

# Pain Science and Manual Therapy

with Ulrik Sandstrom

6<sup>th</sup> May 2020

## TRANSCRIPT

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Steven:

Well today we're going to be talking about pain science and I'm joined by Ulrik Sandstrom who is a chiropractor of some 30 years experience. He's had more than 11 years with the premiership rugby club, Leicester tigers. He has worked at many elite levels at the Olympics with Chelsea football club and he's a senior lecturer and the international sports chiropractic diploma program as well as lecturing around the world. Great to have you with us.

Ulrik:

Thank you very much, Stephen. Good to be here.

Steven:

Did I get that right?

New Speaker:

Yes, you did.

Steven:

Thank you. I'm glad to hear that. Ulrik, we said we start by just discussing what it is that got you into pain science. So how did that all happen?

Ulrik:

Yeah, I have sort of a very much a very manual chiropractor. Obviously when you work in sport, that's what all the athletes want. They want that crack. And so it's a little bit odd that I sit here, probably haven't done a significant amount of pain science in the past two to three years. What really got me into it was actually I was speaking at a European chiropractic association conference in Cyprus and a Canadian chiropractor and his name now completely escaped me. That will, that will come in a second. And he was out there talking about pain science and great Lehman. So Greg Lehman was out there talking about pain science and for those who've seen Greg, he's quite a he can call it a controversial figure and he swears quite a lot during his, his lecturing and he was very entertaining.

Steven:

I like him already.

Ulrik:

Yeah, no, I love, I love Greg. And one of the things that he did, he's very good at rattling cages and I'm quite a big fan of this when you present, is that he was grating up against my perceived wisdom and, and my confirmation buys enough that I was started going, no, no, no, no, no, no. This is too strong. But then after about half an hour and I'm thinking, you know what, this is actually starting to make sense. So I decided to look into a little bit more. And Greg actually came and did a course that I then took for a weekend.

Ulrik:

And I always say it was one of those strange experiences where I, I did the course, it was a day and a half course on pain science and I'm driving home. You mull it over in your brain. And I was

thinking this was, that was really good. It was a great cause. He's a phenomenal presenter, but I wasn't quite sure how I felt like would use it in practice. And then I found Monday morning my, my thinking had completely flipped. My thinking had completely flipped in terms of how I thought about what my patients were telling me and the conclusions that I drew from that and was very much putting it very basically. But you know, patient comes and go, it hurts when I do this. I would have said, well, don't do it. And I go, Hmm, maybe we should do that a bit more, but control and giving you power from it.

Ulrik:

So that was sort of my way. And then, and as I like to say now, I would say that the pain science has probably changed the way that I think in what I do and how I'm managing my patients more than anything else in that in the past 10 years.

Steven:

You know, I'm really encouraged by that because when, when I was first told that you were coming on the show that were going to be talking about pain science, I was thinking, well that's great and it's going to be really, it'll be interesting from an academic point of view, but all too often these things are very hard to put into practice, literally into practice. And I'm glad to hear that. That's what we hope we'll get some of that in the course of the next 40 minutes or so. So you've only been doing the pain science for three years you said?

Ulrik:

Yeah, sort of. Again, it's one of those sort of, maybe it's become the new thing. And I say, Oh, well, you know, I knew pain science before Covid, you know, before became trained, because before we all had to do it, because we now had to do video consultations and whenever you get a new thing coming out, you always get the camps. So you always get one camp, you go, Oh, so you just want, you know, you, you're asking patients the colour of their pain and want them to do a drawing of it. And of course you get the pain scientists who then go, right, we should never ever touch a patient ever again because you're now making them dependent. I've got fairly strong views on that, which I'll give you later on. And of course, as we all know, there's a, there's a middle way.

Ulrik:

And, and to me it's all about the toolbox. The pain size is just another tool, you know, everyone goes, Oh, you know, you pain signs everybody. No, I don't. Just the way that I don't acupuncture everyone, you know, I don't even, I just don't manipulate all of my patients. I use the tool that I think is, is the most relevant for that patient. And if I get, you know, Bob the builder in who's tweaked his lower back yesterday built, you know, lifting up a ton of breaks, I'm not going to, you know, sit and hold his shoulder and go, Bob, I know how hard this is for you, that, you know, he needs a smack and he needs to get on. But if someone has had 30 years of back pain and they firmly, firmly believe they're broken, we need to address this.

Ulrik:

And so again, it's very much a case of, you know, you do, you do what is whatever is appropriate. And of course, that's where getting an understanding and a feel for what it's actually going on inside the patient and asking them, I ask patients so much more about, how do you feel about this? And also what do you believe is going on? And that's a really, really powerful question. And sometimes

the answers will blow your mind. And we need, we need the beliefs. We need to understand the patient's belief. Cause I had a patient with acute recurring low back pain. Her back would go. And I said to what, what? So what do you think actually happens? You know, she, she obviously she, she was doing less and less. She was getting more and more, kinesiophobic. And she was becoming a very, very chronic sufferer and it was having a huge effect on all aspects of her life.

