if they don't have a really good sort of immediate application of what it is that they are talking about. It's an interesting hybrid between being a research meeting and being a typical education meeting, where you might go and learn some interesting new technique while framed around two days of general sessions. Typically Raja has workshops with some of these scientists and researchers of who are also clinicians where you get to spend an extended amount of time with people. I have not done the workshops. Yet even what I was hearing about this year's workshops I might reconsider that for next year, although I'm not in practice right now and I don't even see clients. I am not a clinician but I am so intrigued by what these people say about how this applies in real life setting, that even I am interested to pursue that. So that's a little overview of the San Diego pain summit.

TIL LUCHAU: Well that's great.

RUTH WERNER: Takes a lot to make me interested and I am perfectly happy to say this to anyone who wants to listen. When I was in practice, which I was for a long time, it was not my favorite part of my career; I didn't feel like I was good at it. I was confident and I was safe and I enjoyed it a little bit. But it wasn't my favorite part and then I stopped being in practice, which was when I was hugely pregnant with my second child. I ended my practice and I didn't go back and I didn't miss it. So, to be exposed to ideas that make me really interested about hands on application is kind of a big deal. So, for people like you who still work with clients or patients it's an even bigger deal.

TIL LUCHAU: Well that's an interesting point because yeah, I do still see clients because that's what helps me play with all these fun ideas. I don't love ideas for their own sake and do a bunch of reading. I learn online when I can but the question is like you said, where does the rubber meet the road? And, in our field of massage therapy and body work with related disciplines, I think it's probably a pretty common value that people want to know how it's going to affect what they actually do. We tend to be pragmatic to people. We want to know how does this really wash out in terms of what am I going to do with clients. So that's kind of interesting to hear a feature of the speaking of the things that went on there. So, I look forward to hearing that through you, and how do we use those ideas. Sometimes that's one of the critics of pain science, in that it makes a lot of sense to people and yet how do you use it when you actually get with your client.

RUTH WERNER: Til, you and I have had conversations leading up to this about what are the key points that we might want to focus on. I went to my first experience with the pain summit last year, and I came away from that with some interesting takeaways because it was the first meeting I had done with a lot of physical therapists. They are a cohort of people that I haven't spent a lot of time with and I learned of lot of interesting things of how our professions compare. This time my main takeaway was quite different. It was about the applications of pain science as being less about what we are doing with our hands, but even more so what we are doing with our mouths, right? Because a huge amount of what we are learning is that when people catastrophize, and are so focused on their pain and their limitation, then their pain and their limitation get exponentially worse. One of the things that Dr. O'Sullivan spoke about as the key note speaker was his research about how and when you combine things like fear and boredom (?) and then throw out the wonderful? Lots of wonderful language about how people get tied up and tangled in their pain. When you combine that with pain and dysfunction they each get exponentially worse.

Where if we have the same kind of physical situation in a person who is generally not fearful or generally has a better sort of personal resilience, then the long-term repercussions look really different and that is where the "new pain science" separates from a paradigm that you and I came up in which is that pain is a result of injury, right? There's a biomechanical problem that generates these signals and we understand this as pain. So, if you

solve that problem then the pain signals go away and the problem for chronic pain situations, not acute ones, but for chronic pain situations, turns out not to be true, right? And so I come back to my original point.

TIL LUCHAU: Or not necessarily true.

RUTH WERNER: Right not necessarily. But the biggest difference or the biggest change that a lot of the presenters were suggesting, in terms of how best to meet people where they are with their chronic pain situation, is just to change the messages coming out of our mouth. So, instead of saying "oh you have a short leg or oh you have a rib out or oh you have osteoporosis and your back it's really fragile" those messages need to change away from focusing on limitation to focus on what would you like to be able to do? What do you want to be able to do that I can help you with and how can we work together to help you get to that point? It might be something simple like "I want be able to tie my shoes without pain." Or it might be something more ambitious like "I want to be able to play a round of golf."

Either way we need to shift the conversation away from what we can't do and restore the things that we can do and begin to set goals that are client driven. These are functional goals that are set by the person and our chances of having success are better. And success means having people not necessarily be out of pain because that's not always a realistic expectation, right? But success is a person feels able to manage their life even though pain is part of it.

Another image that one of the presenters came up with that I really loved, is to think of a circle and the circle is pain, ok? And a person who lives in pain, their life might be only a tiny little circle bigger then that pain, right? So, the pain is the biggest part of their awareness in their life. Yet, if through body work and therapy and good things happening that shifts the attitudes, the pain circle might stay the same size but we can make the life circle much bigger, then the pain is a smaller proportion of what they have to pay attention too. Does that make sense?

TIL LUCHAU: I guess.

RUTH WERNER: It was a good image for me because, you know, we live in a culture where we think pain management means making pain less, and the only drugs we must do are opioid drugs and that turns out to be kind of a dead end. It's really problematic. So, what if we shift to that instead of saying the only successful outcome for someone who lives in pain is for them to not have pain? What if the successful outcome for someone who lives in pain was, for them, to feel like their pain was manageable and that they could still have quality of life and that's all about attitude and self-efficacy. And you know, the good news for manual therapists, especially for massage therapists, is just how good we are at that. You know the research on massage, and things like anxiety and self-efficacy and optimism is quite strong. So, it's a great match for us if we can avoid saying stupid stuff like "Wow you really have a lot going on. Oh, this trigger point feels so hot or oh this." You know, whatever. We just have to be careful how we communicate both verbally or not.

TIL LUCHAU: Alright, let me grab on to that one.

RUTH WERNER: Ok.

TIL LUCHAU: That's great by the way. I made a list of your little points too. Let's grab onto that one for a second, is that ok?

RUTH WERNER: Yeah.

TIL LUCHAU: You said, or one of the things you said is "There's a lot we can do with our mouths." Meaning our words, I presume.

RUTH WERNER: Our words, yes of course.

TIL LUCHAU: And that a lot of that has to do with, as you said, the anxiety or the expectations or the way people think of or conceptualize their pain. And you just gave the example of saying... what did you say? Your trigger point is really hot? Give me a couple of those things you just said.

RUTH WERNER: Right, or I remember saying that to one guy once, and I was new therapist alright. And in my own defense I've been licensed from 1986.

TIL LUCHAU: We have all been there.

RUTH WERNER: Ok.

TIL LUCHAU: We are still there

RUTH WERNER: And he is giving me this list of things going on and I said "Wow you are really a mess, aren't you?" and his face totally changed, and not surprisingly he never called me again. I mean all I wanted to do is validate that he was having a hard time but I was not, a reminder of things not to do.

TIL LUCHAU: Well yeah, and I see this come up a lot in my trainings and with our assistance its really part of something that we all work on and try to be aware of. It isn't easy though, because sometimes the clients don't come back but sometimes they actually get more interested in what we are giving them. If we want a picture that there's something wrong with them {INAUDIBLE} that meaning too you know. With the best of intentions we can decide things in a way, and you know it happens all the time. When I'm going to someone to get some work they go "oh you are really tied here" and that might be a little more in the grey area and then you really messed up. But there's that language that takes over and the more we will say "Boy your shoulder is really messed up," you know, or something like that as they are being worked on. And I can think "wow great that I am here getting fixed by you" which is an interesting set up.

RUTH WERNER: Yeah.

Til LUCHAU: Yeah. Or, like in your case, I can just not come back or I can go away with something in my mind like "what is it about my shoulder? Something is messed up in there? Wow!" So that the next time it actually feels funny I think "Oh yeah there's that messed-up thing she told me about."

RUTH WERNER: Right, so I must move it.

TIL LUCHAU: So that can progress to some place like "yeah I'm not going to move it."

RUTH WERNER: Right.

Til LUCHAU: "If I'm not very careful with it. I won't mess it up more" and that...

RUTH WERNER: Yeah.

TIL LUCHAU: You know that starts that cycle of more chronic pain.

RUTH WERNER: Right and limitation and fear.

TIL LUCHAU: Limitation, more fear.

RUTH WERNER: Exactly so, exactly so.

TIL LUCHAU: Like you said it's linked with pain levels.

RUTH WERNER: Right. If we now take that idea from a shoulder and put it in L4, L5 or the SI joint where we know chronic nonspecific low back pain is sort of the gold standard by which chronic pain issues are compared, people can feel so fearful because they are going to bend over and wreck their disk, or they are going to bend over and tear a ligament, or a muscle is going to spasm. And I don't want to say "oh no, you are not really experiencing that." That's not appropriate or fair or true.

TIL LUCHAU: Ok.

