**Transcript of RELIEF Podcast With Christopher Eccleston**

**RELIEF:** Hello, this is Stephani Sutherland. I'm here with Relief.News in Boston today at the World Congress on Pain, the meeting of the International Association for the Study of Pain. And joining me today is Christopher Eccleston, who is a psychologist and researcher at the University of Bath. Thank you for joining me today.

**Christopher Eccleston (CE):** Hi, Stephani, it's nice to be here.

**RELIEF:** You gave a great talk yesterday, a plenary talk, about where do we go from here in terms of psychological treatments for chronic pain. Can you just start by giving us a little bit of background about psychology as a treatment for chronic pain and how our psychology is such a crucial part of the chronic pain experience? Maybe you could just talk about where we are today in terms of using psychology for chronic pain.

**CE:** Sure. I think of psychology as an integrated part of our offering in pain medicine. It's not something separate. It's not something that's an addendum or an adjunctive, or something you do when everything else fails, it's a critical part of the way we think, and how we try to help people who are suffering and trying to make sense of a life blighted and interrupted by chronic pain in particular.

It's worth saying right at the very beginning though that what we're not saying is that when you're involved with the psychologist and you have chronic pain that somehow that means that the pain is being caused by your psychological state. That I think is just another way in which people can be harmed by ideas in our culture. We are not saying that if a psychologist is part of your care, then somehow it must be a condition that's caused by some past psychological state.

What everybody with chronic pain knows is that it doesn't stay in its box. It's not simply a physical problem. It affects all aspects of life. It can affect your emotions, your goals, your motivations, your relationships, your ability to be who you are. It can really spill out into all aspects of life. That fundamentally is why psychologists are involved, to help people, help make sense of their own experience and find ways in which they can reduce the suffering that's associated with pain.

**RELIEF:** One thing that you said in your talk yesterday that not only I, but a lot of people have been repeating, because it was such a great line, is that, when it comes to psychology, we need to put the body back into psychology and we need to put psychology back into medicine. What do you mean by that?

**CE:** Well, that's interesting, isn't it? What happens to the body in psychology? It was there at the beginning, and somehow we lost sight of it and, of course, don't get me wrong, I'm a psychologist and I'm interested in the mental, I'm interested in thoughts and feelings and how they relate to behaviors and why people think one thing and not another, and how we make sense of our experience. In fact, not only am I psychologist, I'm an academic. So, I love reading, and writing and thinking. But if we're not careful we start to think that the body is only really a taxi

for the minds to take us from one place to another. When actually, it’s what sets all of the limits in our experience.

Another way of thinking about the body is, to be embodied is, we are what we experience. We are how we experience, and we are who we experience, all at the same time--quite mind blowing. What I mean by putting the body back into psychology is that I think we need to remind ourselves that the body sets the limits of our experience and the mind explores that experience around those limits.

What I mean by the second part is a little easier to understand, which is just simply that medicine has become a very specializing set of disciplines. To be extremely good at what you do, you need to be very focused on a particular part of the body and a particular set of functions and a particular set of diseases. And it’s very easy, and I completely understand why to lose sight of the person and their experience, and the individual phenomena that they are experiencing. We need to find a way to help everybody, I think, more psychologically.

**RELIEF:** You actually describe the experience as sort of an epiphany that you had a body, how did you come to not understand that you had a body, and what happened?

**CE:** Well, there’s a little bit of rhetoric at play. I was trying to make an extreme case that somehow we can enjoy the mental too much. Or, that’s my experience as somebody who works as a mental health professional. But actually, when you have a problem as well, it can overwhelm and overtake you. Remember most of us live in the past and in the future. Most of what we’re concerned about is what we worry about, what did happen in the past and the consequences for the future.

So, we become extraordinarily mental. When life gets interrupted by our physical presence, we’re often surprised by that. It’s almost as if, nobody told us we had a body. So, I went back, and I thought, why is it in our culture that we don’t talk about bodies. I thought, well, it’s not there at the beginning. We talk about the big five senses, but we don’t talk about all of the other physical senses.