Ulrik:

And she said, well, what happens when I bend over that little bit of the disc brakes off? And then it, it then nearly severs the nerve. Which then gives me all that pain in my lower back. And the key thing of course is then just, you know, not do a big belly laugh and go, God, that's ridiculous because that's her belief. But it's so important. I could do the best adjustment in the world. I could, I could acupuncture all her paraspinals and release her performance or whatever else I wanted to do. If her belief is that whenever she bends forward something nearly severs her, her spinal cord, she will never be well. And so it's understanding and taking that belief away in a non-derogatory way. And of course you go, well, you know, I completely understand why you feel like that because the pain can get that severe fortunate you was actually happening.

Ulrik:

It's just your muscles are overreacting and trying to protect you and spasming and everything else. And, and taking that belief away is crucial and actually getting an inroad into making her move comfortably and safely again.

Steven:

So just to take this back to the source as it were, where, where are you getting your information? I'm assuming that it's going to be pretty evidence based, but have you, if you were watching last week when we had Georgina Oldfield talking about SERP as approach to chronic pain, which again, a lot of emotional stuff involved in that. We also talked about understanding pain, the Lorimer Moseley approach . Are all of those things which are familiar to you and part of your philosophy?

Ulrik:

Absolutely. Yeah. So again, I quote, you know, probably most of us have seen the, the, the one with a snake with, with Lorimer Moseley. And again, I, I actually have have an email that I send to patients. Again, I'm very happy to share. I've actually got some slides on this. Again, I'm very happy to share some of the resources that I use and also the email that I send out to patients because of course, sometimes the key, one of the pitfalls of pain signs is that I can tell, I can tell a patient, I'm like, listen, I'm not saying you're making this up. You know, this is very real. When we understand how our brain is processing pain, that's not you just imagining it is very real. But you know, the brain has the power to either turn pain up and down. You're not making this up. And of course then the patient walks downstairs and says to reception Ulrik says, I'm making it up. And so that is the danger.

Ulrik:

So therefore to me the timing of pain science is quite important. And I'll often do that after about maybe three or four sessions, even if I feel there's a lot of stuff and you start getting little ideas, this person is at, it's catastrophizing it's the patient, you know, I'm in agony. And it's the patient who the way they describe pain actually doesn't make biological sense anymore. Or you know, I wake up in

the morning and I can't move , what on earth do you do to cause that other than the burial of overreacting. So again, it's this idea of taking away the pain does not mean damage. And I think Lorimer Moseley's video does that perfectly well. Yeah.

Steven:

I must say, Ill have to dig the video out and put a reference to it on the site because again, it's a useful thing for people to go refer to and again we'd be very grateful if you'd share the resources that you mentioned, even if it's just references to the papers that you, you use to justify your approach.

Ulrik:

Yeah. And one of the things that, because I didn't send an email to Greg Lehman's has got, I think it's Greg Lehman.CA. But again, I'll put that in the notes because Greg has actually produced a beautiful PDF of all the little analogies to pain science. There's a, there's an American physio called Jared Hall who's also got a book out on what to tell patients and also something that patients can read. Because the reason Greg did this was because it's difficult for me to tell patients this because I will hopefully formed a rapport with a patient. And, and now that we're three or four treatments and I start talking about how the brain works. And again, people like, well, I thought I went to the good guy but now he's saying that I'm making this up. But what I can now do is if, if we feel that mechanically they're getting better and we can show them the tests, look how much movement we got here.

Ulrik:

Remember how stiff that was, see how much more strength and power we have here. You remember that was really weak when we first tested it and they go, yeah, but I'm still in a lot of pain. Right? Well maybe we need to start looking at that aspect. There's a Canadian chiropractor physio who has made some really interesting stuff on this. I'm going to send you an email with a link to his PDF, download the PDF print two, one, two out, one next to the toilet and one next to your bed, and then just have a little read from time to time. And then, because it's not me telling them that they're making it up, it's Greg. And I can then go in and, and, and when they come in and go, well, yeah, I'm not sure I agree with him. When he said, he said, well, what he meant was this and this and this, and we can start making it relevant for the patient. But it just distances me a little bit from that, which I actually find can be really useful.

Steven:

We had a chap on the lunchtime broadcast a few weeks ago. Jonathan Hirsi who works quite a lot in the NHS and he says, you know, he's just sent this question in and he says that the NHS is of course now moving away for good reasons or other, we don't know from manual therapy. What's your opinion on that?