RUTH WERNER: Right, you can't say to someone you are not really in pain. What we can say to someone is "Is there another way to accomplish this task that you want to do?" So Dr. O'Sullivan gave this lovely example, including some video of this man who is just in his 40's. He had a lot of chronic back pain and they were talking surgery for him and he went to see this PT and he demonstrated how hard it was for him to bend over and pick up his shoe. I mean he had sort of a movement like watching a giraffe kind of get down and, you know, try to get ready to get a drink of water. It was that labor intensive and the PT Dr. O'Sullivan had him sit down on a chair and from the chair reach down and pick up his shoe. Then he said "Ok, from the chair reach down and touch your feet and now try to straighten your legs a little bit." And you know, within 20 minutes the guy was bending over and he had no pain. And it was all about approach, and what can you do rather then what can't you do.

TIL LUCHAU: So he incrementally took him through a series of things that he could do without pain and build those into a larger task that he wasn't letting himself do before.

RUTH WERNER: Because it was so scary.

TIL LUCHAU: Yeah.

RUTH WERNER: And because he was doing it from a direction or a positon or whatever where he had pain and the pain was terrifying.

TIL LUCHAU: And at least what you told me here, Peter O'Sullivan wasn't challenging his concept yet, except through his experience.

RUTH WERNER: Exactly...

TIL LUCHAU: You say "now what happens if you are in a chair and you bend over, does that hurt?"

RUTH WERNER: Right.

TIL LUCHAU: Referencing it I imagine, I wasn't there. But I imagine he was referencing it back to the client or patient's experience in the moment. So, he didn't have to convince him the pain is in your brain or whatever. It was more like "oh do you hurt when you bend over? No? Ok let's try a little more then."

RUTH WERNER: Yeah exactly. I mean that's really where it went. So, you know, this obviously is not going to work for every client, but it was a really lovely example of someone who felt so limited and so scared and in his 40's was thinking about a spinal fusion. It's probably a good time to talk about this. In our conventional medical system and the biomechanical model, where if someone is in pain, you look for what's wrong and then you try to fix that thing that's wrong and then their pain is supposed to go away. So, in that biomechanical model you know, he had a bunch of X-rays and MRI's taken of his back and it showed some arthritis and it showed some disk degeneration and so the assumption was that, that was the source of his pain. I do want to emphasis that this man never had an accident, he wasn't in a car wreck, he didn't have a fall. He slept wrong. He slept on a floor one night and then woke up with new back pain and sort of tracked everything back to that.

TIL LUCHAU: Yeah.

RUTH WERNER: And by no means disrespecting conventional medicine because it is, you know, lifesaving, but for chronic pain situations, it sometimes is not the most successful option to follow and the statistics on back surgeries in particular are really poor. And that's probably because the correlation between what we see on an X-ray and in our MRI and where someone's pain is, is almost nonexistent. You know there's been some studies where technicians and surgeons will look at random x-rays or MRI's and predict where people's pain is, and these were pictures of people who had no pain. So, you know the correlation between those imaging tests and pain is not always strong.

TIL LUCHAU: You're saying that experts can't spot from MRI who's in pain and who's not?

RUTH WERNER: Yeah.

TIL LUCHAU: And there are a lot of people that have really ugly images who don't have any pain.

RUTH WERNER: Exactly.

TIL LUCHAU: So just because you have an ugly image, there may or may not be a connection to the pain, and the tendency, I mean, this is the baby with the bath water question, does anybody who has a bad looking MRI have pain because of what we see in the MRI? And here comes the opinion, Til's opinion, yeah, sure.

RUTH WERNER: Yeah, oh I totally agree.

TIL LUCHAU: There's a bunch of people, and apparently not just Til's opinion, but there's a lot of people who get back surgery and feel better. You know, there's stories of like, patients who as soon as even in the operating room they can feel the difference. So, there's those stories, and, on the other hand, there's this point of view that you're putting forth that it doesn't always correlate. And in fact there are many, many cases where it doesn't. So, just because I have back pain doesn't mean I need back surgery, or doesn't mean my pain is because of some biographic finding or some mechanical, biomechanical thing going on in my back. And it doesn't necessarily, might, but doesn't necessarily. And strategically it can be helpful to uncouple those. In our own minds, and in our client or patient's minds, that automatic association that we can go for "Oh it's my back. It must be my ugly looking MRI", or "it must be my disc or it must be my such and such." It's helpful to kind of tease those apart. Not to try to disprove either one but to say that maybe they don't always go together.

RUTH WERNER: Well, in one of the things that Dr. O'Sullivan pointed out to his patient was that his images looked pretty much like the back of any typical 45 year old. It wasn't astonishingly different from anyone.

TIL LUCHAU: Yeah

RUTH WERNER: And that was important!

TIL LUCHAU: I think it's a 50, I'm probably getting it wrong, but at 50 half of us have bad looking MRI's. It's 50 percent of us look bad.

RUTH WERNER: Yeah.

TIL LUCHAU: By the time we're 80 years old, 90 percent of us have awful looking MRI's. I'm sorry that's not 50 percent of us, that's 50 percent of asymptomatic people. 50 percent of us who don't have pain, have an MRI that would suggest, in the conventional view, that we might have pain even though we don't.

RUTH WERNER: Yeah. For our listeners, we've been talking about setting aside the biomechanical approach and I don't want to. I'm not abandoning it, not abandoning the biomechanical approach to pain management because, especially for acute pain, if you break a bone, the pain is probably coming from the break. Or the pain is probably a response to the damage and the inflammation that's happening, right? But, you know, the biopsychosocial model of pain, and it refers most often, is in the context of people who have lived with pain for a long time. So, there's a biological aspect of it, and there is a mood and mental attitude aspect part to it, that's the psycho part, and there's a social aspect to it which is how we create or abandon our social support systems when we live or identify with being in pain. So, the biopsychosocial approach to pain management really tries to look at all three of those and to realize that, you know, your best results are going to happen when we can address the mechanical factors, plus the mental and mood factors, plus the social support factors. And here we are, massage therapists, and we get an hour or an hour and a half of time alone with someone to give them our full focus. And you know, the only other people in health care who do that essentially are dental hygienists and surgeons.

TIL LUCHAU: Well there are structural integrators and Rolfers. There's people that don't identify themselves as massage therapists

RUTH WERNER: Ok.

TIL LUCHAU: Who might be able also to have that care and time with people.

RUTH WERNER: Yeah.

TIL LUCHAU: And might be here listening or reading as well.

RUTH WERNER: Thank you. So we'll broaden that to manual therapy, alright? So, manual therapists have this beautiful privilege of having someone in this incredibly intimate setting where every word that comes out of our mouth is going to resonate in a little different way than it does when you just have a casual conversation. So, it just points out how important it is for us to make sure that the words coming out of our mouth are supportive ones rather than limiting ones.

TIL LUCHAU: It would be interesting to go through the body, as I'm asking myself, how do we make this practical to go through the body and say, do the stuff that practitioners say kind of list, joint by joint almost or part by part.

RUTH WERNER: Yeah.

TIL LUCHAU: You could start at the feet and say some of the things that we all hear from clients, stuff clients say.

RUTH WERNER: Yeah.

TIL LUCHAU: My arches are falling.

RUTH WERNER: My ankles are unstable.

TIL LUCHAU: Yeah, my ankles are unstable, my arches are falling.

RUTH WERNER: Yeah.

TIL LUCHAU: I've got flat feet, and going up from there every one of these places in the body has their own lexicon of pathologies or things that, as we describe ourselves, may not allow for helpful change. They may limit possibility rather than create it. It's not just a question of not using those terms. I mean, I can make a whole list of things not to say. But then, often what happens is, then I feel really inhibited, or I get really fearful as a practitioner about saying the wrong thing.

RUTH WERNER: Yes.

TIL LUCHAU: So, they just get a whole bunch of don'ts in there.

RUTH WERNER: Yeah.

TIL LUCHAU: Then that's not an empowered place to work from either.

RUTH WERNER: Right. So, we can talk a little bit then about the do's. And again, here I am totally triangulating, because a lot of that came in the workshop sessions with these people who are really building a specialty around these good communication skills.

TIL LUCHAU: Ok

RUTH WERNER: If our listeners are familiar with the basics behind cognitive behavior therapy which is a type of talk therapy, this is about identifying patterns that are maybe less useful and replacing them with patterns, or thought processes, or choices that might be more useful to get people toward the goal that they want to go.

TIL LUCHAU: Okay

RUTH WERNER: So....

TIL LUCHAU: So, let's not assume anyone is familiar but go ahead and I'll see if I can fill in.