If you were to look at the textbooks that we give our small children, their play books, it’s all about seeing and hearing and smelling. It’s only if you get really sick and you go to hospital, do you get a book about being tired or being sick or not being able to stand up properly. We don’t talk about it in a normal way. And that continues.

Even in orthodox psychology, as I said, when you look at the psychology of perception, there’s very little that’s about embodied perception. I think we’re all colluding in the denial of the obvious, which is that we have a physicality.

**RELIEF:** Right. That’s more than a taxi. Right.

**CE:** It’s more than a taxi.

**RELIEF:** So, you mentioned that the books that we read as young children and even into college and graduate levels, mostly focus on the five senses. One of which they call touch, but you described ten neglected senses. Can you talk a little bit about those?

**CE:** I can. I wanted to really draw attention to these other aspects of physical being. And let me just first say, that, of course, the five senses are not unimportant. I just think they've had enough attention. In focusing on these neglected senses, I wanted to give them a small moment in the limelight, asmall moment of attention.

And of course, you often experience them together, never in isolation. They're all wrapped up together. But, just bear with me, I wanted to focus on them. So, there's an experience of being imbalanced. We know what it's like to actually be out of balance or to be in balance. We don't necessarily have a feeling of being in equilibria, of being balanced, but we know what it feels like when we're not. When we're about to fall, or we fear that we're about to fall.

There's a whole set of experiences which are around operating under pressure. Being in a gravity environment and that can be experiences of things like feeling the weight of things, even feeling the weight of your own body. You know, there's a whole psychology on how one makes sense of the weight of an object, very little on how you make sense of the weight of your body, what it feels like to judge your body. Most people underestimate or overestimate how heavy they actually are or light they are. So there's a whole set of those experiences that I think of as pressure.

There's a set of experiences on the sense of moving, which is different than balance. It's about moving in the world, it's about being in or out of control with your movement. Then, you have to count me through these, there's what we call interoceptive senses, the senses of itch, of pain, of fatigue, of temperature, of being too hot or too cold. There's a set of experiences around appetite, of being driven towards or away from consumption.

And there's a whole set of senses which I think of as expulsion, which are about matter leaving your body. What it's like to cough, to swallow, to defecate, to micturate, and these are actually extraordinarily important, especially in the cases of things like palliative care where people are really struggling with all of these different senses. I often tell junior psychologists we really need more people to be researching in the psychology of continence, because it's an incredibly important problem for people who are incontinent and the urge and the motivation that comes from that.

I think the point of all of those different senses is that maybe we take them for granted. We take this wonderful thing of our bodies for granted.

**RELIEF:** You also talked about some of those senses, those neglected senses, are less of just the physical sensation, and more of a drive to a call to action. So, for example, like hunger and thirst are driving us to consume, as you said. And pain has its own drive.

**CE:** That's right. What makes those individual neglected senses interesting is that unlike the big five, they all operate with the same overarching function which is to protect and coordinate a

consistent behavior to protect you and that's why, when you're falling or when you're too hungry or you're too hot or you're too cold, they're all about bringing you back into equilibrium. But, unlike those interesting big five senses, they all have a singular drive.

They're not always straightforward, as I said. Pain is an interesting one because what people think of about pain is about the experience. But pain really functions to promote an urgency to escape harm. That's what it does. That's what it is.

The reason that that's very important is because that should set the stall out for what we do psychologically. It starts and ends there. If you don't understand that being in chronic pain is to be chronically urged to protect your body from threat, you are not going to do very well for your patients.

I think it's really very important that we understand that the lived state of being in chronic pain is going to be chronically motivated to flee the unfleeable.

**RELIEF:** Let's talk a little bit about how chronic pain can disrupt someone's life. You talked about three different levels that we can be disrupted by chronic pain, that there's interruption at the first stage and then it goes to interference and then identity challenge at the highest level. Can you explain what you mean by those?