Ulrik:

I'm a manual therapist and I'm a manual therapist who does pain science. Yeah. And much more so than a pain scientist who does manual therapy. So I still love manual therapy cause I've seen the effect of manual therapy for 30 years. So

Steven:

You were telling me about some research which is about to come out as well, which perhaps is useful in justifying the manual therapy.

Ulrik:

You know, I spoke to recently to Jan Harbrikson, which probably quite a few of you will be familiar with. You know, he's worked with Alliance of papers. And Yan was telling me that there's a study coming out that he working on fairly shortly, I believe it's a meta-analysis on a manipulation spine, many patients on low back pain. And he was telling me that actually the conclusion that we need to stop researching spinal manipulation for low back pain because the conclusion of this project was that it is unlikely that any further research will change our mind, which is a hugely powerful that, that actually it is beyond doubt now that that manipulation works for low back pain. Again, what we can possibly now think of now. It's like everything else. We know that what we do works maybe sometimes not for the reasons that we think.

Ulrik:

And of course the great thing with manual therapy is in terms of the pain science and the placebo, it's huge. And I had a great quote that plus placebo basically was what we used to call it before we knew, knew what it was. And because placebo unfortunately is usually prefixed by the word just isn't it? It's just placebo. Placebo is massively powerful. And rather than poo-poo it what we actually do in pain science is we, we turn this thing up to 11. And that's why understanding and showing care and understanding and ask the patients how they feel about it will actually really wind up the placebo effect of feeling cared for. One of the great thing was procedure is we know that actually this isn't just them thinking themselves better. We know that the body physiologically changes when we feel cared for and looked after them.

Ulrik:

So rather than poo-poo it, we can actually, we can really use it. And in terms of the practical aspects of, of pain science, the belief of it is actually probably one of the first things that we need. And this is where we ask our patients what do you believe is going on? Cause we need to actually take those. And obviously we know that all our patients regardless of age will say, Oh it's my age. Yeah. And Oh it's wear and tear and, and Oh my scan showed up an L four five disc bulge. And of course we know now that all the research shows that most of these are incidental findings. That was just as many people with four or five disc bulges without back pain. Then there are those with. So, but the problem is once the patient has got the image of that disc bulge, as soon as they bend forward and feel it back pain, they're going to make up all sorts of beliefs about what is happening, which actually then cause kinesiophobia which causes over-protective muscle spasm, which again then leads them down this route of just getting stiffer, weaker and more ingrained in a, in a vicious circle.

Steven:

You said earlier on that if you're a manual therapist, you know, that what we do, what you do works. In terms of justifying that to people, no, in terms of justifying that to the establishment, we need more than just clinical opinion, don't we? We need something which says, hang on. It's a combination of all these things that work. Have we got that?

Ulrik:

Yeah, Alliance of papers from, it's probably 18 months ago now. So again, led by Jan Harbrikson and certainly one of the four papers. So the alliance of papers have got it nailed there are some papers that basically suggests that the appropriate treatment for low back pain is is again holistic. It is bio-psycho-social we, we've been using this word for so long that actually no one knows what it means. And also we haven't really been doing it. We've been paying lip service to it but it means looking at the bio. So we need to look at the mechanics and get that spine moving better. And we know that manipulation does that, but we also know that rehab and strengthening and patient empowerment does that and we know that actually looking at getting the patients involved, patient involvement is this thing of patient choice, patient centred care. And that's what we do and I think most of us in manual therapy now do some degree of patient involvement, rehab patient education. If you stick pain science on top of that. And you've now got your, your manual treatments as well. You've pretty much ticked every box in, in, in, in what those alliance of papers concluded on, on low back pain.

Steven:

I'm pretty sure the NICE guidelines still say that generally I may consider low back pain, don't they? But they say low back pain can be treated by manual therapy only. Provided it's accompanied by an exercise regime as though manual therapy on its own doesn't work. But what they haven't said is that an exercise regime and some appropriate psychological approach as well. Do you think they should?

Ulrik:

I think they should look at that. Again, the NICE guidelines do tend to lag behind research and papers by, by a number of years. So I'm certain that, that, that, that will be the next step. Yeah.

Steven:

But I suspect the, the obvious question that comes on from that is, are we as osteopaths, chiropractors, are we qualified to give that psychological support? Just on the basis of, not just on the basis, but on the basis of pain science as opposed to a training in counselling or CBT or any of the other things that NHS recognizes.