RUTH WERNER: Ok, good. So, a way to do that is to use a nice analogy. If we are doing this with hands on work instead of calling it cognitive behavioral therapy, and again I'm not making this up, this is from O'Sullivan. He talks about functional behavioral therapy. In other words, having people replace behaviors that don't help

them with behaviors that do help them. Like if you can bend over and pick up your shoes that way, let's find a way that you can without pain and without fear.

TIL LUCHAU: Nice. So you are saying CBT, or cognitive behavior therapy is the point of view that says "I can start to be aware of how I'm thinking of things and then maybe chose alternative explanations or other ways of framing it in my mind". That might be helpful.

RUTH WERNER: Yes, it makes it sound really easy doesn't it?

TIL LUCHAU: Well, it's probably easier said than done. But in has proved really effective with chronic pain and lots of things. So now functional behavioral therapy with of all O'Sullivan's terms.

RUTH WERNER: Sorry there must a squirrel. Excuse me a moment. (Talking with dog) Woody come here, sorry Til

TIL LUCHAU: No worries.

RUTH WERNER: I have all blinds up so he can see anything. Like if someone walks in front, or if there's a squirrel on the roof.

TIL LUCHAU: He is going to bark.

RUTH WERNER: As to protect me.

TIL LUCHAU: That's fine. So

RUTH WERNER: So alright...

TIL LUCHAU: So, functional behavioral therapy. Let's give it a little pause here for just a second.
Ok, so what you are saying now is that cognitive behavioral therapy and functional behavior therapy would be looking at functions, movements or actions that can perform as re-evaluating or re-imagining those re-conceptual, you know, re-doing those ideas essentially.

RUTH WERNER: In a way that works for people. So, I have sort of two ways, two directions I want to go with this and I just lost one of them. I mean one of them is what we have been talking about with this gentleman who wanted to bend over and pick up his shoes. So he, you know, he learned a different way he can do this that he could do without pain and it gave him some new options.

So, one of the different presenters at the pain summit spoke about exercising movement as therapies, and I was really intrigued at that. Maybe it was totally my projection on the differences between exercise and movement. I hate to exercise. But, I love movement and you know, it's just addicting, isn't it? So, it's an issue of finding a way to move that is fun and that is appealing and that is attractive and we see biologically in the brain. We can see people sort of carve out pathways for pain patterns and what we want to see, and this has been demonstrated to a small extent, that we can replace those carved out pain pathways with carved out fun pathways. To me this is really exciting! It's less in the world of manual therapies and more in the world of physical therapies. But, we can certainly be boosters for people to find, if you must stop using the word exercise then do that, but find movement that is enjoyable and fun. And you know, you ask any doctor what's the best exercise and the doctor will say the one that you do.

TIL LUCHAU: Yes

RUTH WERNER: You know for me is I get out for two miles on the beach every day. And for other people it will be hiking in the mountains or it will be swimming or it will be whatever. But the research about exercise and pain is again not a one to one correlation but the research is about pain and self-efficacy. That means feeling like you have a sense of control in your life, that's clear.

TIL LUCHAU: Then I can make a difference in my experience.

RUTH WERNER: Yes, and I have some control and some management options.

TIL LUCHAU: Well you said something interesting. You said that's more of a PT thing than a body worker thing and you know, the movement or the exercise piece. And classically yeah, in some place in fact, there are very clear lines of distinction between scope of practice. You are not to give exercise recommendations unless you're a physical therapist. It is not like that everywhere.

RUTH WERNER: Right, yeah.

TIL LUCHAU: And often clients do ask those who are body workers, "now what or how can I take this with me?"

RUTH WERNER: Right.

TIL LUCHAU: What exercise you are going to recommend they do, and some body workers are very specific about that. Others don't do that at all. So, if we lay that out as the scenario, where does that take you?

RUTH WERNER: So, when someone says "Ok how can I, how can I bring this home? How can I take care of myself? How can I do homework?"

TIL LUCHAU: Yeah

RUTH WERNER: I think we have several options. One is to encourage people to do things that they love to do. Another is, and with this you need to know for sure that this is true. But, if people feel they have a limitation because they are scared of their disk or they are scared of their ligaments or they are scared of their muscles and if we had knowledge from their health care practitioner, then they really don't have to be that scared about it. Then we can encourage people to, I don't want to say, push the boundaries. But I want to encourage people not to be scared of their pain.

TIL LUCHAU: Ok, how do I? I'm playing Devil's advocate a little bit.

RUTH WERNER: Yeah, please.

TIL LUCHAU: How do I, as a massage therapist, Rolfer, and body worker whatever, do I know that to be true? How do I know that what the client is coming in with is ok for them to move?

RUTH WERNER: Right. We don't always and so that's an issue of being able to work with someone's health care team, if necessary, to do that. So, you know an example of this would be Dr. Smith has Miss Jones come to see me for her chronic back pain. Before I do anything, or give her any advice about self-care, can you confirm for me, deny or confirm what the risks would be if she would start swimming or if she would start weight lifting or she would start doing this or that?

TIL LUCHAU: I'm going to challenge you a bit there?

RUTH WERNER: Please do.

TIL LUCHAU: That is a safe answer. I make sure that every article I write says "check with your doctor." and every class I teach that's an important practice. And it's important for us as educators to be emphasizing that over and over. And what if my provider doesn't have the same reference? What if my providers reference is the thing that's making me afraid to move? Let's say.

RUTH WERNER: Yeah.

TIL LUCHAU: I'm going to help you out here too.

RUTH WERNER: Good, but let me...

TIL LUCHAU: Go for it.

RUTH WERNER: Let me see if I can get this right.

TIL LUCHAU: Alright.

RUTH WERNER: No, I think there are many possible right answers and a few possible wrong answers.

TIL LUCHAU: What if I was told my neck or my rib is out? You know this is a classic. But what if I'm told that my rib is out? And...

RUTH WERNER: My primary care provider...

TIL LUCHAU: Let's make an easy one. Let's go to that one later.

RUTH WERNER: Ok.

TIL LUCHAU What if I was told I have disk issues and you know I've got to be careful not to bend. I said I was going to make it easier, sorry.

RUTH WERNER: Yeah, no I'm thinking. I'm thinking, and part of the reason that I'm hesitating is that I have a few ideas but again I want to emphasis that I am triangulating.

TIL LUCHAU: Yeah sure.

RUTH WERNER: Alright. Because, I am just conveying to you what I have heard from other people.

TIL LUCHAU: Yeah.

RUTH WERNER: Ok, so I have disk issues and my doctor said I shouldn't bend over. Is this our scenario?

TIL LUCHAU: Let's say.

RUTH WERNER: Ok, my doctor said I shouldn't bend over. I'm a little bit stuck. So, you know I mean among the things that I could say, I'm very careful about not stepping in between a relationship of a person and their primary care provider.

TIL LUCHAU: Absolutely.

RUTH WERNER: Even if we don't agree with them, even if we don't respect their opinion, we don't get to say, "well your doctor is full of crap."

TIL LUCHAU: You're saying it's not a helpful intervention for us to cause them to question their primary care provider.

RUTH WERNER: Yes. I will stand by that.

TIL LUCHAU: Yeah.

RUTH WERNER: Yeah. So, I'd say "well let's focus on things you can do and let's focus on maybe helping you find ways you can do the things that you want to do that feels safe."

TIL LUCHAU: Nice.

RUTH WERNER: That's the best I can come up with.

TIL LUCHAU: Nice.

RUTH WERNER: And it's, you know, it's pretty good.

TIL LUCHAU: Yeah. Could I throw one in there?

RUTH WERNER: Please do.

TIL LUCHAU: Yeah, and I'm the same.

RUTH WERNER: Please help dig me out of this hole.

TIL LUCHAU: I'm the same way. I'm going to start everything I say with, “I'm not a surgeon, I'm not an orthopedist, and I'm not a physician.” I would never second guess any of those practitioners or providers that you have and let's explore a little bit. Let's see what happens if we do this work or this other movement. I'm not going to tell you to do something your doctor told you not to do. I would never put you in that situation. I'd never try to second guess what they're telling you and at the same time I want to help you find the way to know what's ok for your body. I want to go through different options and see what you experience and we're going to learn that together as we go. And we can come up with a way for you to evaluate does this help or does this not. And I do, I'll say this to people as I do want to question the assumption that you are broken, damaged, or fragile.

RUTH WERNER: Thank you so much for saying that! That's huge, that's such a huge thing.

TIL LUCHAU: Because it's easy to take that away from what other people are telling us, even if they don’t mean that. It's easier for me as a client to make that meaning out of what's being told to me. Is there something wrong with me? I’m trying to be careful with my body that it might get worse.

RUTH WERNER: That it might break

TIL LUCHAU: Or break.

RUTH WERNER: Yeah.

TIL LUCHAU: Get damaged by something I do.

