Pain, Answered

NAVIGATING THE CHRONIC PAIN JOURNEY

JASON W. SIEFFERMAN, MD

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To Sharon Gates, DSW, whose mentorship and kindness continue to guide me.

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Foreword

Most pain, or at least the severity of most pain, is unnecessary; it's just not adequately understood.

Pain is a signal. When it is new, it gives clear, simple information. When it is long-standing or recurrent, the signal changes and layers of complexity develop. By the time patients arrive at our practice, many have spent years cycling through specialists, treatments, and explanations that did not fully add up. Often the secondary and compensatory pains that have developed over time are worse than whatever started the cascade.

The work of figuring out what is actually happening and what to do about it is the work this book describes. We approach each patient as a system to be understood, not a symptom to be silenced. We reverse-engineer what generates the pain, how it came to do so, and what keeps it from healing. Those answers tell us what to fix, how to fix it, and how to keep it fixed.

This book, through a series of questions and answers, presents that approach. It is meant for patients and their families, for clinicians who refer to us, and for anyone who has been told the pain is unexplainable, untreatable, or in their head. None of those answers tend to be correct. There is almost always a reason. Finding it is the first step.

Generally speaking, the most common practice of pain medicine involves a simple single-step “if-then” algorithm: an epidural for a herniated disc, or a facet block for isolated back pain. This predictable cycle of medication, therapy, injections, and/or surgery may diagnose the symptom, but without any curiosity about how it began, it will rarely resolve the pain long-term.

The challenge with a solution based on a single layer of understanding is that it often misses the root cause and fails to produce a long-lasting result. For example, spine issues like disc herniations, facet arthritis, and radiculopathy often originate from altered hip joint biomechanics that quietly misalign the body. Without correcting this primary driver, treatment provides temporary relief at best, leaving patients to rely on repetitive care, such as an epidural every three months. By the time the hip degenerates enough to declare itself and receive treatment, the structural toll on the spine has already become an irreversible condition.

My Journey

I‘ve lived through this type of diagnostic blind spot. During my teenage years until late in residency, I suffered from chronic irritability, constant fatigue, and severe sensitivity to sunlight. At the time, I just thought “that’s how I am,” or perhaps even “who I am.” I also had severe neck pain, but attributed that to a childhood biking accident.

In my final year of residency, to smooth out the frown lines that developed from years of pain and squinting, I tried Botox. The frown lines didn’t actually improve so much, but I noticed significantly less light sensitivity and was consistently in a much better mood. I no longer felt the need to nap every day at 4 p.m. The neck pain also got better. It clicked - Migraines!

How could I have missed it? Even though I was still in training, I had a distinct advantage over most, including access to top-tier academic doctors(!) My point here is to illustrate how easy it is to miss a diagnosis, even an extraordinarily common diagnosis. This set me on a path to deeply reconsider the diagnostic process I had learned, and view the chronic pain experience as more of a journey than just diagnosis and treatment.

About this Book

Pain may begin with an accident or trauma, which is the most straightforward option. The more common story is insidious. No clear trigger or inciting event, just progressive pain which crept into their nervous system, affected how they use their body, and changed the way they engage with the world. With time, one pain leads to another, and without recognition and treatment, it snowballs into a jumbled, layered experience of various discomforts and limitations.

The greatest insult of pain is how it changes one’s sense of self. When work is no longer possible, social engagements are difficult and cause more recognition of the life lost than joy, and family cannot provide meaningful support (because they aren’t trained for this), one becomes desperate, afraid, angry, insecure, and often resentful, in addition to tremendously uncomfortable from pain.

This drives a need for a diagnosis, a need for understanding, and most importantly, something to make it stop. Patients are often so relieved to have a diagnosis that they may unintentionally adopt it as an identity that defines them.

The person under duress from pain wants the shortest path back to the life they had. They are simultaneously afraid to hope and quick to try anything that might help. Their pain doctor, well-intentioned or not, does not need to dig deep for comprehensive understanding in order to offer a treatment that makes sense, will be accepted by the patient, and maybe provides some amount of relief.

Unwinding complex chronic pain and developing a robust treatment plan takes time, often several visits. It is an iterative process that requires significant time, energy, emotional and financial investment from both the patient and their physician. Although it's easy to understand that the years of progressive pain won't be cured with a single visit or intervention, mustering the emotional fortitude for this endeavor can trigger anxiety, despondence, and apathy. This even assumes that the patient has access to this level of care.