Ulrik:

It's a really interesting point and in fact you have people go up, you know, how do you think you're qualified to that? And then the main part is, I'm a human being and we, because pain Science is sort of, it's been built as this new science. It's actually isn't, it's just using what we already know and starting to flip our thinking a little bit more rather than necessarily using new science. And most of it actually does come under the very much common sense umbrella. And it's this whole idea of patients, if we don't ask patients, we don't know what they're thinking. And their thinking could be such a barrier to us actually getting them better because we are, we're all here to get people

Ulrik:

In less pain, more mobile and back to doing the things that they want to do. You know, that's, that's what we're there for. And if we can start taking these poor beliefs away from them and allowing them pain. And this is again you know, it's the classic wear and tear, you know and patients walk in and we've all had the patients walk in. We just started treating them, but they were getting better and now they come and go I've just had some really bad news and you go, well, what happened? Well, I

had my X-Rays back. I've got, I've got degenerative disc disease and it's very easy for us to go you know, Hey, Hey, Hey ho degenerative this disease is normal, but we know that. But to a patient degenerative disc disease sounds pretty horrible. And again, if that's going to kick off some more protective spasm and more kinesiophobia, that's certainly is something that we need to address.

Ulrik:

And, and depending on, I could be right or occasionally be flippant with the right patient that I feel we, we get, we get on with and sometimes I will flick, I'll flick it back and go. If you also tell you that you have degenerative face disease and yeah, I have degenerative hair disease

Steven:

Dare I say not nearly as much as I,

Ulrik:

It's being covered by not having it be able to cut it for about two months. But, but, but that's what it is. I tell patients, listen, my face doesn't look the same as it did 30 years ago. Neither does my spine. That's not a disease. But we again, we need to frame it in context. We need to take those beliefs that get in the way of them getting better and actually start breaking them down one by one. And then the next thing we need to do is show them what they can do.

Ulrik:

And, and such a common test that I do is again, just to see if I can keep a microphone with me. It's just the bending forward. You know, how many patients just go?

Steven:

That's fine. Yeah.

Ulrik:

So, you know, we have them standing sideways on and we go, right? Ok bend forward and they go and go, I can't bend forward anymore. And we think we should listen. But there's, there's clearly a physical barrier for them bending forward. And what I now do is just sort of, i adjust them back and forth. I literally tell them right, let everything go. Just let this go. I've got this, let this relax and just let it go. And then you ask them to bend forward and you can feel, Oh no, just let it go. And you literally getting 20, 30 degrees more out of them and you go, right, so what do you think held you back?

Ulrik:

It was your brain. There was nothing in your back that that meant that you couldn't move but your brain was telling you this is dangerous. I need to protect you. So there's some really, really nice phrases in here and of course that sort of is a little bit of an eyeopener. And I said, well I've done nothing to you but nothing has changed in your low back and but what has changed is your belief about what was going to happen because you now felt a little bit safer. Cause I told you I was here then. And that's because we all know that patients don't believe what we say. They want to believe what we demonstrate to them. But that's just a really nice demonstration of see nothing. We got 20



degree further out, a lot more mobility doing nothing other than just convincing you that it was actually safe to do.

Steven:

Yeah. Yeah. Going back just slightly, Keith has sent in a question saying, are you saying that spinal manipulation is just placebo?

Ulrik:

No, absolutely. No,

Steven:

No. I said it. I said just placebo.

Ulrik:

No, absolutely not. Absolutely not. No, I think we have a significant mix. Again, I subscribed to the idea that what were the main, probably the main effect we have with most of the stuff that we do is neurologically neurological and afferent and affecting tone and coordination and everything else rather than breaking stuff down necessarily. But we do know the spinal manipulation really increases range of movement and we, we know that it actually has a physical effect and I absolutely firmly believe that. Do I believe that there's quite a significant placebo effect on top of me touching the patient, doing something quickly and then feeling a big click? Absolutely. Absolutely. The reason why we know that is because the ones who it didn't click, then they're not going to get quite as much better.

Ulrik:

Whether that was just because they, they know it didn't, didn't click or that it actually had another effect. You know, we don't know quite yet, but no, no, no, no. I, I firmly believe that that manual therapy has a physiological effect, but I also firmly believe that it has a significant placebo effect that we shouldn't poo poo. We should milk it. Part of getting our patients better.

Steven:

Wendy's asked how you go about convincing autistic people, she says she has a patient that can move really well since being treated and has more strength. But the consultant at the hospital told him he would never mend.

Ulrik:

Yeah. And again, this is just so horrible. And again, you know, obviously the flip side of placebo is, nocebo. Yes. And that's, it luckily doesn't happen or happens very little now. You know, I'm so old that I actually remember when we used to put people to bed, you know, GPs would put people in bed with back pain and I had patients walking in regularly telling me My GP says, I'm going to end up in a wheelchair, you know, talk about instilling a self fulfilling prophecy in someone and you know, and it, it is horrible and it basically shows someone who's, or who should take some pain science courses, but you can't convince them. You have to show them. And this is where the idea of poking the bear comes in. And this is another great Greg Lehman idea that that we need to keep poking the bear and the way that we poke the bear is "well it hurts when I do this". How much

does it hurt? And most patients have not been used to answering this. What do you mean?, it Hurts? Yeah, but is it two out of 10, six out of 10 and even actually starting to quantify the pain can start to help patients because patients are used to pain, bad pain, damage, not even always a little or a lot.