**CE:** We tend to start with interruption. Everything starts with interruption. If you think about what I've just described as most of those senses operate out of your awareness at a physiological level to keep you in homeostasis. But when that fails, if you're too hot or you're too cold, or you're itching too much, or you are in pain, then what happens is your awareness and your consciousness gets interrupted.

Now, actually all interruption is disabling to a certain extent. Imagine if you have to work in an open plan office or you're working with multiple conversations. Maybe this is a male issue. I don't know. Dealing with multiple demands, being constantly interrupted is fatiguing. It has a cognitive cost, it has an emotional cost. Imagine if those things that are interrupting you are actually painful as well.

I think that's the first experience that we need to understand, that people are being interrupted repeatedly and often by painful events. And, there's a lot of psychology that shows that those interruptions can actually interrupt your planning, interrupt your actions, interrupt your conversations, interrupt your memory.

So, why do chronic pain patients complain about having poor memory? Because they're not laying down consistent memories because they're being constantly interrupted by this painful noise.

Why do people forget where they're going and what they're doing? It's because often that they are not being able to consistently plan or follow through with those plans. Why can't people remember things they told you or hold a conversation? It's because halfway through your body has just demanded all of your attention.

So let's take that and think, what might it be like to be constantly living with interruption? Remember, not just the interruption itself that you just switch away from, what the interruption does is trigger a set of thoughts that say, oh there it is again, this is very difficult, why can't I cope with this. People become quite depressed. All of that can interfere with your life.

We have mealy words for it, like disability, but really they don't even begin to capture the sort of damage that it happens in people's lives. I think of it as it interferes with everything. And that, in a way, is what we're often trying to deal with, psychologically or in rehabilitation or working in pain management as helping people understand the extent of that.

Then lastly, the third area, but we really haven't done very much work on it, is identity. If you talk to somebody in chronic pain, yes they'll tell you what they can't do in their life, yes they'll tell you how bad their pain is, yes they will tell you, people tend to be very obedient. They'll answer the questions that you ask them. But, we have to ask some different questions. And if you ask somebody how's it changed how you feel about yourself and who you are. They'll tell you, this is not who I want to be. This is not who I thought I was going to be. I want to get back to being a different sort of person. It makes me feel older than I am.

People will tell you if you ask them the right questions. These are the questions of identity of who am I, who can I be.

**RELIEF:** You talked too about engaging our natural defenses at each of those different levels. How can we do that? What are the ways? You talked about different ways that people cope with those interruptions or with that disability.

**CE:** I think that the best way to understand the psychology that we do is to think of it as a normal psychology. We didn't talk very much about that yesterday. But really, I think of myself as a normal psychologist. Let me tell you what I mean by that.

Most psychologists are working in medicine or in primary psychological areas, they're interested in the abnormal. It's not that different than most of medicine. If you were to meet any specialist in medicine, they know about unusual presentations. They don't spend a lot of time on normal physiology or normal anatomy. What they're interested in is disorder, because they can help that.

**RELIEF:** They can fix it.

**CE:** They can fix it. And in a way, psychologists do the same. They're interested in abnormal, the stranger the presentation the better. I'm interested in the normal. I'm interested in why do people do the things they do every day? Why choose a brown suit instead of a blue suit? Why do they decide to say the things that they do? What are their normal everyday decisions?

The reason I'm interested in the normal is not because I lack imagination. It's because in the normal is where you find what's working for people and what isn't. So, when somebody has a pain problem, there isn't a small box they have at home, that says, here's how you respond to an unusual event, and I'll start behaving in those ways.

What they do is they apply all of the normal ways that they normally respond to every other threat in their life and they try and make it work for pain. So I think we need to understand those normal responses, how people attempt to cope with their responses, when they work, when they don't work.

One of the things that I learned quite early on working in pain is that I met people who have dealt with extraordinary things in their life, terrible losses, grief, loss of work, loss of homes, all sorts of losses. And they've managed to cope with them. But pain somehow just unraveled them.

I think it's humbling to know that somehow what can work in other threats of your life, pain can just be, it's a different type of threat. We need to find ways of helping people cope with that.