Those seeking this path have great difficulty finding it. How does a patient know which provider to trust for their knowledge, skill, and commitment? **My grandmother used to say, "I don't care how much you know, until I know how much you care."**

And still, plenty of caring doctors cannot solve every pain. Even with a good doctor, though, that's only one step. An entire team is needed: multiple providers, physical therapists, pain psychologists, and others. The financial challenge prohibits many from this path as well. Ultimately only a small percentage of those with complex chronic pain find resolution.

For these reasons, we seek to transform the practice of pain medicine. This handbook details the pathophysiology of pain, the care team, the journey of chronic pain through Discovery, Treatment, and Maintenance, and notes for the patient to most effectively engage with and prevail on this journey. It acknowledges many of the challenges and provides practical tools. We are here to support this journey.

If you or anyone you know is struggling with a neverending chronic pain journey, I hope you feel heard *and* felt.

How to use this book

This book is organized as 128 questions and answers across six parts. The questions move from what pain is, how it works, why chronic pain is hard to treat to what treatments exist, how diagnoses are made, what the Maintenance Phase actually looks like.

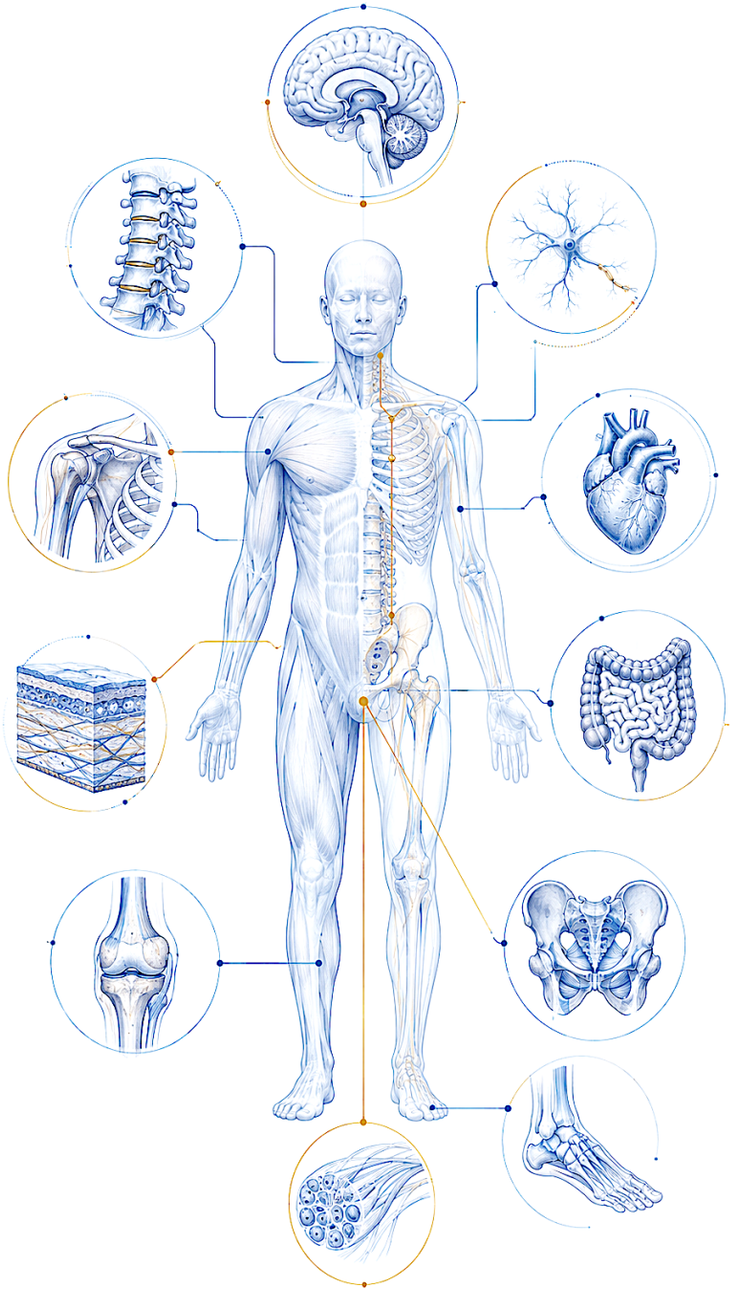
Beneath the questions is a single arc: the journey that nearly every person with complex chronic pain travels, whether or not anyone has ever named it for them.

