

Therapist and patient fear of bending: Does the McKenzie approach – need a shift?

By Louis Gifford – first published in: PPA News 14 December 2002

Fear avoidance behaviour and beliefs are widely recognised as a major factor in creating unnecessary disability. For patients with back pain, fear of bending and lifting crops up time and time again. Since bending is a major part of normal life avoidance of bending can make it very difficult. For patients with back pain fear of movement, and bending in particular, could well be generated by clinicians whose own beliefs and fears about bending being ‘dangerous’ are passed on to patients. My argument here is that avoidance of bending and fear of bending very easily gets established and soon becomes a major hurdle. The fact that many people injure their backs bending may be a primary factor. However, management strategies, like the McKenzie system or approach, whose traditions predominantly seek to avoid bending may be part of creating a greater problem than is necessary. Although protagonists of the system go out of their way to promote their approach as addressing all movement restrictions, I am not really convinced and address here some of my misgivings of the system and the interpretations that are used in this rather lengthy editorial. For me the central issue is ‘therapist fear of flexion leads to patient fear of flexion...

I wrote the following in a recent article for the OCPPP journal ‘In Touch’ (Gifford 2002):

‘...but what if a back pain patient was told never to bend – like many so often are in the early stages of management. Fine to suggest care with some forms of bending to start out in the early stages perhaps, but surely bending confidence should be restored in a graded way at some stage? It is my belief that around 20 years of propaganda based on the disc derangement model and the concept of centralization of pain relating to dubious biomechanical models for back pain has led to an unprecedented therapist fear of flexion that is passed on to patients (nice research project for someone!). Older therapists and those who have looked into earlier approaches to back pain will be aware that there was a time when the ‘Williams’ lumbar flexion exercises were the ‘in’ thing.’

In other words, flexion, way back in Williams’ time (50’s and 60’s), was not a feared movement and patients still got better.

Time and again my back pain patients when shown simple bending movements respond with ‘I was told not to do any bending and never to do any bending stretches!’ The reason given: that their disc is vulnerable and will ‘go out’ or something inside it will ‘shift’ in some detrimental way and their problem will go back to square one.

These patients have invariably been treated by physiotherapists using a McKenzie style of approach or been advised by chiropractors, Drs and osteopaths to avoid bending. Whatever the intention of the McKenzie system, or any other system that gravitates towards disc derangements and mechanically biased explanations that imply that simple flexion movements contain danger – there are a great many patients in the community who unnecessarily fear flexion or fear that their disc will ‘go again’ if they bend – as a result of the way they have been dealt with by this treatment system.

Clearly restoration of flexion is part of the McKenzie approach, but it is usually after some form of extension and introduced with caution.

I have always felt very alone in my criticism, but I was relieved to hear a fellow dissenter at the International Association for the Study of Pain (IASP) world congress in Vienna in 1999. The lady was apparently an anaesthetist and she made this comment during a discussion on the management of back pain by physical therapists: ‘When are physical therapists going to stop forcibly extending patients – I am sick to the back teeth of seeing patients who have developed a full blown radiculopathy following this treatment approach’.

While teachers of systems like ‘Mckenzie’ go out of their way to state that such methods are not taught – the clinical reality is that this type of management and its outcome is common. The Mckenzie book that I have and the courses I attended with Mckenzie pushed further and further into extension to achieve the desired result. I still have my ‘Mckenzie’ belt to hold the pelvis down while the patient forcibly extends against it.....

I would like to make a few points and then make a few proposals. I would also like to thank Peter Ward from Tameside General Hospital for responding directly to me about the statements I made above in the ‘In Touch’ article. I will pick up some of the points he made in this piece and would welcome his or anyone else’s comments back again for the next PPA News.

(If this doesn’t get a few letters – what ever will!!)

1st observation – attention and expectation move and change pain with repeated movement

Is the centralisation phenomenon – that relies on instantaneous changes in location of pain and changes in pain intensity something that we should really trust? – I don’t think so, but many do.

Long ago I gave up using a combination of asking about pain while getting the patient to repeat a movement – because it wasn’t productive and often made matters worse, and quite often a lot worse (for me). Having to face patients who one moment have simple back pain and then later rapidly develop leg pain and a neuropathy is not nice and something I would preferred to avoid (fear avoidance- yes!). If something is a possibility and is unpredictable – the tendency is to avoid it, or at least go very carefully with it. (Going slowly and carefully over time – graded exposure – is probably the best form of ‘wise action’ to offer and suggest here.)