RUTH WERNER: Like it's going to crumble.

TIL LUCHAU: Yeah.

RUTH WERNER: Right.

TIL LUCHAU: Yeah.

RUTH WERNER: No, that's so important and so, you know, even people who have been told that they must be very careful with their back can still feel vital and energetic and powerful. They may have to, you know, go about that in a different way than some other people.

TIL LUCHAU: The other thing I do is I have a lending library. So, I don’t have to say “take it on my authority,” yet I say “here take this book and read it over. If there's anything in there that jumps out at you great, if not, don’t worry about it.” And that's the follow up question “So what in there was interesting? Was there anything in there that was different than you've been thinking about things? Anything that you want to know more about?” And the books explain pain. Anything by Mosley of course, or Butler. Those guys and their books that basically just lay out the case, let's say, some of these things you've said. The tissue damage can cause pain, cause pain say, that doesn’t necessarily relate to pain at all. Or the pain, say it this way, pain doesn’t necessarily relate to tissue damage at all.

RUTH WERNER: Right.

TIL LUCHAU: So sometimes just that piece of information for someone that is post-surgery, say four months out and is still hurting, in this kind of a gray zone. Is it the tissue, or is it just my responses to all that history I’ve had before and the surgery itself that's causing it to still hurt? Just that piece of information that says, you know, pain doesn’t always, or even often, correlate to tissue damage that someone gets.

RUTH WERNER: Right.

TIL LUCHAU: They go, "what?"

RUTH WERNER: Certainly not when it's been long lasting like that.

TIL LUCHAU: When its, let's see, let's take it out a year. A year later it's pretty safe to say that some of the pain you're experiencing may be, and some people say all the pain you're experiencing is, unrelated to your tissue damage or any tissue damage at all. So, I'll say it again, it could be a year out and there are people that say that if you have pain a year later it's not because of tissue damage.

RUTH WERNER: I think it's a safe bet.

TIL LUCHAU: Yeah. If you want to be really safe you could say they don't correlate. You know, the pain you have after a year probably, your chances are, doesn't correlate at all with any tissue or biomechanical things going on.

RUTH WERNER: Yeah, I mean I think we can probably all think of exceptions to that rule, but very often, I think that's the case.

TIL LUCHAU: Yeah, yeah.

RUTH WERNER: And I think for me, the thing you said that was what got to the heart of it is that, even if someone's been given a diagnosis that looks scary, having the attitude that we are broken, fragile, or crumbling people is not a helpful way to move forward. And we can be more helpful to people by helping them experience themselves as vital and focusing on their strengths and looking for client-centered functional goals. What would you like to be able to do that you can't do now that we can work on together? You know, I'd like to be able to sit at my sewing table for an hour, I'd like to be able to take my grandkids to the zoo.

TIL LUCHAU: Yeah, yeah.

RUTH WERNER: Whatever.

TIL LUCHAU: No, I work that way. I'm just thinking of a client who came in with back pain and his request was, when I asked him what do you want out of this, he says "I don't want my back to hurt." And it's like, naturally, so then when we started to unfold that a little bit my response was "Well that might be the case. Your back might get better. It might feel better after this work or it might not, it's hard to say." So, if your back didn't hurt what would that allow you to do that's important to you? What's your back stopping you from being able to do in your life now that you'd like to change? So right there, and he thought of it for a while, he says "You know what it is? It's getting down on the floor to play with my grandkids."

RUTH WERNER: There you go.

TIL LUCHAU: He says "I'm trying to play with them from the couch and then I hear words that it's not very fun to play with them that way. So, if I could get down on the floor, that would be something." So then, yeah, right, then, that was our goal. So, our goal and our practice became, let's do some hands-on work and then have you pretend like you're getting down on the floor and see what you run into and that gave us some ideas to go back to the table with about new places, new ways, new movements he could do that and would help him focus on his goal of getting down on the floor in a comfortable way.

RUTH WERNER: Yeah, that's very much what this is about. It's focusing on what we can do and reasonable goals working together. Another person who I have seen now twice present at this pain summit, is a wonderful occupational therapist named Bonnie Lennox. She's from New Zealand and focuses a lot on chronic pelvic pain. She and Sandy Hilton, who's another woman with similar expertise in Chicago, have done a lot of wonderful work and I think it was Sandy who had this leading question, "what does better mean to you?" And you know, we can focus on that as manual therapists.

TIL LUCHAU: Nice.

RUTH WERNER: And if we listen carefully to what your guy, who wanted to play with his grandkids, was telling you about, that was the social aspect of how his pain limited him.

TIL LUCHAU: Yeah, right.

RUTH WERNER: So, we really want to look for that whole big picture approach.

TIL LUCHAU: Yeah. And I just wanted to say too that some practitioners will hear an example like that and know exactly how to put it into practice, know where they want to go. Others may not, and that's fine too because, there is this model, there's a whole continuum, you could say, in hands-on therapy between the passive client coming to you for you to work on, then wanting to feel better as a result. It's at one end of the spectrum, and at the other end it's like, "I'm going to be an active participant in this, I'm going to take things home and do them. I want to change the way I move and live and exercise and all that kind of thing." So, clients exist on that spectrum and so do styles of working. And what seems to happen is a lot of practitioners want this kind of client. They want the ones who have self-efficacy and are willing to engage. And what they feel like they get are the ones that just, you know, just want to lie down and have you work on them today please. There's a way to work across that spectrum that could be satisfying, I think more satisfying to both people involved.

RUTH WERNER: Yeah, I agree with you, As people begin to understand that they can have an hour, where their pain is very much reduced, then they start looking for more of that and how they can maybe look for ways to actively create that for themselves.

TIL LUCHAU: Yeah.

RUTH WERNER: I love your comparison of the prepositions. There's a huge difference between working on someone and working with someone. And, when I was in practice I was a "working with", you know, I really wanted that interaction and the teamwork.

TIL LUCHAU: Yeah, me too. I have the luxury of doing that in my private practice. People come to me and that's part of what we talk about, part of what I explain early on. But, you know, early in my career, especially, I worked in resorts, I worked in spas.

RUTH WERNER: Yeah.

TIL LUCHAU: I still have a lot of people coming to my trainings that do that and sometimes they can do that and a lot of times they can't.

RUTH WERNER: Right.

TIL LUCHAU: And that scenario, it really is, the expectations that are working on kind of scenario, and yet there are little places where we look to, you know, at least wiggle the needle, if not move it all the way over there. At least get people a little more interested or a little more willing even if it's simply taking a breath, say.

RUTH WERNER: Exactly

TIL LUCHAU: Even if it's something that can be done right, a way to actively move on the table, those are the easy ones, you know. Or a way for me to think about the help I'm providing because, like you said, my anxiety or my agitation or my fearfulness are all going to contribute directly to my pain. And sometimes just receiving a great relaxing massage or positional bodywork is just the thing to ratchet that down in a way that it actually doesn't hurt as much anywhere.

RUTH WERNER: Well there's that. And there's another little tangent that I'd like to walk down if you have another minute or two.

TIL LUCHAU: Yeah, let's. What do you want to do, where you want to walk next?

RUTH WERNER: Well, I want to talk about fibromyalgia. So, fibro was not a topic at the Pain Summit that caught a lot of attention. If it came up it went right by me, and I usually pay attention. Because I teach a class about fibro and I'm always looking for more and good information about it. But, I think the very things about

many people who have fibromyalgia, and many people who live in chronic pain from other things are very similar. And part of what that is, is that people when we… I'm going to back-up one more step. I bet every single one of us; you and me, and everybody who ever listens to this does something in their life that's not good for them and they do it anyway. Like coffee, chocolate or staying up too late or, you know, whatever.

TIL LUCHAU: Sitting in front of the computer too long.

RUTH WERNER: Yeah, for instance. So, we all do things that aren't great for us and we do them anyway. One of the things that happens with people who live in chronic pain do, not everybody but lots of them, that's not great for them, is they get really, really attached to that pain. And there's a good human reason for it, which is that it always believes them. If you live in pain, and its pain that doesn't show up on an MRI, or an x-ray, or in a blood test, or in a neurology test, but its pain that just really knocks you out, nobody must believe you about that except for your pain, right? So, your pain becomes a part of . . . when I say your, I could say that my, I mean I have an analogy for this in my life and it's not pain, thank goodness, but it's anxiety about raising teenagers, right? So my worries about my kids were sort of my identity in the world. People who live with fibro, their pain can be their identity in the world. It's the thing that makes them who they are. And the prospect of getting out of that for an hour reminded me of when someone once cornered me and she said, "Ruth, what would it be like if for this weekend, you just didn't worry about your kids because it's not going to make any difference anyway." And that prospect was terrifying. It was terrifying because if you lift off that layer, what if there's nobody left?