The first three parts build the map. They describe what pain is, how chronic pain becomes so tangled, and how the journey and the care team function. The last three parts walk the road itself: through Discovery (diagnosis), Treatment, and Maintenance.

A note on what this book does not do: It will not tell you what your diagnosis is, and it is not organized around conditions. A limiting fixation in chronic pain, enabled by patients and doctors alike, is anchoring prematurely on a particular diagnosis to explain everything.

The real challenge in solving chronic pain lies in the process. Anchoring to a single diagnosis, or even a list of diagnoses, states a conclusion which is often incomplete or incorrect. This derails the diagnostic process and often leads to unnecessary 'goose chases'.

The *problem* is the chain of events that produced the diagnosis, and the reasons it has not already healed. This book is about that: the journey of understanding and unwinding chronic pain, whatever its name. ***If you are looking for a book about chronic pain because you still seek answers, this book is for you.***



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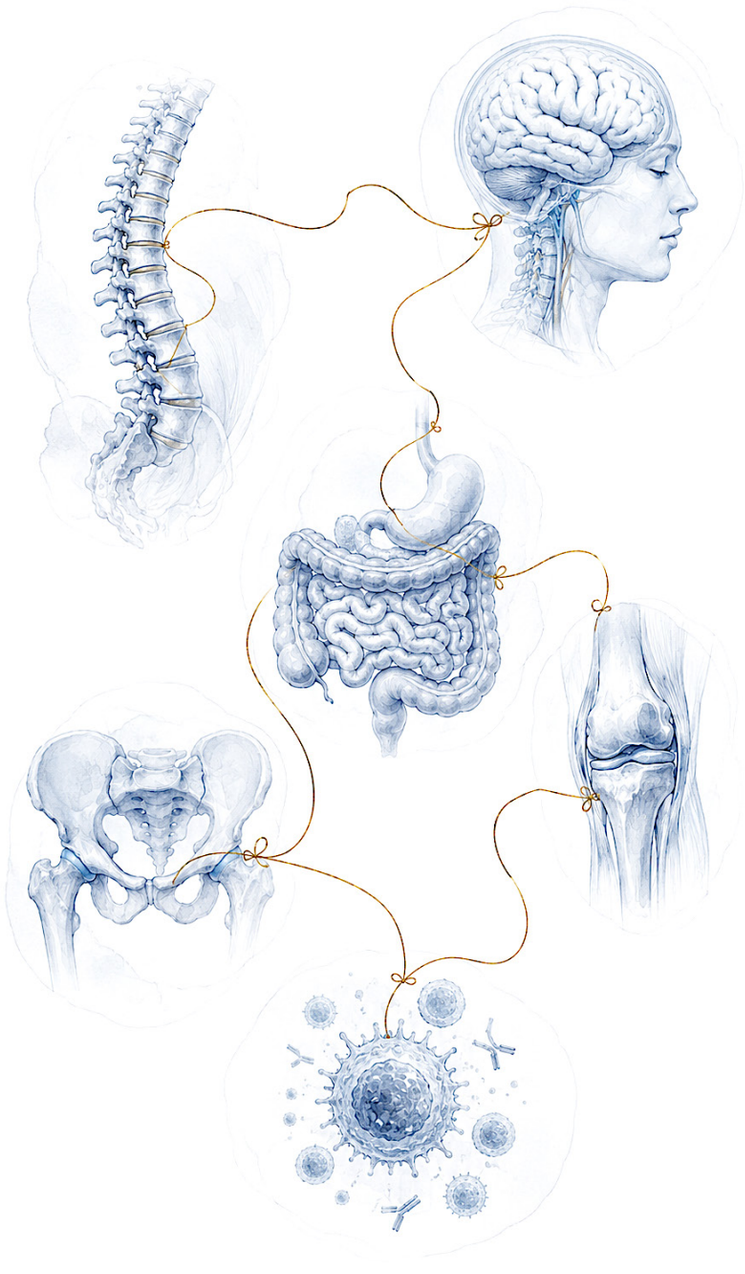

PART I

THE CHALLENGE WITH PAIN MEDICINE

If you have spent years bouncing between specialists, received no definitive answers or been through several unsuccessful courses of treatment, this first part is going to feel familiar. Understanding how the usual approach failed is the first step toward something that will not.

