# Introduction
## What is the goal and how do we get there: An overview

Believe it or not, people have chronic pain and are not particularly upset about it. They aren't angry or anxious or depressed about it. They don't typically avoid doing things out of concern for what their pain might be like if they did them. Instead, they know what their pain is and what to do about it. They stay on top of it. They actually know how to deal with their pain so well that the fact that they have chronic pain is really just a sidebar issue in their life.

What is more, people can have chronic pain and make fairly significant changes in their lives while at the same time they aren't overly upset by these changes. True, they may no longer do certain things that they used to do. They might no longer snowmobile in the winter or water-ski in the summer. They may have stopped long distance running or playing on their park and rec soccer team. They may have even changed their position at work to better accommodate their chronic pain. But, they still work everyday. They still do lots of fun things with friends and family. They sleep at night. They do the chores at home. Their relationship with their spouse and kids are good.

Now, they might also do certain things that they never used to do. They might make sure they get their walk in on a regular basis. They probably do some type of daily relaxation exercise. They may have made it a point to manage their stress well. They might pace their activities when engaged in a large project. Again, though, they aren't upset about these changes. In fact, they may have even come to a point where they like doing these things. It makes their life easier and more rich. It certainly helps them to manage pain. They know it too, and so, it maintains their motivation to do these things most everyday.

All of this is to say that some people manage chronic pain well, even though they may have made a lot of changes in their lives. When asked about who they are or how they are doing, they talk about their families, jobs, or activities. It might not even occur to them to mention that they have chronic pain.

What would it be like to put chronic pain into the background of your life like that?

How do they do it? Some people just naturally do it. Other people have to learn. There is no shame in needing to learn. Some people just naturally bowl or play basketball better than others and we never give it much thought if we are some of those people who don't do either of these sports naturally. Likewise, if you are one of those people who don't naturally deal with chronic pain in the ways I described above, don't be ashamed or embarrassed. There is nothing wrong with you. You are not doing anything wrong that you need to feel bad about. At this point, don't give it too much thought. Later, we'll talk more about differences in how people deal with pain and the stigma that can be attached in our society to these differences.

The point here, though, is that it is possible. People can learn to manage chronic pain so well that it no longer upsets them and the changes that they have had to make in their

lives to deal with the pain don't upset them either. Instead, they have chronic pain and they are involved and engaged in their lives, working and having relationships that are meaningful and satisfying. In other words, they are engaged in their lives and have no more or no less stress and problems than anyone else has.

This description is our goal.

You too can learn to do it. In healthcare, what we call the way you do it is "self-management." In general, self-management is a two-pronged approach to managing any kind of chronic health condition, whether it is a chronic pain syndrome, heart disease, diabetes, irritable bowel, or any other chronic condition. The two prongs are healthy lifestyle changes and increasing your ability to cope with the condition so that the condition itself is no longer a major problem in your life.

Now, when it comes to chronic pain conditions, specifically, where you learn the two-pronged approach to self-management is in *chronic pain rehabilitation programs*. In such programs, you learn that the two prongs are a) a number of lifestyle changes which you can learn and that, if you do them, you will have less pain over time by positively affecting the physiological bases of your pain and b) to increase your abilities to internally cope with the pain that you will in fact continue to have. The purposes of these two strategies are to reduce your chronic pain and to reduce its impact on you. In other words, you will still have it, but it will no longer be a major problem in your life.

This book aims to tell you all about how to do it. It also aims to make chronic pain rehabilitation more familiar so that you and your friends and family can know that help is available. Taking back your life and self-managing pain is possible. People learn how to do it everyday in chronic pain rehabilitation programs.

*Chronic pain rehabilitation programs*

So what are chronic pain rehabilitation programs? They are a traditional form of chronic pain management that focuses on self-management. In one form or another, they have been around for the last forty years or so. They are intensive. They provide multiple therapies on a daily basis over a three or four week period of time. They are interdisciplinary, meaning the program staff consists of psychologists, physical therapists, physicians, and nurses. Sometimes, depending on the program, they may also have occupational therapists and vocational rehabilitation specialists.

They typically have nine core component therapies to them. These core components are the following:

- Daily pool therapy
- Daily stretching and core strengthening
- Daily mild, low impact aerobic exercise
- Daily relaxation therapies
- Daily coping skills training
- Weekly individual psychotherapy

- Individualized non-narcotic medication management
- Individualized tapering of narcotic medications as needed
- Life/work exposure therapy

Unless indicated, these component therapies are done in a small group of patients. All patients in the program have chronic pain. In the following chapters, we will discuss all of these core components, not only how to do them, but why do to them and how they are going to be helpful.