Ulrik:

It literally, it triggers that pain response of I can't do this because this is something, you know, my disc is popping out again. So even just making them grade, it is actually part of the process. Oh, it's probably three, but three is fine. So you can do whatever you like as three out of 10 pain. Because it's not actually, if someone has an acute, you know, discoradicular conflict, I might modify that a little bit. For most chronic pain patients, you're not doing any damage to three out of 10. So if it hurts, keep doing it until it gets to 4, because then at four you go, right, that's fine. So you basically make a little deal with your brain because your brain has done what on earth is he or she doing? They're causing pain, they're causing damage. Things are breaking things and snapping and wearing and grinding.

Ulrik:

And if you can then go to not just carry on and gradually, they will realize, you know what, I actually did that 20 minute walk. Yeah, it hurt, but it didn't get any worse. And then of course, as they keep doing that, they now build up resilience. They build a calming down of the brain and that goes, maybe some pain is actually okay. Maybe we don't need to be pain free. Maybe we can actually go about and enjoy life and go for a walk and enjoy the bird singing and go for a bike ride with some pain. And that's a huge change of mindset in the patient's head.

Steven:

Yeah. A lot of what you've said so far revolves around just taking a patient and saying, well, you know, not that it's in your head, but we can control it by adjusting how you think about this, what's gone on today. There must be more to pain science than just saying, well, what are the recent events in your life which have made you catastrophize this event?

Ulrik:

Yeah, no, that certainly is, and again, I'm very much, I don't particularly believe in, let's go behind and go, why do you think the way that you are most CBT as far as I understand how I'm no expert but goes away from, well, why, why is it you're doing what you're doing? And much more towards a super pragmatic approach where, these are your beliefs. Let's try and find ways of changing them. You know, so rather than looking at cause let's do this right, well if you think that, let, let us do little things that's going to prove to your brain that this actually isn't what is happening. So, occasionally I do swear, sometimes am I allowed to swear gently.

Ulrik:

So I tell, I tell patients the problem with the brain is that it's a bastard. Your, your brain will make you believe all sorts of shit that isn't real. And once patient has realise that you are not your brain. And some of the resources that I use, a lot of things like, you know, the Chimp paradox and those sort of things just to get the patient to look that just because you feel a certain way doesn't actually necessarily mean that that's real and pain is, you know, it's a classic, classic example of that. So the way that we work with getting them on board is again, just showing them and, and pointing out, do

you remember what I saw you two weeks ago? You thought you'd never walked. Now you've walked 20 minutes. What is that also telling you about what's actually going on and where we can get.

Ulrik:

And again, it's just getting those little bits of progress that makes the patient believe it. Oh, maybe things can change. And again, to me, we're going back to the spinal manipulation. This is where spinal manipulation is super, super, super cool. Because we can change function. I'm a huge believer in showing, you know, pre and post-test treatment outcome changes. So when I've adjusted or manipulated or needled or whatever I've done to the patient, I want to show them that after treatment they have now got better movement, less pain and or more strength. And I will literally retest and go, Oh, you see how that's changed because of course that actually is it's really powerful because that gets them, Oh, I'll never get better, but can you see in 10 minutes I have just changed something with you that you thought you were going to be stuck with forever.

Ulrik:

This is just a start. So again, manipulation and manual therapy is, is effective. We know this, but we can actually use it to become even more effective if we use it to backup our pain science and back up our showing the patient that you can actually change,

Steven:

This is a fascinating observation that's been sent in by Christopher relates to that demonstration you just did of you put your hands on the patient and they can bend further. He says that he once discovered that if he got his patients to count back from a hundred in sevens, you know it's a standard neurological test, while they were doing that, actually the function increased because presumably the brain is distracted.

Ulrik:

Literally and it's using the fact I mean another one of my absolute favourite books is thinking fast and slow by Kahneman. It's Super, it's like sort of the chimp paradox, but the next level up, right, and again, basically what you, what you're using is the fact that we have bandwidth scarcity: multitasking. It's complete fallacy? No one can. Now the Brain can give us the illusion of we can do two things at the same time, but we can't because of bandwidth scarcity, we've already got so much bandwidth to go about. So if you're now using most of that bandwidth to count backwards from 100 in 7's you actually haven't got enough bandwidth left to do your protective mechanism and for your brain to think, Oh, but what about that disc and what about this and what about? So yeah, no, that's a fantastic observation. And again, again, it just proves that point. Yeah.