In the late 1980’s I had a patient who had back and right leg pain – ‘Geoff’. This was his first episode and he was about 35 years old. He was quite fit and getting worried by the pain as it was spreading down his leg and was not getting better. The pain had reached the back of his right thigh but was most intense in his buttock. His problem was three weeks old. I did a Mckenzie style of assessment using repeated movements but instead of focusing on pain centralisation I deliberately altered my initial bias towards peripheralisation. *‘I’m interested in where you feel most of your pain as you do the movements....., what’s happening in the back of your thigh?..... keep going, any change in the pain intensity?’* I touched his thigh, *‘what about here? It would be good if you got less here (touched buttock) and more in your leg (touch leg) – any change?etc..* The pain rapidly increased in intensity in the leg compared to the buttock I carried on, *‘keep going with the movement, but now I want you to concentrate on the centre of your back and the pain you feel there, (three, four repetitions) – ‘what’s happening now, how’s the pain in your back compared to your buttock and leg...’*

The pain was now more intense in the back and less in the leg..... *'keep going and now let's see if the pain can get less in your back too....'* And it did!

You may be wondering what movement the patient was doing – it was repeated flexion in sitting.

I saw the patient again the following day and he reported little change, if anything he had had quite an uncomfortable night and was a little worse than before. He had been doing the repeated movements and concentrating on getting the pain into his back if he could (centralising). He found it quite easy to do and the pain moved and eased well.

I went through the whole repeated movement thing again – moving the pain out to the leg and back to the spine using straight forward verbal and touch cues to direct his attention, but this time using a different movement – crook lying, pelvic rock with the emphasis on extension. Again the pain moved as directed!

Here I had a patient – where pain could be centralised or peripheralised no matter which direction of movement was chosen! Was it an anterior derangement on day one and a posterior derangement on day two? Or vice versa?

Part of an explanation for pain moving location and changing with movement surely has to include a consideration of attention and expectation – and therefore mechanisms of processing. In other words, the 'pain gate'. Focusing the patient on the desired area by touch or verbal cues effectively facilitated the sensation of pain there.

It seems to me that all studies that have investigated the centralisation effect/phenomenon have been done by highly trained McKenzie therapists – who must be biased (whatever they may say, they say and do) to finding and proving the centralisation phenomenon, rather than disproving it.

Good science should go out of its way to try and prove that an observation **does not** exist - and this is not apparent in the centralization studies that I have seen (e.g. Donelson et al 1997). But, I sympathise, the problem with the types of situations pain therapists observe with patients – is that what ever they set out to find they probably will! Pain so often has a creepy conforming personality and behaviour style. It responds to the control freak therapist and the patient who goes along with the control freak!

Perhaps patient's and their pain are simply being bamboozled into moving in the direction desired no matter what may be happening to their tissues..... and if you're a normal human and involved in a trial that involves something close to your heart you're going to want to make it work!

Geoff's pain changed intensity and moved location with the movements – but most musculoskeletal pains do – and it doesn't seem to matter which movement direction is involved.

If anyone sits for long they get uncomfortable – movement, any movement, tends to relieve the discomfort or change it in some way. If you sit for long you tend to want to straighten, if you stand too long you want to flex. So too with patients in pain – **pain likes variety**, pain is just not consistent in its reporting. Hence, different movements are required depending on the current situation. Directions that we think might be detrimental may not be, but at other times they may be. The discomfort from a freshly cut knuckle doesn't stop us bending and straightening it. In fact bending and stretching, even to the point where it weeps and bleeds often feels good and it still ends up healed and functional. Normal movement is the key I think.

That only one direction should be used before others are allowed just doesn't seem to follow and needs a healthy challenge.

Many of us who suffer pain on movement repeatedly and instinctively keep trying it to see if we can free it and to test it to see if its getting better and to urge it on a bit. Clever. Pain seems to sometimes want pain to make it better and stimulate healing. Patients who wake in the morning and have pain when they move – often just have to get going rather than continue to rest. Thus, many patients with musculoskeletal pain problems who stay still for a while find relief with movement – but later on while moving become painful and find relief with resting. Pain just isn't consistent – one minute it wants you to move, the next it wants you to rest. One moment it wants one direction later another and so on. At an extreme end of the spectrum patients become 'maladaptively' restless - think of many severe nerve root pain syndromes (acute or more chronic) and many chronic pain problems too. For me restlessness is good for healing – but in chronic maladaptive pain states, this adaptive phenomenon becomes a terrible disturbance and one that is very difficult to overcome. Adaptive biology going mad.