TIL LUCHAU: What if there's nobody left.

RUTH WERNER: Right. What if there's nobody left? So, for people who live in pain, and their pain becomes the thing that is there, the biggest part of the circle, right? The circle where they hide the pain and there's almost no life around it, and we offer the option of getting out of that pain even if it's just for a little while it can be a really scary thing. And, for people who live in chronic pain, to show up for an appointment for manual therapy is very, very brave. And, they are sometimes not the most fun people to be around and not the most fun people to work with because they seem to just really be married to this thing. And we'd like to be able to say, you know, step out of it, there's more to life than this. That doesn't work. They need to learn from the inside.

New patterns and new ways of thinking and new relationships with their body. So, this is where I was going with, for that one hour—the person who's in this bar, the person who's in the resort; with their stress and their whatever; for that one hour—to step out of that and give them a new experience of this gift that we live with, and a relationship with this body that is positive, instead of unrelentingly negative. And I think it can really be challenging to communicate cleanly, and clearly and positively with people who don't communicate positively about themselves. Because we don't want to invalidate someone by saying, oh, your pain is not that big a deal, your tests show that there's nothing really wrong with you that's really not helpful things to hear. What we want to hear though is you have a lot of power in you, and you have a lot of options for how to get the best out of it.

TIL LUCHAU: Nice.

RUTH WERNER: So, that's my little tangent on living on…

TIL LUCHAU: That's great.

RUTH WERNER: On the personality part of living with chronic pain.

TIL LUCHAU: Well, that's great. And it could be said for a lot of chronic symptoms.

RUTH WERNER: Oh, it took…

TIL LUCHAU: And we talked about that person not being so fun to be with. There's the social part of the pain cycle too. It's as if your pain cycle is eclipsing the rest of your life, and that's all really what's meaningful to talk about or that, like you said, the pain believes you.

RUTH WERNER: Right.

TIL LUCHAU: Or the pain becomes all of the secondary gain things. The pain becomes the way that I organize my life. My story, really briefly. I have a three-year chronic symptom that in the end, when it started to go away, I realized, this is a whole different game now. Now I can do stuff.

RUTH WERNER: Yeah. Exactly.

TIL LUCHAU: That I couldn't do before. It was helpful to catch it through some friends help and things like you mentioned where I realized, okay, I don't have to do anything. Even if I don't have this, I don't have to do anything I don't want to. Even if I don't have the symptom, because the symptom allowed me to do lot of things that I probably didn't want to do anyway. Too sick to do that whatever.

RUTH WERNER: You thought you can get out of things. Yeah. Yeah.

TIL LUCHAU: So as the symptoms started to go, for me it was like, okay, I still don't have to do what I don't want to do. And that was liberating.

RUTH WERNER: That's wonderful. That's a great example. Yeah, and so you know, as people are involved in the bio, and the psycho, and the mechanical aspect of living with pain, and I'd say the social aspect of living with pain, I think we need to acknowledge that whole picture.

TIL LUCHAU: All right. I'm back with Ruth Werner and part two of our conversation. Last time we got some of her impressions on the San Diego Pain Summit 2017. And we started to talk some about the application. We're going to continue that conversation now and Ruth, welcome back.

RUTH WERNER: Thank you very much. It's my pleasure to keep talking.

TIL LUCHAU: Great. Now, I made a few notes last time and I have some bullet points that I want to go a little farther with you, and maybe you'll have some more things that you want to throw in too. But, the things that stuck out when we talked the first time, was the idea of working with our hands. Even as much and as more of our hands is the fact that we can use our words to have an impact with our clients as much as we want.

RUTH WERNER: And we want to do that on purpose and not by accident.

TIL LUCHAU: Yeah. There you go. There's ways that we can use our words, say, that might not be helpful.

RUTH WERNER: Exactly.

TIL LUCHAU: It might be working against ourselves. And it is common in our field.

RUTH WERNER: It's really easy things to do that, sound supportive and validating but in the long run end up being less helpful.

TIL LUCHAU: Yep. Anxiety and its link with pain. I'm just going to go through the bullets.

RUTH WERNER: Sure.

TIL LUCHAU: And then we're going to dive in. Anxiety is linked with pain. How much people's emotional state is a result of, or it contributes to, peoples pain states. And then it's hard to change one without paying attention to the other at least.

RUTH WERNER: Absolutely.

TIL LUCHAU: That sometimes our usefulness can't, or doesn't always involve getting people completely out of pain.

RUTH WERNER: Right.

TIL LUCHAU: The pain is not always the enemy. Sometimes it just doesn't seem to be possible to you, but even when it's not totally gone, there's a lot of ways that we can be useful. That was a great point you made.

You had this metaphor of pain being a certain size circle and our life being another circle that overlaps. And maybe the pain fills up the life one way, and we can think of the work as reducing the size of that pain circle. The other way might be increasing the size of the life circle. So, we're going to be working in more options that don't necessarily involve having to get rid of pain to live a satisfying life.

RUTH WERNER: You can have quality of life even if you live in pain.

TIL LUCHAU: That was, I mean I'm getting distracted here. I want to go in to that one, even for just a second, before I continue with the rest of the bullets.

RUTH WERNER: Okay.

TIL LUCHAU: That was so useful for me in my own dealing with the chronic symptom. The idea, the questions I want to ask is, let's say, "you can't end this situation. How could you have a satisfying life anyway?" And it really had to be the right time if you're going to hear that question to ask.

RUTH WERNER: Yes.

TIL LUCHAU: And that's really the wrong question to ask at other times.

RUTH WERNER: Yes.

TIL LUCHAU: But that question was super useful for me, and its one that has also been useful in my work with, especially chronic people, chronic pain or chronic symptom situations where people tried everything.

RUTH WERNER: Right.

TIL LUCHAU: And then, how do we work with acceptance and when do we know that acceptance is what we support. When we can, we can't eliminate…

RUTH WERNER: I'd like to dig into that some more as well. But the note I just wrote was on revisiting chronic versus acute, sort of guidelines.

TIL LUCHAU: Okay. Good ones. Language, we mentioned. We talked about that last time. Some like "yeah, you're really a mess, I'm going to help you out" kind of syndrome we can get into as therapists. And it's great that we help people, but do we have to say they're a mess to help them and how do we manage that? Then the question of how the biomechanical factors influence or don't influence pain. The belief our pain is related to biomechanical factors such as disc problems as the most talked about example. But, uncoupling those could be real useful and the biopsychosocial model. Just thinking that actually pain has a lot of dimensions, and if we're going to think about it holistically, then that involves perhaps looking at it from different points of view too. And then comparing that to what is, what are we good at, what's our scope, what do our clients expect? How do we keep this big picture even as we, you know, are working within what is really our purview? All right.

RUTH WERNER: Where there are some rich things to talk about.

TIL LUCHAU: There's a lot to talk about. We've got a little time. Where would you like to start?

RUTH WERNER: I would love to before I lose my excitement about this. I'd love to sort of lay out some thoughts about acute pain versus chronic pain because I think that that provides some nomenclature against some points of reference that can help clarify things like the tension between the biomechanical model and the biopsychosocial model of pain management.

TIL LUCHAU: Let's do that, and I'll try to be disciplined in terms of stirring this toward application too. Let's get to your…

RUTH WERNER: Yes, please.

TIL LUCHAU: Let's get your thoughts out.

RUTH WERNER: Right. That's great. Good. So, if you, if I… go for a walk on the beach like I do every day and I put my foot down wrong and I twist my ankle and it sprains, right. So, it got some torn ligaments and it swells up and it's painful. And you know, all those things that we see with sprained ankles. It's completely fair and appropriate to say, yep, there's a biomechanical cause for your perception of pain in this ankle because there's been this damage.

TIL LUCHAU: If I twist my ankle and it hurts, there's a biomechanical cause.

RUTH WERNER: Because it's new.

TIL LUCHAU: It's new.

RUTH WERNER: Right. And you have this inflammatory response and all this things go on. But, let's say someone has chronic foot pain, or chronic knee pain, or chronic back pain. If we were to take some of our amazing imaging techniques that we have today that we didn't have 20 or 30 years ago, when I was learning this stuff, we didn't have functional MRIs, we didn't have the things that we have today. If we look at older injuries that people associate with the source of their pain, lots and lots of times what we find is there's not a big inflammatory response. There's not a big whack of scar tissue, there's not the lesion, if you like, the pathologic change in tissues is not that pathologic.

TIL LUCHAU: Not that pathological.

RUTH WERNER: Not that pathological.