*Common patient reactions to hearing about chronic pain rehabilitation program*
When first hearing about chronic pain rehabilitation programs, many patients respond that they have already tried most of the nine core component therapies. They might say, for instance, that they tried physical therapy soon after they initially got injured and they may have tried it a few times since then too. They might also say that they have seen a psychologist in the past or that they have tried a number of different non-narcotic medications, but they still have pain which has made them depressed or anxious about their future or disabled from work. They also frequently say that they have tried to stop taking narcotic pain medications in the past but that their pain became overwhelming and so they resumed taking them. The upshot of all these responses, though, is what's so special about doing these therapies in a chronic pain rehabilitation program?

To answer, we might recall the old saying about how the whole is more than the sum of its parts. Sometimes, of course, that old saying is true and it's certainly true when it comes to chronic pain rehabilitation programs. Patients typically have done some or most of these therapies, but they have done them on an individual basis, at different times in the history of their chronic pain, and often without coordination between other providers. What goes on in a chronic pain rehabilitation program has two important differences:

- All of the nine component therapies are done on a daily basis across three to four weeks
- They are done in a coordinated fashion by an interdisciplinary team of healthcare providers

Doing all the therapies in these ways makes all the difference.

First, you essentially learn everything you need to know in a coordinated fashion. It's like going to chronic pain school. The interdisciplinary staff are like the different teachers of a school, teaching you how to live well with chronic pain. The fact that all therapies are done on the same day, everyday, across three to four weeks gives you the opportunity to learn the two prongs of self-management and really practice them well before going off on your own. Second, it does more than that and here is the crucial part. The fact that all the therapies are done on the same day, everyday, across three to four weeks teaches patients how to be active for up to a full day, everyday. It's a way to learn and practice returning to an active life on a daily basis. Like no other chronic pain treatment, chronic pain rehabilitation programs teach people how to get back into life

and/or return to work, because you are essentially doing it in the program. You are taught how to do it by a team of experts, coaching and supporting you all along the way. After a number of weeks, patients learn not only how to do it. Just as importantly, they regain the confidence that they really can do it. That's the crucial difference. It's what makes the whole, greater than the sum of its parts.

What I just described is the ninth core component of chronic pain rehabilitation programs – life/work simulation exposure therapy. Even if you have done all eight of the other core component therapies, you will not have done this last and crucial one – assuming you haven't already been in a chronic pain rehabilitation program. Doing the other therapies on an individual basis at different times in the history of your care is simply not enough to learn how to get back into life while self-managing your chronic pain. Meeting with a physical therapist for three, one-hour appointments, each week or meeting with a psychologist for one hour each week, just isn't similar enough to your real life or to your full-time job to learn how to become active again at that level, all the while keeping your pain tolerable. The life/work exposure therapy that is contained within a chronic pain rehabilitation program makes the crucial difference. Chronic pain rehabilitation programs are in fact similar enough to real life. When you commit to attending a program, you put yourself in a position to allow the team of experts to teach you how to be active for up to a full day while keeping your pain at a tolerable level. Most patients just don't learn how to do it until they participate and complete a chronic pain rehabilitation program.

When I recommend and describe chronic pain rehabilitation programs to patients for the first time, they often react with protests that they would never be able to do it. They are too disabled, they say, to do anything that active everyday for a number of weeks. You might be saying this right now as you read this introduction. However, I would ask you to consider the following description of a typical patient who succeeds in a chronic pain rehabilitation program:

- A person who has at least one chronic pain condition lasting for years, and has been unable to work for years
- A person who struggles to do daily chores, if he or she even does them, and may have difficulty even doing the basics of life, like getting dressed or getting in and out of the shower
- Emotionally, the typical patient tends to have very poor sleep, is irritable and/or depressed, anxious about the future, and his or her relationships are strained.

As you can tell, chronic pain rehabilitation programs are set up to help the most disabled and distressed people with chronic pain. And they succeed in doing so. Indeed, chronic pain rehabilitation programs are generally considered the most effective treatment option for individuals with chronic pain (Gatchel & Okifuji, 2006; Turk, 2002).

If the above typical patient describes you, at least in part, then you can succeed in taking back your life too. You just have to give it a chance and learn how.

Are you ready?

*How this book should be used*

Let's look at how this book is set up and how it can be used, because it can be used in a number of ways.