My clinical observation is that it is very rare for common back pains to want to only move in one direction – except when they are fearful of a particular movement.

Geoff was useful – he exposed the 'attention' aspect of pain as well as making me realise that a bias to a particular movement direction was not required, not natural and not necessary for my own clinical comfort.

2nd observation: - It doesn't work if you're sceptical!

I don't know if this is helpful, but as soon as I started doubting the value of centralisation - it never happened again in a way that was helpful! All I found was that patients became worse because I was doing movements repeatedly that hurt!

When a patient does a movement, or is requested to do a movement and it hurts I think its worth asking them what *they* feel would happen if they kept repeating the movement (as well as asking them how they feel about doing the movement). Some patients instantly say that it frees up or that it will make it a lot worse. If they are a bit uncertain and not sure it is usually more than likely to make them worse. A key clinical point here then – is to ask them a) whether they mind doing a particular movement – and if they don't mind doing it and you want to examine repeated movements – ask them what they think might occur before you do them.

In my clinic I always demonstrate a movement, say something like 'how do you feel about doing this movement?' - and then point to my white board where there is a list of responses:

The activity movement....

- Happy?
- Confident?
- Not sure?
- A bit anxious?
- Not keen at all?
- No way!
- Get lost!

My stance is that it is always best to start easy, comfortable and relaxed, pain free if possible, build confidence slowly and then gradually move into range and greater repetitions over time – it may take a few days, occasionally many weeks, but it seems more natural and minimises risk (whether acute or chronic).

If you go too quickly you ruin your chances of a graded exposure approach if the pain gets worse. Patients quickly become very reluctant to repeat a movement, however gentle, if it has already made them worse. Backing off and starting again is far harder than starting easy and working gradually in. Desensitising is rarely achieved rapidly just as sudden restoration of confident movement is rarely achieved rapidly.

3rd observation: Patients whose pain centralises, moves location and/or gets less often get worse later.

Using pain response (lessening/increasing, shifting location) with movements as the main guide to treatment ‘direction’ needs a note of caution. Consider the following:

- While pain may lessen or move location with repeated movement - as described above – the movements done could well be irritating or injuring. Recall that many people who have sustained significant injury may feel little at the time and can often perform remarkable physical acts – more especially when focused or preoccupied by something. The patient’s strong desire for pain relief is often fulfilled by the therapist – and the therapy or exercise - whatever they do. A treatment that causes physical harm may relieve pain. However, the harmed structure has the potential to cause pain later.
- I think the story of ‘I walked in doubled up and walked out cured’ is an unfortunate myth that puts undue pressure on naïve/inexperienced clinicians to achieve the impossible ... ask the patients whether they were sore afterwards – ‘oh yes, the inflammation took over a week to settle down....’ etc. Would they have got better faster without the intervention one wonders. Shouldn’t we be thinking that rapid gains in range of movement or changes in antalgic postures are undesirable or most likely, risky? The McKenzie approach seems hugely linked to the rapid correction of the back pain patient who is flexed and shifted. If the patient doesn’t go out straight (sometimes taped straight)– we’ve failed. I hated that pressure and it took me years to feel comfortable with slowly working out antalgic postures. Shifts are likely a part of biological wisdom – they sometimes remain unnecessarily long, but just like correcting abnormal gait – its better, I think, to take a little time.
- It seems likely that from a **tissue** perspective the pain gate in some circumstances can be detrimental (survival over-rides the needs of the tissues). Once the novelty or the excitement of the movement/activity/treatment/therapist subsides (perhaps hours later or even the next day) the freshly injured or freshly irritated tissues’ nociceptive activity starts to gain access to consciousness - the pain gate swings ‘open’ – and the patient begins to feel worse. Continuing to repeat the movement may just stir it up even more (but may depend on the patient’s beliefs about the exercises). I can hear some of you shouting – ‘you’ve got the wrong direction Louis....’ No, for me, the more you tangle with a stirred up pain, whatever the direction you go for, the most common outcome is ‘pain worse and worse’ ... and therapist sick in the guts. Maybe I’m rubbish at it – but remember there was a time when I was enthusiastic and it *appeared* to work regularly. Perhaps the best rule to follow is that pain is slippery and often does not accurately reflect the tissue status of its location or the tissues that might create it or amplify it.