TIL LUCHAU: Well, or, that's the point at which a lot of us gets sent home by our surgeons, to say there's nothing wrong anymore.

RUTH WERNER: Right.

TIL LUCHAU: Or, that will be more precise to that…

RUTH WERNER: So we'd like to hear that, right? We'd rather have the surgeon say, "I got nothing for you, than to say, I'd give that a shot." Right? But that doesn't leave the person who has the pain with any options.

TIL LUCHAU: Yeah.

RUTH WERNER: And so.

TIL LUCHAU: Or that nothing is wrong with you that's different that we can see on the MRI.

RUTH WERNER: Yes.

TIL LUCHAU: And you know there's been a lot of change.

RUTH WERNER: Right.

TIL LUCHAU: Just recently in people's language about MRIs. Because you'll get more accurately, there's nothing showing on the MRIs. But people will still hear that as "there's nothing wrong with me and so this thing I feel is probably my problem or maybe it's in my head," or something like that.

RUTH WERNER: Right. And I think, probably, a lot of our listeners have had experiences like this. So, and if it becomes appropriate later, I'll talk about mine because it's an ongoing thing and it's a great example. But the reason I think it's useful to talk about acute pain versus chronic pain is that it sets up, from my own perspective at least, a better understanding of the tension that exists between what we have called a biomechanical model of pain management, which is fix the thing that's broken, and what we find with chronic pain. The issue is the thing that's broken probably isn't broken.

Even though there's still a lot of perception of pain, it's like trying to fix an old ligament or trying to fix an old disc or whatever and it doesn't yield the results that we look for. And so that biomechanical model of pain

management might not work after we've left the acute phase and we're in a more chronic, the word that I keep trying to reach for, or "chronification," where the sense of the pain response becomes really all about interpretation of sensation. So, the pain response becomes long term. And we see changes both on the peripheral and in the central nervous systems that can help that become self-sustaining. And so, when someone has an old injury and the injury itself isn't really the problem anymore but they still have the perception of pain, their pain is real. I have said this may many times, you can't tell someone that "oh you're not really experiencing nothing that you've experienced, that you're telling me that you're experiencing." You know we don't get to say that.

The pain is real but the source of that interpretation, the source of that pain response, is probably no longer the disc, the ankle, the knee, the whatever. Now it's; I feel weak, I feel like I must limp all the time, I have a lot of fear about how I walk, I think I might have to start using a stick when I walk because I feel so unstable. And so, those kinds of quality of life issues start coloring how we feel about the strength and the power of our body. I hope that makes sense. So that's the life we put then.

TIL LUCHAU: Yeah. So, let me summarize, and then let's talk about application a little bit. So, you're saying that in an acute situation definitely there could be clear biomechanical things that cause pain.

RUTH WERNER: Sometimes especially with orthopedic things, right?

TIL LUCHAU: Orthopedic things. The classic example given was, I put my finger in the fire and it hurts I pull it out.

RUTH WERNER: Yeah okay.

TIL LUCHAU: That's potential tissue damage, immediate pain. And that can happen with injuries.

RUTH WERNER: And appropriate pain.

TIL LUCHAU: It can happen with strain. It can happen with lots of things. There's somewhere along that line that if it still hurts at some point it lets you know. There's different numbers that can be thrown out and some people say after three months. Other people say after six months, but it's variable. But at some point in time, the tissues probably had the chance to heal any direct tissue damage, and if there's still pain, theirs moved into what you're calling a chronic phase, where it's the pain that you are feeling is probably less related to mechanical tissue damage and more related to your nervous systems continuing attempt to protect you. To keep a sense of awareness from that point of view. So…

RUTH WERNER: So much gentler description than I gave and I like it very much.

TIL LUCHAU: Well, then the question is, "how do we apply that as hands-on therapists?"

RUTH WERNER: Yes.

TIL LUCHAU: Yeah. So, for me there are some indicators and I'm going to work up. I don't have it right now, wish I did. I'm going to work up to clear bullet points. Not that it's always a clear line between chronic and acute. How do I know? For example, one of those is being about the time of occurance. If it just happened, then I'm going to approach it way differently than if it's something that's been going on for quite a long time. And I think we already do that now as practitioners. That is one of the things we start to sort out, but how are we going to work on this?

Now in a classic, direct manual therapy approach, conventionalists then say, don't work on it if they're just hurting. Because this needs a chance to heal. Maybe there's inflammatory processes going on and it still hurts.

RUTH WERNER: Work on it differently in any case.

TIL LUCHAU: Well, okay. So, there's some approaches, and they work kind of differently. But again entrepreneurship (?) in this direct approach that we say don't work on it. You're not going to try direct tissue effects in a place that's just been hurt.

RUTH WERNER: Okay. Let's go with that for now.

TIL LUCHAU: Yeah. And there are some good arguments for that. I mean, if the tissue is damaged and in inflammatory state, you're not trying to do the classical myofascial "let's get the tissue to change approach."

RUTH WERNER: Right.

TIL LUCHAU: We're going to leave aside for a second all the controversy about whether that's possible or not.

RUTH WERNER: Right.

TIL LUCHAU: Anyway, conventionalists says, let's not work at it right now. Let's wait until it had the chance to heal and then we can work with tissue elasticity, pliability, and all that kind of stuff. It's got to be conventional effects of direct tissue work. This is one model. Now to your comment. There are things we ca do, even in the acute phase. And the simple version that I think about when I'm working, or when teaching, is we're going to think about an acute situation as work with the nervous system. We're going to think about the effects on someone's startle response, on their autonomics, on their protective responses. As in those early phases of an injury, or when the injury is still really guarded, or seems to be effecting someone's autonomics, say a whiplash injury that's still giving someone pain for quite a while later. That's an autonomic situation; it's not necessarily a tissue damage situation. So there's a lot…

RUTH WERNER: I'll expand that. Certainly, it's an autonomic situation. But I think there's basic motor and sensory neuron issues as well when you have two shoes that are too constricted and held close. It's not, I agree with you, that it's the nervous system. But, I don't necessarily read as just the autonomic system.

TIL LUCHAU: Okay. So let's get into that. I want to hear everything you have to say about that. But I was talking about how in an acute phase, at least in this model in acute phase, often my approach and my application is to think about nervous system first and foremost and autonomic responses, let's say. Then, we start to differentiate when are there potential tissue responses. And, as I've said, there is some controversy about the role of how tissue responses will play in pain. But let's reframe that for a second and say it's the chronic pain phase. If there's still pain after a certain amount of time, and the initial tissue damage has had a chance to heal, then it becomes a different question. Then it becomes…

RUTH WERNER: It's harder.

TIL LUCHAU: All right. So this is good. This is good because as I start to talk through our usual whiplash progression, let's say, which is really work with the nervous system first, and then let's look at tissue effects later. I realized that there's some remapping there. If I really take the pain science perspective, then I probably should do, and you know I am not doing it so good here right on the fly. But there is the autonomic, that is just the point you're trying to make, but the autonomics are important throughout. They are clearly important right after I've been injured. And if you missed that you're going to make the autonomic responses worse.

RUTH WERNER: It could happen for sure.

TIL LUCHAU: Yeah. Especially if you're just going to go for "let's get everything elastic and mobile."

RUTH WERNER: Right.

TIL LUCHAU: Then if just recently injured, clearly that's going to make peoples nervous system less comfortable instead of more. Now in the chronic phase later on our conventional approach has been "let's think about mobility." Let's think about what isn't moving so much and bring movement into that. But you can't do that until the autonomics are calmed down to some extent. It's going to work on something…

RUTH WERNER: And so by autonomics… can I put in the word? Protective. Is that a way of thinking about, you know, sort of knowing when someone's ready to move to an ani-phase?

TIL LUCHAU: Yeah. I think that.

RUTH WERNER: That they're less protective?

TIL LUCHAU: That is right. I think it is at the point at which someone stops describing, let's say, whiplash again as feeling fragile or feeling like they're in spasm whenever they move. That's clearly an autonomic arousal that needs to be addressed before I get in there, before I think about mobility for goodness sake. If there is movement, movement's going to be helpful. But it is probably going to be more helpful if client generated movement as opposed to me trying to mobilize them from the outside. As a lot of massage, or even a lot of other manual therapy techniques might do. That might be helpful and appropriate. But it's going to be later once those protective responses have had a chance to calm down some.

RUTH WERNER: Right. Okay. I understand that better now. And so as you're making this transition then, Til, what happens next?

TIL LUCHAU: As for making the transition from acute to chronic?

RUTH WERNER: Yeah.