First, it can be used as a companion guide to your participation in a chronic pain rehabilitation program. While in these programs, it is often helpful for patients to read about the condition that they have and how to treat it. As you progress through your chronic pain rehabilitation program, your treatment providers can assign you chapters to read as a way to reinforce the concepts and skills that you learn in your therapies. Or the chapters might introduce new ideas, which you can later discuss with your providers. Or they might simply provide greater detail and background information to what you learn in your program.

The sections and chapters are written in a progressive manner to be read from start to finish, but also as short sections, which can stand alone and be easily read individually as assignments. Your treatment providers might jump around from section to section, based on your progress or your individualized needs.

Second, this book is also a guide for your chronic pain rehabilitation provider. It's what's called a *treatment manual* for therapies within a chronic pain rehabilitation program. While such programs are known to be effective, no treatment manual is widely available to guide these programs and provide a standardized protocol and rationale for them.

Third, we know that chronic pain rehabilitation programs are not widely available in all areas of the country and also there are often insurance barriers to obtaining such care. The sad truth is that while such programs are the most effective form of chronic pain management many patients will not have access to them because either there are no such programs in their area or their insurance does not cover them. As such, many patients end up trying to pursue chronic pain rehabilitation in small group therapies or even in individual based care with different providers at the same time. In such situations, it will be helpful to read this book as a stand-alone self-help book.

As such, this book is written to be an intervention all by itself – to get you motivated to make changes in your life so that you deal with chronic pain more effectively. Roughly, the chapters alternate between the two afore-mentioned prongs of self-management: a) external lifestyle changes to make which can positively affect the physiological basis of your pain and b) internal coping strategies to deal more effectively with the chronic pain that remains. The emphasis here is on what you can do to get better. As such, there is nothing in the following pages for which you absolutely need to be in a clinic to learn. For the motivated chronic pain sufferer, this book can be your guide to taking back control of your life.

*Who might benefit from this book?*

The answer might be the same whether you are using this book as a guide to participating in a formal chronic pain rehabilitation program or using it as a stand-alone self-help book. The answer is that it is for people with chronic pain. As we will see, it is often hard for people to accept that their pain is chronic, but let's try to clarify how the phrase "chronic pain" is used in this book.

Chronic pain is not any old pain, but rather pain that meets two rough criteria. First, this book is for people whose pain is lasting longer than six months. The time frame of six months is a rule of thumb commonly used among healthcare providers who specialize in pain management because most acute injuries or illnesses will have healed up by then – either on their own through the body's natural healing process or with the help of medical therapies or procedures. The second rough criteria for what chronic pain means in this book is that the pain is due to health conditions that are not terminal. Examples are low back pain, neck pain, daily or recurrent headaches or migraines, fibromyalgia, and any of the neuropathies or complex regional pain syndromes. There are, of course, more types of chronic pain but these are the most common. Notice that there may be a large number of conditions which may cause chronic pain, but none of these conditions will lead to death, which is what 'terminal' means.[1] So, chronic pain refers in this book to the pain of health conditions which you will likely live with for the rest of your natural life and when in fact you do die, you will die with them and not from them.

There is one more point to make when discussing who will benefit from this book. Briefly put, it's that you have to be interested in what you can do to reduce pain and improve how you deal with pain. As we will see, there is a time and place for relying solely on healthcare providers to make you better, but there is also a time and place for you, the chronic pain patient, to begin the process of learning what you can do to get better. As a patient, if you see your role as solely finding the right specialist to make you well, then this book is probably not for you. But, if you are at least willing to entertain the notion that it would be helpful to learn some things that *you can do* in order to reduce pain and its impact on you– even if it doesn't cure you, then this book is for you.

*The goal of chronic pain rehabilitation programs*

So, again, what is our goal? The aim of this book is to assist you in dealing with chronic pain so successfully that despite having chronic pain you are no more stressed or disabled as anyone else is – even people without chronic pain. In other words, our goal is for you to be involved and engaged in your life, work and relationships, and find them to be meaningful and satisfying – at least to the extent that most people's life, work and relationships are meaningful and satisfying.

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[1] Others might use the term 'nonmalignant', as in the phrase, 'chronic nonmalignant pain.' By and large, 'nonmalignant' is used interchangeably with non-terminal, but it is less general because it usually refers solely to cancer, which, as I am sure you know, is often terminal (i.e., leads to death).

Notice that it isn't a super lofty goal. No one is promising divine bliss here. Nor are you promised a pain free life. Our goal is just to get somewhere into the normal range of functioning in life *despite having chronic pain*.