- You can very rapidly make pain worse but its very difficult/impossible to make it rapidly better again.
- Inflammation takes time to build up in many musculoskeletal tissues. Injure a tissue now and it may be many hours before inflammation reaches its peak. Peripheral nociceptive activity (though not necessarily conscious awareness of pain) usually bears a direct relation to inflammatory status.
- My biggest concern, like that of the angry anaesthetist mentioned earlier, is that by doing lots of repeated movement, moving rapidly into ranges of movement, often to end ranges and pushing them and repeating the movement we are entering a potential minefield – for the nerve roots (as well as for the patient whose probably never been asked whether they like or dislike the movement). I believe that I have been responsible, and that many others have too, probably unwittingly, for producing horrid exacerbation or precipitation of nerve root pain and subsequent, sometimes dramatic – neuropathy. I would do anything to try and help other therapists and newly qualified therapists to avoid doing the same. To follow the rules of repeated movement and centralisation/peripheralisation and believe you're safe – I'm sorry, its not good enough – centralisation may nicely occur but the next hours, next day or a few days later the pain can spread and increase in intensity, become more constant and a neuropathy can develop. The pain may last months or become a chronic pain problem. Following this rule is not a guarantee that no harm is done – it relies on instantaneous pain response and pain response is just not reliable enough, not to be trusted - sorry. Peripheral nerves have been shown to increase their sensitivity states hours or even days after being injured (see Devor & Selzer 1999) and may show little or no nociceptive activity at the time of injury. Repeated movements may be injuring neural tissue that only starts to generate nociceptive activity and become sensitised much later on.

It's anecdotal but when I am teaching I often ask groups of physiotherapists whether they have treated patients whose sciatica's developed following forceful manipulation by chiropractors, osteopaths or physios – invariably nearly the whole class raise their hands. I have received the same response from classes of chiropractors and osteopaths in response to Mckenzie extension exercises by physiotherapists.

Maybe the sciatica was going to happen anyway? Well, yes, but it's so frequent.... My clinical experience, if I had to pick a 'fear' direction, is that repeated extension (including when there was a fad for combined movements – often into extremes of extension) is more provocative than repeated flexion whether the pain centralises or not. Ultimately it probably depends on how far into range you take the patient and how many times the movement is repeated. Interviewing and managing a very distressed young physiotherapist who attended a combined movement course where she was repeatedly taken into extension combined with lateral flexion and who quickly developed a cauda equina syndrome – is just one example of why I am writing this piece with a passion. Permanent saddle anaesthesia is not funny.

There is plenty of room for unbiased research here – but don't ever ask me to get involved in doing repeated movements further and further into range in my assessments – been there, done that, seen the disasters, backed off, gone slowly, got people physically confident again – happy!

Remember, extension decreases the size of the intervertebral foramen, the radicular and spinal canals – and the effect is far more marked in the presence of degenerative changes and lesions that occupy space like disc herniations. Standing up, standing or sitting up with a lordosis and extending compromises and compresses neural tissue in the spine. Most back pains/sciaticas seem to naturally find most relief in a degree of flexion.

Antalgic flexion here is a 'nerve friendly' posture (see Gifford 2002b for further discussion). I agree that the nervous system is designed to cope with being squashed and stretched, and extension is a normal spinal movement that should be healthily maintained. But extension, like any other movement that is limited or painful –needs respect – whether it be for reasons of pain, or mechanical dysfunction.

Lastly here, if you want to move fluid around structures like a disc – just move, do simple easy movements mid range that are comfortable and relaxed, and take time – just like most people do who are a little stiff to move when they get out of bed in the morning.

4th Observation: Peripheralisation may be normal for some back pain patients.

From my observations of everyday back pains over time it seems to me that there is no nice set route or mechanical explanation of pain on which a risk free therapeutic rule can be based. Everyone is different and everyone is unique. Back pain, its development and recovery, are blatantly unpredictable, so much so that the term 'predictably unpredictable' seems justifiable. Pain moves, intensifies and disappears from hour to hour and day to day. One moment its worse in the leg later its in the buttock or back and so forth.