Steven:

Yeah. it would be nice as well too to put the re the references up to the Chimp paradox and thinking fast thinking slow. You said it was any others that are useful and I think the Chimp paradox is a brilliant book. Yeah. Here's an interesting one for you.

Ulrik:

I don't have a name for the question, but, so there are a number of animal osteopaths and chiropractors who were asking you how we explain or how we use what you're saying in treating an

animal; how do they catastrophize. How can we influence that? I'll have trouble getting my Labrador to count backwards from 100 in 7's.

Ulrik:

And that's a really good question. I haven't had that one before and I have not even thought about it before, but actually I may be skirting the question a little bit here, but one of the things about placebo is that we, and the change in in blood chemistry and in healing hormones that happens when you feel cared for was actually done on chimpanzees. So that when you know, the big daddy chimpanzee takes the, you know, the, the crying chimpanzee who's hurt themselves under their arm and that actually changes, you know, the feeling of being looked after cared for and that things will be fine and actually changes the way we heal.

Ulrik:

You know? And that's physiology. That's not just making things up in your head. And so whether something along the lines of animal chiropractic and the animal instincts, we know that someone is here. I think most animal chiropractors would probably feel that they have an affinity with the animal that the animal who was otherwise unruly. Now that the chiropractor comes in, that animal instinctively feels, Oh I'm fine. Now things will be okay. They probably don't think of it in that way. But that actually would again change their healing. I'm not taking any mechanical part of things away. I'm just adding bits because that to me is always the key. But then whatever, I'm too old to start throwing things out that I've used for 10 or 20 years that I thought worked well. I'm a really, I have a low boredom threshold so therefore I'm a big fan of adding new things in but generally not taking things away.

Steven:

Rosemary is asked whether when you refer to the brain, you're talking about the subconscious.

Ulrik:

Yeah. Yes. Yeah. To certain extent. But also obviously that the conscious thinking and the, and the beliefs, cause obviously the beliefs such as my disc is slipping out, I've got degenerative disc disease and they are very conscious but they drive the subconscious protection. So it's, it's a little bit of both. And that again is where these sort of positive messages. Cause one thing is we can't just take beliefs away. We have to replace them. And it's replacing them well with you know, your body is constantly healing. Cause again, we all, we all have these people who go, Oh, I've had neck pain for five years. I think it was because of an accident that I had 30 years ago. And of course, you know, there isn't a single cell left in your body from 30 years ago, you know, so whatever happened 30 years ago has now healed.

Ulrik:

But once they then go, ah, it's come to get me that accident from 25 years ago that I was fine within a week has now finally come to get me. And of course we know that that's not the case. But again, in that becomes a belief we need to start addressing this. And, and as I said, you know, the whole idea of the words that we used and I, I used to go all, you've got a bit of an unstable pelvis. I would never use that anymore because what I think that means and what the patient thinks it means can be very different. And in terms of if the patient is, I have an unstable pelvis, what's that going to do to their Kinesiophobia well next time I bend over, my pelvis is going to fall apart. We know that that's

ridiculous. But we've got to be careful with those words that actually may invariably or without us wanting to actually change the way that the patient thinks and worse, the ways the patients believe about what they can do. Right.

Steven:

I think the same about patients who come in and say, I've been told by a practitioner, whoever, I've got a scoliosis and of course you know, chiropractor or an osteopath thinks of a scoliosis as being a minor deviation in the, in the spine, in its earliest stages or whatever. Whereas a patient thinks oh my god, I've got a bent spine and a, and I just wonder, cause you can never shake. Perhaps you can, I don't think it's easy to shake that belief out of their brains.

Ulrik:

No. and again cause very often if they've got a scoliosis we often see them, you know, in their forties and they've had pain for five years. And of course I'm thinking well you've had a scoliosis most of your life. So it's you're not getting back pain because of the scoliosis you're getting back pain now because your body has now stopped compensating appropriately for the fact that you have a scoliosis. And I tell my patients the body is a compensation machine. Your body will compensate for unbelievable things if it has good function, good range of movement and good strength. Yes.

Steven:

Somebody here has asked, what do you now say if you don't say unstable pelvis?

Ulrik:

And I might report a finding. It's incredibly generic. I don't use a spine in a report of finding anymore and because patients don't care. I always thought that patients need to know how clever I am. They don't. Patient needs to know that I understand them and care for them. That's actually all they need to do. And I can sit and point to a facet joint. Well, see this little facet joint is what you, what moves and then the facet joint gets trapped, a little capsule around it. And then we've got little multifidi that a patient really doesn't care. And the other thing of course is that I don't actually know if that's the case. No, because another one of my hobby horse, I'm sorry, Steven, but who was the chap who was on last night about the fascia?