**RELIEF:** What do you mean when you said, in the context of threat, if we're talking about threat, and pain is a signal that we're under threat and need to escape it, what does it mean in the context of threat, pain will always out.

**CE:** What I meant was, pain is an alarm and as I said earlier, it motivates you to avoid harm, even when that harm is unavoidable. Just because the harm is unavoidable, doesn't mean it stops motivating you. It's there all the time.

There is a certain school of psychological therapy where people are interested in helping people not attend toward their painful sensations. At its most crude, people have attempted in the past to help people distract themselves. The evidence shows that it doesn't work. But it's a popular idea.

Many of the people listening to this podcast today, if you're patients, will have had people say to them, just don't think about it. It's one of the most hurtful, damaging things people can say to a person who's in pain. Because it underestimates, and it shows a lack of understanding of how you can't simply stop listening to the fire alarm in the building. It's like telling somebody who's starving, hungry, to stop thinking about food. It might work for a moment, but in the end, that pain will out, that alarm will come out, it will because it might work for a few seconds, but it will come back.

In a sense that's what I mean. And there is a tradition of building on those treatments where people have attempted to find other ways of capturing attention, filling your memory, finding ways of giving you the power to do that.

I think in acute settings, in short-term pain, it's useful. Getting over a really difficult flare of a pain situation, it might be helpful. If you have learned certain techniques that work for you, that are highly meaningful for you and motivating often in music and other areas, that will work for you. But in the end, that pain will find its way out.

**RELIEF:** People have different coping strategies too. You talked about people, as a coping strategy, immersing themselves in the pain, or on kind of the opposite end of the spectrum, almost becoming disembodied. How do people use those as coping strategies?

**CE:** Well, one of the things that I've become quite interested in is the experience that people have at extremes. And it's really an idea, it's the beginning of an idea really, if I'm honest, that we don't know very much about the body's ability to protect you in extreme situations. There's a lot of anecdote and there's a lot of story about what happens in those near-death experiences, for example. or what happens when you actually find a way to disassociate from your body. It's almost the ultimate defense, if you really cannot escape, then you can depart from your body. There's enough evidence to show that it happens in a number of very specific ways depending on the sensation that you're in.

My proposal, is how might we capture that? Might it be possible, it might not be. It might only ever be a final defensive solution. But if it is possible to capture that in other ways, through new technologies or other ways of creating immersive experiences, for example, of being able to find meaningful, fully immersive, different ways of doing things, then it might be possible to imagine new ways of helping people.

**RELIEF:** Coming back then to how psychology is working for people with chronic pain, and where you think we need to go, I also want you to touch on the idea that very few treatments, no treatment that we know of, in most cases, for chronic pain is going to completely get rid of pain. It's more about learning to live with chronic pain. I talk to patients who sometimes, quite frankly, I think, find that demeaning. I'm sure you must encounter this, where it's like, "well I can't get rid of your pain and you're just going to have to learn to live with it," which I think is how some people hear it. Can you talk a little bit about that?

**CE:** Language is very important. You know that better than I do. The words that we use can be very harmful or very helpful. Some of it's about really trying to understand why saying that to somebody doesn't really help. I think that it can be helpful for some people to be free from a struggle to find a cure that's not possible.

I have met many people who've just said, thank you, somebody has finally been honest with me. That can be helpful itself. But I've also met many people who say that's just a defeating, unpleasant idea that they can't deal with.

But the reality of where we are in terms of an aging population and the realities of multi-morbidity, the realities of having bodies that will impinge on our lives, is that we will have multiple sensations that will become part of our everyday life. It might be tinnitus, ringing in the ears. It might be chronic itch. There are many people with psoriasis who live with constantly being interrupted by an itch. It might be chronic pain, it might be all three.

The background noise in our lives from our bodies is going to get louder and louder. What makes that difficult to deal with for many people, I think, is when it happens suddenly, or when it happens and they're not prepared for it. It's a very interesting set of ideas around how we normally age. One of the things in normal aging is that we slowly accommodate, get used to these changes that happen. And we slowly give up some of the goals that we have and take on new goals.