The normal range of life can still be hard at times. Good things happen. Bad things happen. People get stressed and depressed or anxious. People stop doing things that they once enjoyed and find new things to do. Life comes with these things. Our goal in chronic pain rehabilitation is not to get away from these normal problems of life. Rather, our goal is to get to a point where you are not overly stressed or disabled by chronic pain. It's possible to have chronic pain that isn't overwhelming or disabling, but you have to learn how. By learning to effectively deal with chronic pain, you get to the point where the good and bad things that normally happen in life are what occupy your time and energy – not chronic pain.

While it's not a super lofty goal, it is difficult to achieve. It's going to take hard work on your part. And it's going to take a long time. There are no easy and quick fixes in chronic pain. But, you know that. If your pain was quickly or easily fixed, you wouldn't be reading this book or seeking the help of a chronic pain rehabilitation provider. Motivation and perseverance in making personal changes over time are the strongest predictors of who is successful in chronic pain rehabilitation.

So, again, are you ready?

# Chapter One
## The place of chronic pain rehabilitation in the healthcare system

When it comes to treatments and therapies for health problems, our healthcare system has two broadly defined approaches. One is the acute medical model. Patients likely pursue this approach most often when seeking healthcare services. I like to call it 'the fix-it model.' The second is the rehabilitation or 'self-management' model. Patients likely pursue this approach less often, even though they could benefit from it more than the acute medical model, at least for some health conditions. It may be due to its not being as well understood by patients. Let's review both, one at a time.

*Acute medical model, or the fix-it model*

The fix-it model is what we tend to think of as standard healthcare and in large measure we are right. When we get sick or injured, we go to a physician and a few different things occur, which we have all come to expect. First, we tell the physician or other medical provider what our symptoms are or how the injury occurred. We then undergo a physical examination. Following this 'history and physical,' the provider performs a procedure on us or prescribes medications, which act upon us. The overarching goal of submitting to these procedures or taking the medications is to get cured of what ails us. That is to say, we are presently sick or injured and we want to get back to how we were before we became ill or got injured.

Now, when this type of medical care works, it is a wonderful thing. With advances in understanding and in technology, a great many ailments have come to be curable. Antibiotics cure us of a great many kinds of bacterial infections. A cast can return a broken arm to normal over time. A surgery can cure a potentially life-threatening appendicitis. Certain types of cancer are now considered curable with combinations of surgery, radiation and chemotherapies. Again, the fix-it model is truly a wonderful thing and it is testimony to the goodness of its achievements that it has become the standard model by which we have come to think of as medical care.

Sometimes, of course, a cure is not immediately available and a physician delivering care within the acute medical model will provide or try to provide *symptom relief*. This approach is a little different than trying to fix the patient's medical problem, but it is a medical approach that nonetheless lies within the acute medical model. When what will fix a patient's problem is not immediately obvious, a provider will begin a process of trying various things to fix the problem and this process will essentially be one of trial and error. The physician will try one thing and then another until he or she finds the procedure or medication that will fix the problem. While this occurs, the provider might prescribe a medication, say, that won't exactly cure the patient but will in the meantime help the patient feel better. Such symptom management is intended to be temporary until the cure is found. For example, we might take a cough suppressant to reduce the symptom of a cough while also taking an antibiotic to cure the underlying pneumonia that is the cause of the coughing symptom. The cough suppressant is intended to be for symptom relief and the antibiotic is intended as a cure.

By the way, this is often the intention behind prescribing narcotic pain medications for chronic pain. A primary care physician might begin providing pain symptom relief with such narcotic medications while he or she sends you to the different types of specialists – neurologists, interventional pain physicians[2], surgeons, or physical therapists – who will attempt to cure your pain. Sometimes, such specialists will take over prescribing narcotic pain medications, but whoever prescribes them, the medications are intended to provide temporary pain symptom management while or until a cure can be found.

Other times, of course, there is no cure for what ails us and all healthcare providers do is symptom management. Many acute medical problems are managed in this way. The physician provides some type of treatment that is designed to keep a patient comfortable while the body naturally heals. Consider, for instance, when we experience a cold. A physician might prescribe medications or we might take over-the-counter medications to reduce the fever, chills, and aches that we experience from the cold virus. Over a period of time our bodies will fight off the virus and we naturally return to how we were before we caught the cold.