Steven:

Julian Baker.

Ulrik:

I was sat nodding pretty much throughout Julian's presentation because we think very alike and I have this idea of the diagnosis. Illusion. Yes, this is this. And you were talking about slaughtering the sacred cows. And I'm thinking, I was actually thinking when you said that last night, I said, well, there might be a few today. And we can't diagnose, we literally can't diagnose for toffee,

Steven:

They're all hypotheses is what you're saying.

Ulrik:

So we take, you know two year chronic back pain patient in and have them see a hundred different manual therapists. How many different diagnoses are we going to get?

Steven:

110 probably.

Ulrik:

One is going to say is the subluxation. No, no, no. It's the pelvis. No, it's the short leg on. And I think it's a piriformis. No, your glute not activating properly, no,. It's a facet joint is it?

Ulrik:

It's an annular tear. And the amazing thing is we have no way of knowing which one of us are right. We all get the patients better sometimes, maybe not for the reasons that we think we do. But we all get patients better. And we know this because the research shows it. And so I don't point at things because whenever I do, I still question myself and go, but do I really know that that's what it is? So that was a long way of coming back to my generic report of findings, which essentially is your spine isn't working very well. Right?

Steven:

Several people have currently asked whether this is a form of counselling or mindfulness you are employing here.

Ulrik:

Again, not knowing a huge amount, but I guess there, there is, and I, part of my resources is I encourage patients to meditate. And again, it's this whole idea of control. Cause we know that the biggest cause of fear and anxiety and worry is a lack of control. And that's where the Chimp paradox comes in really, really easily. Because it's that, Oh so that's not me being stupid. That's just my chip brain kicking off. And people go, ah, and, and to be honest, even just that start, cause we know the people who, who catastrophize and panic and get anxious, they then beat themselves up about it and which then just feeds the vicious circle. So if we can take this away from patients and go, no, no, no, that's not you. That's your Chimp. You are the one that half an hour goes, Oh Why? Why did I overreact like this? Why didn't it, it wasn't anywhere near as bad as I thought it was going to be. And even that distancing, Oh that's not me. That's my Chimp is actually a really big first step. So yeah, mindfulness essentially mindfulness is in my terms, is realizing that your brain can be a bastard. It's realizing that just because you think something doesn't necessarily mean that that's who you are or that that's real. Your brain can do stuff on its own. And that's where looking into this and being able to switch your brain off and, and meditation is something that I use quite a lot with my patient. I just say download the app. It's, it's brilliant. The other caveat that I put in is, but do, be prepared for the fact that meditation is ridiculously difficult. It sounds so easy. You know, I do a reasonable amount of myself and again, my brain works at a hundred miles an hour as my mouth does.

Ulrik:

So therefore you know, the idea, I'm going to sit not thinking of anything. And of course 10 seconds later you're literally often changes, but the more you do it, the more you do get that space. So, so

yes, absolutely. It's a big part of it is, is taking control and realizing that when it comes to our pain, our brain can actually really get in the way of us getting better as well.

Steven:

Yeah. Joe had asked some time ago actually in this discussion whether all this discussion with a patient about pain could exacerbate the situation. I mean, how much of it makes them catastrophize more because you're bringing pain to the fore in their psychology.

Ulrik:

Yeah, no, that's a good question. And again, the thing about whenever we talk about pain, it will always be followed on along with pain. Pain is actually a brain construct.

Ulrik:

So pain is something that your brain uses to protect you. And the problem with that is that the more your brain thinks you need, protecting, the more pain is going to generate. And of course this is where now stress comes in and again, patients can then see how that fulfils the vicious circle. And again, we know those sort of maintenance patients that, you know, Kim used to see every three months, they now come in and go, Oh, I don't know what's happened in the past month. My back's been really bad again. Oh, you've been pretty stable for the past year. Yeah, it's really bad that old shoulder injury is really playing up again. What have you done have you been in the garden? We're Looking for a physiological change? Yeah, there's nothing really, are you, are you sitting more driving?

Ulrik:

And one question that I never used to ask them was, you know, where's your stress level at? And they go, Oh, you know, my husband just lost his job. And invariably not invariably. And so often once we get those unexplained aggravations and you start asking, stress levels are horrific, my mother is really, ill, and then they go, well, do you think that has an effect? But absolutely pain is a protective signal. Your brain is literally now on high alert because of the stress level. Your brain is now hyper aware. Because that's a good thing if you're an antelope running away from a lion. But that means that that little niggle that your brain before when niggle, yeah, probably nothing to worry about, about better. Your brain now has the magnifying glass out and he goes, Oh my God, what was that? And so again, how your general mental state and stress affects your pain perception is huge.