Many back pains develop into sciatica, the pain gets worse in the leg, subsides in the back and remains in the leg until finally they get better – or vice versa. However, getting worse in the leg and spreading further and further down it, seems to be fairly reliably associated with slow progress, neural irritation and often, neuropathy.

Proposal – 'the twisted ankle approach' = side step repeated movement examination and the search for centralisation.....

.....focus on maintaining normal/modified activity, with graded resting and graded restoration of all movements – all together, from the word go.

This probably wont catch on but for those of you who have 'failed' at Mckenzie and repeated movement testing for acute and subacute back pains - like me (and the anaesthetist mentioned earlier) - and wonder what's best to do 'physically' – I would like to suggest the humble 'twisted ankle approach' – a tried and tested scheme (by the great unwashed who recover without consulting anyone) that is not tied to any big name or requiring anything difficult or expensive to learn. So:-

- Ponder what an acute back pain racked hunter-gather might do. Also ponder what he might think is wrong..... worry and do nothing and die, or, – get going again as soon as he can and live?
- Watch how your injured pets have a bit of a go slow at first but thereafter test things out for a few days and then get quickly going. We all know of a neighbours dog who was scat off the road by a BT van who had a few shaky days early on but was astonishingly running around again and wagging his tail within a week. Slowly at first, find your feet then gather confidence. Having nothing in your head to worry about and take it as you find.
- Accept and adjust to slow progress sometimes. Tell patients about this.

- To keep patients going/functioning, sometimes its worth actually teaching them an antalgic posture, movement or gait (another good research question!!)
- Pain puts healing and normal movement on hold – so use treatments and management protocols that really do help lessen the pain (acute situation). We are sometimes blinded in our reasoning by changes in ranges of movement.
- Resting continuously for long is unwise – tissue healing strength is governed by the stresses and strains that impact them as they heal. Tissues weaken with lack of use. Rest can be graded down as movement is graded up. Think of the hunter-gatherer and the dog again. Performing a movement in only one direction is denying movement in other directions i.e. it is the equivalent of resting/splinting and immobilising.
- Changing posture regularly is better and more natural than doggedly maintaining one so called ‘good’ posture – i.e. lordosis. Insisting on one posture creates fear of other postures.
- Once a good red flag type assessment has been done - focus attention during assessment on confident movement and what the patient feels they want to do or are capable of doing - not so much on pain response during movement. E.g. ‘I am going to show you one or two movements that move the back – what I would like you to do is show me what you can do within your limits. If there are any movements you are not keen on doing let me know (these can be explored later in different ways/starting positions if appropriate). I don’t want you to feel you have to push hard or hurt unnecessarily, the aim is for me to see what you are comfortable and confident to do...’
- Think about a twisted ankle and what you would do movement wise and use the same principles with the back. In other words - try and promote movements in nice easy relaxed ways *in all directions* to start with. Some directions may be easier and some more difficult than others – so be it. Progress difficulty as per classic rehab principles.

As mentioned earlier, Peter Ward wrote to me in response to the ‘In Touch’ article – he is a ‘pro’ Mckenzie therapist. In his letter to me he stated that in his opinion 65-75% of acute low back pain problems require extension *initially*.

I strongly disagree! What’s the response if I said 90% of my patients get significantly worse pushing repeatedly into extension? Or, 90% of my patients don’t require just extension? Or, 90% prefer and find gentle and progressed flexion, side flexion and rotation much easier to do and have to go very carefully before they get going with extension?

I believe this type of statement (a requirement wholly based on the centralisation phenomenon and repeated movement testing observed in assessment) is a significant factor in creating therapist and patient fear avoidance of flexion. It might be a fact for you, but its not for me. There is no evidence that I know of which has found that flexion or extension movements are any more detrimental/helpful than any other movement of the spine.

For me, if patients find extension easier to do than flexion – that’s fine, but, just like exercises for an ankle or a frozen shoulder – all directions need a bit of movement from time to time and need grading up at a pace appropriate to the pace of the individual and their recovery.