In terminal cases of illness or injury, a healthcare provider might solely focus on symptom management as well. This type of symptom management is a special type, which we call *palliative care*. A good example with which most of us are familiar is terminal cancer. After a cancer has progressed to the point of being incurable, a physician might provide palliative care, a type of symptom management, which is intended to provide pain relief and other symptom reducing measures that will keep the patient comfortable until the end of life.

In these cases of general symptom management, the acute medical model provides needed and admirable services even when there is no actual 'fix' for the medical problem. All of us, it could easily be assumed, are grateful for such symptom management therapies.

The strengths of the acute medical model are that for many types of ailments it can provide a means of cure. When there are no cures, it can provide measures that help us to feel better until we naturally heal or, as in the case of palliative care, naturally die a dignified death. In our society, we have come to equate healthcare with the acute medical model because of its significant strengths and successes, which we have all experienced. Indeed, as we will see, not only patients and the general public equate healthcare with the acute medical model, but physicians and other healthcare providers often do as well.

*The rehabilitation model*

Despite the many strengths and successes of the acute medical model, there are some types of illnesses and injuries that do not lend themselves well to a fix-it model approach.

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[2] Interventional pain physicians are physicians who specialize in the use of 'interventions' to reduce pain, such as epidural steroid injections, nerve blocks, implantable pain control devices, among other types of interventional procedures.

What are they? They are some of the most significant health problems of our day: heart disease and stroke, type II diabetes, certain types of bowel disorders such as Crohn's disease or irritable bowel syndrome, and chronic pain syndromes. While each of these disorders is actually quite different from one another, they all have something in common. They are chronic medical problems.

A chronic medical condition is one in which there is no cure and so the disease or disorder will continue indefinitely. Sometimes, patients can ultimately die from some of these conditions, but death is generally not considered imminent as in a case of terminal cancer. While medical procedures and therapies are pursued with these conditions, the way a patient manages or not manages the condition can in large measure determine the extent of the progression of the disorder. Indeed, what the patient does in managing these conditions is generally considered the most important factor that accounts for how well these conditions are managed.

We might be most familiar with this emphasis on the patient's self-care in relation to heart disease or type II diabetes. In heart disease, a patient might have a heart attack and subsequently pursue symptom relief with a cardiac surgical procedure and take high blood pressure and high cholesterol medications. However, we all know that if the patient does not also pursue certain lifestyle changes, these medical procedures and therapies will likely be ineffective to one degree or another. In heart disease, these changes that the patient him- or herself must pursue are acceptance of the chronicity of the disorder, weight loss, changes in diet, exercise, smoking cessation, and stress management, among others. Similarly, in the case of type II diabetes, a patient might pursue medical therapies, but again these therapies will likely be largely ineffective if the patient does not also make certain lifestyle changes. These changes are acceptance of the chronicity of the disorder, changes in diet, weight loss, exercise, and stress management.

Chronic pain syndromes are similar. Most chronic pain patients have likely pursued symptom relief through numerous medical procedures and therapies but these are largely ineffective in relation to what the patient can do to manage chronic pain. These ways to self-manage chronic pain are acceptance of the chronicity of the pain, regular aerobic exercise; stretching and strengthening exercises; regular relaxation exercises; increasing one's own internal coping strategies; reducing any related anxiety, depression or sleep disturbance; stress management; weaning from narcotic pain medication use; returning to some type of productive activity; and weight loss, when appropriate.

At this point, we could expand on what all these conditions have in common. Besides the fact that they are chronic, successful management of these conditions depends in large measure on what the patient does to get better and not so much on what the medical providers do to get the patient better. This point lies at the heart of the rehabilitation or self-management model of care. The chief ways by which the rehabilitation model is helpful is– not through providing a cure because the conditions that we are talking about are incurable – but to assist you in making changes to best manage the health condition you have. The emphasis is not on what we as healthcare providers can do for you but on

what you can do for you. Because of this emphasis on you making changes in your life, the rehabilitation model is often also called the self-management model

Because these conditions are incurable, the goal of self-management isn't to cure the condition, but to reduce its impact on you. The healthcare community uses a technical phrase to describe this goal of reducing the impact of a chronic health condition. Specifically, the goal is to reduce the *distress and impairment* that the condition causes. Distress and impairment is a short phrase meant to refer to the adverse emotional and physical impact that a condition has on you and your life, whether the impact is emotional, psychological, physical, occupational, financial, or familial. Without using the phrase, we talked about reducing distress and impairment when describing our goal in the introduction of this book. We said that our goal is to get to the point where you are no longer upset about living with chronic pain and that you are able to get back engaged in your life, work and relationships. So, the successful management of a chronic health condition is to accept its chronicity and incorporate it into your life in ways in which you reduce its emotional and physical impact on you. In other words, metaphorically, you relegate chronic pain from being your co-star to one of the cast of extras in the movie that you call your life.