TIL LUCHAU: Well, I mean, I can get more in my sweet spot as a manual therapist and think about their movement, think about the ways that I feel things moving with my hands and the ways they feel movement. That could be more of my approach. But if I'm going to let myself be influenced by the pain sites perspective, I'm still tracking the fact that it's their nervous system that I'm having the most impact on, perhaps, then any tissue effects, if that exists. And that's a different discussion, which is probably secondary in their impact on the client, to their protection, to their nervous system, to their felt sense, and all those kinds of things. That their brains remapped in some ways too, because of an ongoing pain situation. You know, I can help with the adjustment if I'm aware of that. As opposed to just keeping on hammering on their tissue to try to get the movement back, which may not change the protective responses, or may not change the way their brain is interacting with the body, all that kind of thing.

RUTH WERNER: I think it's safe to say in general that hammering on tissues is not probably going to get us to the outcome that our clients are looking for.

TIL LUCHAU: That's a safe bet. Did you get to say what you wanted to say about motor neurons and all that?

RUTH WERNER: No, I'd like to say a little bit more.

TIL LUCHAU: Yeah.

RUTH WERNER: Yeah. So again, I'm not in practice, I am not a practitioner, and I can't fully represent some of the talented people who were there teaching things about technique. But I'm in alignment if we're going to sort of discuss how pain science might affect some of our treatment choices. I think an emphasis on not just soothing sympathetic response, but listening to the parasympathetic response. A lot of these techniques now that are in alignment with pain science really are looking at ways that our sensory and motor neurons are functioning, or not, as they flow through our fascia and our muscles and our other tissues. And so, a lot of that work has to do with freeing flow, right? Allowing the nerves to do their job and then that will get us to the next step of function.

TIL LUCHAU: Okay. Flow of what?

RUTH WERNER: Flow of what a good question. Flow of electrochemical energy through the nerve.

TIL LUCHAU: Okay.

RUTH WERNER: So, in other words, if we're going to think about other terms like multiple crush syndrome, which is like a macro version of a nerve compression, then think about that in a much smaller level for the fibers that are in a tangle of tight tissue. These nerves are trying to get to the skin, trying to get to the muscles, trying to get to the glands, wherever it is that they're going to. So, techniques like German Neuromodulation looks a lot like gentle skin stretching and looking for positions where people are most comfortable with a stated intention to improve nerve function. And by improving nerve function then you

improve tissue function in general. So, you know, all I'm doing is adding the peripheral nervous system through your sort of general focus. And I don't think it's contradictory. I don't think it's an either or.

TIL LUCHAU: No.

RUTH WERNER: It's just a matter of awareness that this is something that happens, so let's do it on purpose.

TIL LUCHAU: Yep.

RUTH WERNER: Instead of by accident.

TIL LUCHAU: Yep. At least in our approach we definitely include everything you just said. Including the skin receptors in the outer superficial fascia, which is rich in mechanoreceptors, and there are different receptors that might be a little bit different than derma modulation, and we're also including the deep receptors in that. There's a protective cycle that you can seem to get into as well and perhaps for sure its nerve function. It's nerve function in terms of their ability to transmit. It's looking where they might be with perhaps mechanical influences on that. But, again with a bit of suspicion, questioning the point that mechanical influences may have been overrated for decades is a really good one. And, not to say were going to throw out that baby with the bathwater at all.

RUTH WERNER: Yep.

TIL LUCHAU: I'm weighing in the mechanical effects at the same time. It's great to question every time I assume that that's the cause. So, even in the case of nerve, a double crush or a multiple crush syndrome, how much of that is the material or mechanical crushing of a nerve and how much of that is the neurology of the nerve during its inhibition and facilitation processes? And how much of that is my sensitization in my central nervous system or even in my world view or my perception of my body that's contributing to what experiences pain? So, I'm not going to try to un-tease those different threads, as much as to say that I'm thinking differently all the time now. A lot of this is what we were talking about decades ago and yet we're getting a lot more refined about. Our understanding of how new all these things are and how important they are, let's say these little fine movements of the skin, and how really our goal is creating safety in the nervous system. As much as mobilizing tissue may be more than mobilizing tissue. You were going to say?

RUTH WERNER: I'm just making a note. This is so beautiful.

TIL LUCHAU: You're calming my nervous systems, thank you.

RUTH WERNER: I'm so glad. Mine is getting very, very excited.

TIL LUCHAU: Yeah.

RUTH WERNER: Because I have many things that I want to talk about.

TIL LUCHAU: Great.

RUTH WERNER: I want to go back to…

TIL LUCHAU: Do you want to say something more?

RUTH WERNER: Say it again?

TIL LUCHAU: Do you want to say one of those things or do you want to go on to another bullet point?

RUTH WERNER: Yes, I'm ready. No, I'm ready to say one of those things because I want to go back to your client with whiplash.

TIL LUCHAU: Okay.

RUTH WERNER: The client who has moved out of the acute stage and is now into a place where you can think about looking for where the movement is, and where the movement's not, and you know, that. One of my

take-a-ways, from this meeting, is how critically important it is to make our clinical goals a match for the client's functional goals.

TIL LUCHAU: Yep.

RUTH WERNER: In other words I've talked with another friend, who does really great work around the neck and the head, and he was sharing his "dumb things therapist have done" story. And it was about working with a woman with a lot of neck pain and very limited movement and he got her movement to full movement. That was very exciting, and he's like "aren't you excited you can look way over your shoulders?" and she said, "well yeah okay, but when will it hurt less?" Because he had completely missed what her goal was. He was really all about the range of motion.

TIL LUCHAU: Right.

RUTH WERNER: And not about what was she wanted to be able to do. So, I am sure that you incorporate that into your strategies when you're working with people who have complicated pain situations. But when we focused that work on their functional goals we have a much higher level of client gain and typically, I'd have to look for some research that backs it up, we get a better outcome.

TIL LUCHAU: I mean, it's one of those things that research could project on that would be interesting, but probably a little boring because the question you're asking is "are patients and clients more satisfied with the results when the practitioner addresses what they want?" That's the question you're asking.

RUTH WERNER: Right.

TIL LUCHAU: So it's kind of like yeah. But, it's also the case that as we have these summits and conferences that put us in contact with different professions, we start to realize that different professions approach this question very differently. So, in my background as a psychotherapist this was the main question. The first entire conversation may be several conversations and is really what you are hoping for out of this interaction. How do you perceive the problem, what's getting you here, and what do you hope for as change? And then, there's a lot of rich things that can unfold in that. But a lot of times it's a reality check, you know. Oh, you want to be a 100% out of pain after today? Well, let's talk about what it could be like if that doesn't happen.

RUTH WERNER: Right.

TIL LUCHAU: What might still be useful today if you're not 100% out of pain, for example?

RUTH WERNER: Right. And another sort of hard question to ask along with that is, "what do you want to be able to do that you can't do now and what are you willing to do to make that happen?"

TIL LUCHAU: Well, yeah, then there's client responsibility-patient responsibility.

RUTH WERNER: Right. Exactly.

TIL LUCHAU: But, other professions focus on this much more than say, massage therapists or even body-workers. Structural integration people do, and you could say most physical therapists.

RUTH WERNER: Which is surprising.

TIL LUCHAU: And especially occupational therapists who have a lot more training and skills and tools in working with the context.

RUTH WERNER: Right.

TIL LUCHAU: And it's like…

RUTH WERNER: Right. And it's, yes.

TIL LUCHAU: I've forgotten who said this, but someone's calling it as, you know, we're contexts architects.

RUTH WERNER: Wow, I'd love that.

TIL LUCHAU: Yeah. We've helped, or we have rearranged, or reconfigured, or reassessed the context that people are living in and even the one they're changing. So, often if my focus is just on the hands-on work, can I have someone come in and then lie down, or I say, let's start with that scenario. They come in, they lay down, I do my routine. I've missed all of that. I've missed everything.

RUTH WERNER: Everything .

TIL LUCHAU: I've missed everything about the context and what they want. And I might get lucky. And I get lucky most of the time and leave them happier. But, even if I take time to ask, "what do you want out of today's session?" that puts me ahead of the game. Now, that's different then what hurts today.

RUTH WERNER: Yes, it is.

TIL LUCHAU: Or, focusing in a conversation around what's not working, or what's broken or what's hurting. Because, then what happens if I only asked what hurts today, "any aches and pains," then what happens is I do my work and maybe those are fixed, maybe those are gone, and maybe I'm good enough that I can have that happen most of the time. But what's going to happen is the client gets off the table and goes back and says, "uh, that still hurts." Oh, you know we got most of it but it's still there so what's left in my awareness as a client is the problem still, and…

RUTH WERNER: Which is a nice sort of transition to another bullet point which is about the power of language. Right? So your first conversation was about what doesn't work?

TIL LUCHAU: Yep.