Peter also gave two patient examples: – Here is the first (note my italics added and comments on them below):

‘**Patient A** has recovering back and leg pain, which has improved with extension exercises. Flexion exercises are *cautiously introduced*, and produce a return of leg pain, and also a loss of extension range plus increased pain on extension. In this case *something undesirable is happening mechanically*. *Flexion would be postponed and retested periodically*. *Once it can be performed without producing a painful block to extension, it can be introduced and gradually progressed.*’

Comments:

- *cautiously introduced* – whoops! – therapist fear avoidance!
- *Something undesirable is happening mechanically* – whoops! – fear avoidance increased!
- *Flexion would be postponed and retested periodically* – more fear avoidance
- *Once it can be performed without producing a painful block to extension, it can be introduced and gradually progressed.....* and more fear avoidance – all implying flexion to be dangerous.

Why not start easy bending, rotation side flexion straight away too? I'm trying to rack my brains for the last patient I had where I got them to **not do** some form of flexion as part of a program from the word go.... Poor outcomes here are invariably associated with yellow flags – not the direction of a movement. Not doing some bending or avoiding it - is **making a yellow flag**.

Every back pain patient that I have seen, as far as I can remember, has been able to comfortably perform all their lumbar movements, in part, in one way or another, from the word go. The more that I have adopted a start slowly and carefully and build up approach – using several or all movements – just like a twisted ankle regime – the fewer flare-ups or disasters I have had and the less back tracking.

Another thing with patient A – the continued flexion avoidance was based on flexion resulting in loss of extension and increased symptoms with extension after flexion. I think this is normal:

- If I spend an hour digging the garden (repeated bending) I notice that my extension range is decreased like no tomorrow when I go to stand up.
- If I spend an hour walking or running – I've noticed that my bending is stiff and significantly reduced in range until I free it up with a few bends. Even though bending hurts a bit it feels freer after.
- My observation of many acute pain patients is that if you stretch or sustain one direction the opposite direction invariably gets stiffer. Put an acute back pain patient prone for several minutes and then get them up and reassess bending – it's often a good deal stiffer. Now get them to lie on their back and do pelvic rocking into flexion and reassess standing bending again – it's often freer again and extension has gone stiffer etc .etc... sometimes its dramatic, but its normal.

The longer flexion is avoided surely the greater the likelihood of flexion being feared/being difficult to recover and the more likely cautious trials of flexion are likely to peripheralise the pain....

Imagine what the patient A is thinking when flexion is tried – they're a bit vigilant and anxious of flexion (mimicking the therapist), and likely focused on any peripheral symptoms (like the therapist) – the nervous system is expecting it and, yep, its going to happen and ... whoops.... better back-off just in case. Not only is fear of flexion being promoted, so too is a fear of distal pain. Once a notion is in your head, it's very hard to get it to go away.

Peter also used a second patient example:

'**Patient B** has recovering back and leg pain also helped by extension exercises. Flexion exercises are introduced and, similarly, produce leg pain. However, retesting shows no loss of extension following flexion. The key point is that the patient is mechanically no worse. The mechanism is probably neurogenic and linked with sensitive nerve tissue. This patient needs

to be gradually exposed to flexion in order to reduce the sensitivity to that movement. (This was a demonstration patient on a McKenzie course here. The above illustrates how their problem was described on the course and how they were treated.)’

My comment here is that this is a bit of a relief – a chink of light piercing through the sacred shroud of traditional Mckenzie doctrine!

I like the phrase – ‘this patient has to be gradually exposed to flexion in order to reduce the sensitivity to that movement’ – agree – but for those brave enough to adopt ‘the twisted ankle approach’ – we get it going straight away and avoid the avoidance and the potential for establishing fear of movement into flexion. All movement is good for recovery – patients know this – use the skin and bleeding with bending example... it’s OK and it promotes stronger healing etc...

I am very aware that a few recognised Mckenzie therapists are realising that the fear of flexion is an issue with the system (though the tone of Peter Ward’s letter seemed to be denying it) and that it needs to be addressed and discussed. For example, Julie Shepherd from the Mckenzie Institute UK has contacted me and is keen to have these issues debated in their Newsletter.

The above is my position, I’ve never heard anyone else with similar view points or brave enough to say anything. I guess there are dangers when folk write books with rules that have been long established and the authors have become quite famous - its hard to find the guts to stand up and make a little squeak or voice a little challenge.

I’ve suffered a bit of angst over writing this I must say, but I’ve struggled with what I was taught and told should happen and I’ve lost faith in it. I’ve created and seen too many avoidable disasters.

Thankfully pain science and uncluttered observation of nature has come to the rescue and made me comfortable again.

Have I just hung myself? What are your views on this?

Have a great Christmas and New Year.

Louis Gifford

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