**RELIEF:** Make adjustments.

**CE:** We make adjustments. Often, we don't notice we're making adjustments. What happens in chronic pain often is that one doesn't have time to prepare, or think about it, it's a life interrupted, one is simply taken down or taken out by this. Suddenly one has to consider something that we're not prepared to or didn't want to be or aren't ready to be. It goes back to what we talked about earlier in identity.

So, you're saying to somebody, hey, this is something that you're going to have to learn to live with. It can feel quite punishing, if we're not understanding the context of that. It can actually feel like somebody saying, "I've given up on you. I don't believe you. You're somehow weak for not being able to manage it." And the opposite is often true.

**RELIEF:** What would you have for advice then for a patient with chronic pain who maybe has not tried a psychological intervention? What would you look for? I know that, as you said, you want to bring the body back more into psychology. What would you say to a chronic pain patient?

**CE:** Well, the first thing that I would say is, go easy on yourself. I think that's an easy thing to say. You know, there's a prevalent myth that chronic pain patients are somehow inactive. It's really not true. I've never met somebody who is somehow lazy or inactive. Actually what they're normally doing is exhausting themselves by trying to find a solution. Working really hard, often invisibly, mentally working really hard, trying to think themselves out of the problem.
The first thing I would say is hey, this is not your doing, this is a problem that we understand. There are ways in which you can find solutions. It might not be easy and straightforward. Things that you've done in the past may not work in the future. But there are things that can be done.

I'd say, yes, psychology can sound unattractive to some people, but it's not something you have to do if you don't like, you can experiment. Give it a go. Try it out. If it's not for you, you don't have to do it.

Having said that, we have to build resources. Not everybody has an easy access to these types of ideas and these types of treatments. We need more self-help resources. We need more patient resources, we need more patient self-help approaches. We need more people to adopt these ideas. So we have our part to play as well. We have to provide more for people.

**RELIEF:** What about the idea, I mean this is a very kind of Western medicine and Western society view that many of us have grown up with and culturally we go to the doctor and we expect a treatment and we expect that to fix the problem. And we become very passive in our own care. How can psychological treatments involve the person in their own care a little bit more?

**CE:** I think medicine is changing and changing quite rapidly, so that that model you describe is still prevalent but something that isn't working for chronic illness and chronic disease. We see it across settings that people are needing to manage their own disease. Most healthcare goes on in the home, not in the hospital. Most healthcare is managed within the family and by individual decisions, not in the hospital.

We don't want patients to retrain in medicine. That doesn't make sense. But people have to be able to manage and learn to understand their own anatomy, their own physiology, and their own condition. And we need to listen from people who are experts in managing their own conditions. I think that medicine will change. Technology will be part of that change, providing access to people around the world. Providing access to expertise.

I have a vision that the future of medicine will really be about experts managing expert systems, not individual patients. So, what we will do is be able to manage, if you like, a whole intelligence of what is helpful and what isn't for individuals, not necessarily be people who are individually delivering it to individual patients.

So we experts will manage those systems, and then it's about creating multiple entry points and multiple portals and multiple ways in which people can get to them.

**RELIEF:** So that can be with a psychologist directly or it might be an online resource, it might be a book, something like that.

**CE:** All of the above. Or it could be a set of podcasts. Or it could be a set of interactive tasks. It could be good old-fashioned telephone interviews. It could be all of the above.

**RELIEF:** Any final words about where you're going from here with psychology for chronic pain, then?

**CE:** I think I'd like to reassure people that psychology is a mature and empathic discipline. That this is a very good time to be working in pain psychology because there are some extraordinarily good people who are working hard to develop new treatments. It's going to feel frustrating for a lot of people because they can't access those ideas very easily.

But I want people to be reassured that they're being taken seriously, and people really do care and they're working very hard.

**RELIEF:** As we've seen at this meeting this week, there are many, many people here working to understand chronic pain. I want to thank you so much for joining me, Dr. Chris Eccleston. It's been a pleasure.

**CE:** Thank you.