Ulrik:

And once patients understand that, I actually talking about it and understanding it actually takes a lot of the mysticism away because at the end of the day, putting it really simply what we're trying to tell the patient is just because it hurts doesn't mean that you're broken or you're damaged. Your brain can literally make things up. It can make pain up depending on what you believe is going on in there. And that way this is where we, we very quickly use rehab for building that up again cause we, we can start to show patients, yeah we can now get you moving better. We can now get a new strength in there "oh I don't think I could do this exercise", well do it a bit, but it hurts do it up to three out of 10 poke that bear. Because gradually they realized that actually what they could do at three out of 10 pain now, they can do twice as much as three out of 10 pain.

Ulrik:

And again, that actually starts, they now start believing it because you're not just telling them they're actually feeling themselves. And this is one of the reasons why I felt he even had an even bigger man crush on Greg Lehman was when he came up with the best slide for rehab ever. And I put that in the, in the pack that that I'll be happy to distribute as well. And he says, you know, cause obviously working at a lead sport, I'm used to, you know, lots of SNC coaches putting rehab and putting concentric before

you know, all these sort of things and isometric and we need to do this before this and stability basically. Greg has two phases to the rehab pyramid. There's the calm shit down phase followed by the build shit back up phase. And when he introduced it, I love this guy.

Steven:

Yeah, yeah.

Ulrik:

And, and of course that also, we can use that with patients when they go, Oh, I started to feel a little bit better. And so I went for a run, what do you mean you went for a run? We were still calming shit down or calming stuff down depending on the patient in front of me. And we were nowhere near getting things built back up again. You know, that's the, and the phrase that I often use to people who get super excited about getting better and go back to the activity two is you've, you've not earned the right to run yet. Where you earn the right to run is by doing your, you know, your Superman and your glute bridging and your side bridging and all this sort of stuff. That's where you get enough strength that we can get you built back up to running. Again,

Steven:

This is all based on pain science, but actually a number of people have said, well, doesn't this just come down to experience in assessing personality types? You know, some, some patients want to know exactly what the facet joint does. Other patients don't. They just want to know how the stress might manage their pain.

Ulrik:

Yeah. And yes, it probably does. I've actually found very now that I no longer use the spine I found very few patients who sort of sit down going, can you just tell me about the facet joint and or the or the golgi tendon organ. You know, that's, that's, and I, I realize that's because patients don't know, but actually very few people want a specific diagnosis. Some do. And I will basically, well essentially it's what we call mechanical back pain, but my report finding is your spine isn't working very well because your joints are stiff, your muscles are tight and weak and your nervous system isn't firing and controlling you appropriately.

Steven:

That flies in the face of everything we were always taught at college doesn't it. It doesn't need to explain exactly to the patient what it is that's going on. Use this model of a spine and all the rest of it.



Ulrik:

Yep. And, and of course the problem is you could justify that if you were certain that that's actually what was going on. But of course we're not, when we say, you know, it's your sacro-iliac joint. We actually don't know that. And most of the research shows that we've got no real way of proving whether it is or not.

Steven:

One more question if I may. Vispi has sent in a question here and he said sometimes the patients on a kamikaze mission, they overdo it on a good day. They hurt, become dejected and that takes them into an emotional spiral. They Swear blindly that they've done nothing or that they've done everything asked of the. How do you manage patients like that?

Ulrik:

Yeah, again, and it's, it's the whole feast and famine. And I actually, I draw the graph cause I've seen them as well and I have seen those patients where you, you go, the problem is that you start feeling a little bit better then you massively over cook it. So we now you get so sensitive and painful that we now have to rest it again. But we never get to the building shit up. We're either calming things down and then you go and over cook it again. So we never actually get to a rehab phase because we can't because then you've irritated again and we now need to calm it down until, until we can build it, build it back up again.

Steven:

And I suppose this isn't really a question, it is a question but we can, we can end with this. Candice has asked is pain science largely about patient education?

Ulrik:

Yes, absolutely. Yeah, absolutely.

Steven:

So actually that feeds nicely into the chiropractic code, the osteopathic practice standards, which talk to us about getting the right communication with patients, giving them the information they need to know in the right manner. And I'm saying this just so that we can make sure that we're justified in putting it on the certificates after this that say these are the things we covered in this particular bit of CPD. We all know we covered that anyway. Ulrik that was brilliant. Thank you very much. I think I would very much like to have you on one of our longer shows and talk about this in more detail if you'd be willing in the future. But that is all we've got time for today. So we'll look forward to getting those resources from you when we'll make those available to everybody. And hopefully we will see you again at some point in the future.

Ulrik:

Lovely.

Steven:

Thank you.