RUTH WERNER: What hurts, what's wrong?

TIL LUCHAU: Yep.

RUTH WERNER: That's a very different conversation than what would you like to be able to do. One question I've got from a talented therapist once was, "a win for you today would look like what?"

TIL LUCHAU: Uh-huh. Yes.

RUTH WERNER: Right?

TIL LUCHAU: Yes. Even reframing. Because clients are going to come with a problem, say my neck hurts. Okay. And if your neck didn't hurt what would that allow you to do? Kind of connected to your question, what would that allow you to do or feel or don't feel that is available to you now? So, giving it a live context as opposed to just the symptomatic context.

RUTH WERNER: And it seems so subtle. But it is not subtle to be on the receiving end of it. Right? And so, you have in your experience, as a practitioner and as a psychotherapist, seen any differences in how people physically responds when emphasis is on improved function rather than decreased pain. You see what I'm getting at?

TIL LUCHAU: You are asking, let me see if I did.

RUTH WERNER: Yeah, I am asking you if have? If you have experienced this, because it's been so many years since I have been in practice. Do you have experience of seeing… How do I want to ask this question?

TIL LUCHAU: Do I get different result when I take time to ask that question?

RUTH WERNER: Yes. Let's start with that.

TIL LUCHAU: Well. Yeah. Totally. Because when I forget to ask the question sometimes it doesn't work out.

RUTH WERNER: It's like working blind.

TIL LUCHAU: When I forget to really take time to find out what the client is experiencing, what they're hoping to be different, and if that is going to be realistic in that session. If I forget to do that process sometimes they get up and go "well it still hurts," and I like, oh, shoot. I forgot that step of the context, which even now I have a really great conversation about that. That still happens to me. And then I see it in our students all the time, that they come wanting some supervision for a tough client. And they tell me all about the client's biomechanics say, and always my first questions are, "Why did they come? What were they hoping for? How did you talk to him about that?"

RUTH WERNER: **Right.**

TIL LUCHAU: And sometimes you can see people willing the clock back, forgetting that step. Even in my own thinking.

RUTH WERNER: Yeah. Isn't that amazing?

TIL LUCHAU: Yeah.

RUTH WERNER: So, here's another take-a-way from this meeting and that we have not yet talked about, which is, when we look at things like posture, or movement patterns, or forward head posture, text neck or even like being overweight, we have assumptions that these are going to raise the risk for X, Y and Z.

TIL LUCHAU: Yes.

RUTH WERNER: But the research actually doesn't bear that out. Research is out that you shouldn't be sitting for ten hours a day. But, there's not great research to suggest sitting one way is any better or worse than sitting another way. The key is change and movement and variation. So, how many times have you seen someone do a visual assessment and say that this scapula is high, this scapula is low, this pelvic is tilt and forward, his knees bulge or whatever? And so his pain will be X, Y and Z. Which may have actually nothing to do with reality.

TIL LUCHAU: Or the chances are pretty small.

RUTH WERNER: Yeah.

TIL LUCHAU: Let say you then point them to some good evidence that shows, for example, experts in posture analysis can't see five people and point to the one in pain.

RUTH WERNER: Right.

TIL LUCHAU: So, from that kind of study it's really shown there's not a strong correlation. Now they say posture doesn't matter at all is a whole different take-a-way, or they say biomechanics don't matter at all is another take-a-way. But, what for sure we can say, if it's static assessment, it's going to be an impressive feat if I can connect what I seen a static situation to the client's felt experience without any bridging at all. If I can look at someone standing still, put them on the table, and they almost by accident got what they're looking for. That's going to be great. And some of us got to be good at it. I mean, that's the practice we did for years. Can we take this static assessment and body read and analyze it in such a way that makes a meaningful impact for the client? Some of us are good at it, but I think there really is limitation to that way of thinking and working. So that, thinking about the fact that you said that, just being able to shift and move is going to have a much bigger impact than anything I can accomplish within that one hour session on the table. Just getting someone to feel their body a different way is something they can take with them. And that's something that I need to perform during that limited amount of time I have with them.

RUTH WERNER: Right.

TIL LUCHAU: So it will become so much more about refining someone's proprioception in having, or bringing in that sense of mindfulness and presence into the body that lets people make different choices. That's the take-a-way. That is what I hope people have when they leave. As well as whatever amazing experiences they had on my table. I want them to have a more refined sense of being able to move and to listen to their body.

RUTH WERNER: I'm ready. I mean, when can I come in for a session? You know, I don't have a lot of pain and that's sounds pretty good to me. I mean, there's a whole field of study that's off topic for today about the sense of interoception, right? The sense of tuning in and being aware of what's happening and conscious of what's happening internally and that's something that body-work and massage therapy is good at helping people to do.

TIL LUCHAU: That is right. Yeah. This is an amazing method for helping people refine their proprioception, interoception, kinesthesia, haptic sense, and all these different gradations of our felt sense. Of the sense of touch turns out that the hands-on work can be a great tool. Especially if we turn, shift it a little bit, and realize that's what we are doing.

RUTH WERNER: So, Til, I'd love to ask you a question. This sort of brings us back to some of our bullet points.

TIL LUCHAU: Okay.

RUTH WERNER: There's a certain level of enlightened self-interest on this too, because it's the topic that I speak and write on a lot. So, let say you have a client who is deeply focused on their pain and who comes for sessions but does not seem particularly invested in getting out of pain. This is, I mean, can you identify a client like this?

TIL LUCHAU: Well. No. I can imagine, but tell how you know they don't want to get out of pain?

RUTH WERNER: Okay. Good. That's a great question. How do I know that they don't want to get out of pain? They do not appear willing or able to make some simple choices that might help, like getting the quality sleep, eating well, getting a modicum of exercise. And you know what, those are the three hardest things to do. Get good quality sleep, eat right and exercise, for people who aren't living in pain. So, to ask people who are living in pain to do those things is a little unreasonable. But, even making incremental steps in those directions can seem really hard for people who just say "I can have the chocolate cake or I can walk the block or walk around the block, let me think for a second about what I am going to do."

TIL LUCHAU: Yes.

RUTH WERNER: Right. And so you got people who are making choices out of the sense of being trapped and hopeless.

TIL LUCHAU: Okay.

RUTH WERNER: About living in pain. And then they come for a massage and I have a huge amount of respect and appreciation for that. Because, that tries on the possibility that for an hour they're not going to be in pain and that can be a little scary if pain becomes your best friend. But, I'm curious to know, given the contexts of things we've been talking about with the biopsychosocial approach to pain management, how as a bodywork practitioner you would recommend we approach our clients who seem to be less invested in a good outcome?

TIL LUCHAU: Okay. That's such an important question and the answer I'm unfolding and developing as I go along in my own practice. And, that's the class I want to teach, or let's say that is the process I want to bring in. But the short version, and this becomes a snapshot of where am I thinking is right now, is the first thing I want to watch is my assumption that they don't want to get out of the pain, for example.

RUTH WERNER: Right.

TIL LUCHAU: Or maybe that they are not taking the responsibility. Or all those things that can frustrate me as a practitioner that is probably assumptions on my part.

RUTH WERNER: Right.

TIL LUCHAU: What I know is that they do have pain. That they are, by their own report, doing behaviors that are probably not helping. Let us say, you know, not sleeping, not moving, eating poorly whatever. That's all I know. Now, can I find compassion for being hard to change those things? You bet.

RUTH WERNER: She said drinking her coffee.

TIL LUCHAU: Right.

RUTH WERNER: Yes.

TIL LUCHAU: Can I find the place where I don't feel very effective in changing some of these seemingly simple things? You bet. And, there's a lot of research that some of these seemingly simple things are hard to change like weight, for example. Yeah, you want to lose weight just don't eat as much and exercise more for goodness sake. While it turns out…

RUTH WERNER: It is easy.

TIL LUCHAU: It's more complex than that. Yeah. Easy. So, the first thing I can do is turn on the compassion lens and go "wow you had a really hard time making these changes, and by the way, good for you for coming to try to get a different kind of input, trying to get some help." Now, the helpless people…

RUTH WERNER: I have to tell you, I went to have some dental consultation yesterday because I had an issue. And the guy, the surgeon, asked me what I did and stuff and he goes, "do you know anything about Rolfing?" Rolfing, they totally changed my back pain. I got Rolfed and it totally change my little back pain. And it was, you know, it was kind of fun to have a little conversation with him.

TIL LUCHAU: Yeah. A lot of people have been Rolfed and there's been lots of history all across the spectrum for people on that one and most of it is great.

RUTH WERNER: Yeah. Most of it is great.

TIL LUCHAU: Most of it is really great. I'm really pleased to have been involved in that.

47:50