The goal of the rehabilitation model then becomes not to cure, but rather foster acceptance of the condition and educate the patient to reduce its impact on them. The words of one of my patients best captures, I think, the goal of the rehabilitation model. She said, "I've really come to accept it and have been able to move on with my life. Yes… my life has changed, but my chronic pain no longer runs my life. I do."

At this point, we can describe other differences between the fix-it model approach and the rehabilitation approach. The ideal goal of the acute medical model is the 'quick fix.' The 'fix' produces a qualitative difference in the patient. That is to say, the patient goes from a state of illness or injury to a state of health. Getting better means returning to how you were the day before you became ill or injured. None of this is true about the rehabilitation model. There are no quick fixes here. It is a long slow process of rehabilitation or getting better over time. The ideal change is not qualitative but incremental. Getting better therefore means less pain, less emotional distress about pain, better able to sleep at night, being able to do more things, less need for narcotic pain medications, and so forth. The goal is not to return to how you were the day before it all started, but to get better from here, from where you are today, however you are, and to get better slowly, incrementally, over time.

To reach such goals, many patients need help from the healthcare community: specialized physicians, psychologists, nurses, physical and occupational therapists, vocational rehabilitation specialists, all of whom are rehabilitation specialists. We act not so much as a traditional doctor attempting to cure you, but as coaches who are attempting to train you to move beyond the challenges that chronic pain has left for you. Within a friendly and trusting relationship, like you may have had or might imagine having with a coach, we train, teach, encourage, challenge, empower, and instill confidence that you can in fact deal with your chronic pain and get beyond it through reducing its impact on you.

Again, notice that the emphasis is less on us and more on you. In the fix-it model of care, the patient is the passive recipient of the care that is provided. In the rehabilitation or self-management model, the patient is the active participant in the care. Indeed, we call it self-care. So, if we are your coaches, then you are the athlete. Like any other athlete, to win the game – to get better – you have to perform. We coach, but you've got the ball. We can be there with you to work through the defeats and challenges, and also to celebrate the accomplishments, but you have the ball and are the one who has to run with it.

In our healthcare system, the traditional form of rehabilitation for chronic pain disorders occurs in what are called *chronic pain rehabilitation programs*. They have been around since the late 1960's to early 1970's and have always been the traditional alternative to surgery or long-term narcotic pain medication management, or they are where patients tend to go for treatment once they have exhausted all other surgical/procedural and medication options. As stated in the introduction, they are interdisciplinary programs, usually involving rehabilitation medicine physicians, psychologists, nursing staff, physical therapists, and occupational and vocational therapies. They are usually intensive, group programs where patients are seen on a daily basis for three or four weeks. Research has shown time and again that chronic pain rehabilitation programs are the most effective approach for patients to successfully self-manage pain (Gatchel & Okifuji, 2006; Turk, 2002). However, not all patients with chronic pain are able to attend such programs for various reasons, such as insurance obstacles or work and family schedules. In most areas, there are also less intensive programs or chronic pain rehabilitation providers who see patients on an individual basis. In any of these modalities, the focus is rehabilitation or self-management.

In the next chapter, we will go into more detail about the many underlying yet important concepts that make up the rehabilitation approach to chronic pain. It will be helpful to have a common vocabulary to use to continue our discussion into the subsequent chapters. In these later chapters, we will then review the many strategies and skill sets that you can learn to a) positively affect the physiological bases of your pain over time and b) increase your internal abilities to cope with the pain that you do in fact have and will have into the future.

*A final summary thought*

Consider this thought the next time you have a quiet, reflective moment: if something in your life is a problem and over time you get to the point where it no longer adversely affects your life, then it remains in your life but it is no longer a problem. That is how you can get better even if there is no fix.

Believe it or not, people can get to the point where, over time and with a lot of hard work, they have accepted their pain and reduced its impact on their life and, as a consequence, living with chronic pain is no longer a problem for them. Now, do they deal with it? – certainly! Would they have chosen it? – never! But do they get down about it or consider themselves disabled by it? – nope. In this sense, chronic pain becomes no

longer a problem.  And if it is no longer a problem, then you no longer need to search for a fix and you can move on with the rest of your life.