1. What are some of the problems with how Pain Medicine is commonly practiced?

Insurance-Driven "Care". In the United States, insurance policies, and most specifically CMS (Centers for Medicare & Medicaid Services), determine the algorithm for what care can be delivered, and in what order, by whom, and in what setting. Even for those who can afford to pay outside of health insurance, the doctors treating them were trained to think within the insurance paradigm. This means a few things:

1. **Only treatments approved by insurance policies are practiced within major medical systems**, which is where all accredited formal training occurs. As a result, doctors in the US receive very little exposure to treatments that are not routinely covered by insurance. Insurance policy, decided by mostly for-profit companies and not always aligned with science, has decided which treatments doctors learn since the 1980s. Several well-established techniques, such as prolotherapy, were routinely taught and printed in textbooks up to this point, when they fell out of practice. If patients wish to have all available treatment options considered, they must go outside of insurance, either within the US or abroad. Those physicians who do start using emerging (or even very old techniques) that are not covered, must do so on their own, with limited opportunities for learning, and standards of care are not firmly established by any regulatory body. This paradigm leaves these physicians to each develop their own recipe or approach, somewhat in isolation, because there is a delay in scientific advancement compared to covered treatments.

2. **There is no financial incentive to research treatments** that insurance has already decided not to cover. Many procedures, such as occipital nerve blocks and ganglion impar blocks, have sufficient evidence for physicians to perform them as routine procedures, but very few insurances will cover them. Adding an additional supportive study has no utility as the procedure has already been blacklisted. Even newer techniques, such as Platelet Rich Plasma (PRP) with several excellent research outcomes, remain uncovered, while steroid injections (which have been shown to advance joint degeneration) remain the standard.
3. **Standard of Care Inertia and Malpractice Risk.** Due to insurance non-coverage, both well-known and emerging pain treatments are less widely practiced. The standard of care is defined by what another "reasonably qualified" professional would provide under similar circumstances, and because the vast majority of pain physicians are in network and do not use regenerative medicine or other non-insurance covered techniques, the physician who does is at greater risk of malpractice, simply because it is not the standard of [insurance-based] care. Evolving care, by definition, is not yet the standard of care, and many physicians are reluctant to treat patients with newer techniques because of the potential risk. For those who do, there is no well-validated way for a patient to distinguish the snake oil from something worthwhile.
4. **Insurance fractures the system.** Providers who want to offer patients the full range of treatment options may be restricted by insurance contracts, and may choose to not work with insurance. Insurance contracts also generally reimburse less than the customary fees for services,

so those who wish to spend the amount of time with patients that complex chronic pain requires, also must often be out of network. Finally, the simple economics of supply and demand: when low insurance payments and limited treatment options drive doctors out of the system, wait times within the system increase. Although many excellent physicians practice within insurance networks, the financial structure of the system often makes it difficult to deliver adequate, highly individualized care that many patients with complex chronic pain require.

The Siloed Healthcare System. Our medical system is heavily siloed into distinct specialties, each with a narrow scope. Typically, a spine surgeon only looks near the spine, while a gastroenterologist only looks at the gut. Complex chronic pain does not respect specialty boundaries, and finding a doctor who recognizes manifestations of a single process across multiple different organ systems is a rare gift. More commonly, that provider will err on the side of declining to help because the situation is too complex, or even worse, dismiss the patient. Even when multiple specialists align on the diagnosis, it is uncommon for them to collaborate (even within large healthcare systems).

Over-reliance on Bloodwork and Imaging Reports. Modern medicine relies heavily on radiologists' interpretations of imaging and population norms for bloodwork. The reliance on physical examination of the patient has taken a back seat. The physical exam provides both patient and doctor a unique opportunity to co-recognize what is normal and abnormal in the body. The moment of truth when the doctor finds the pain and the patient knows that they are believed cannot be

replicated any other way. We have multiple studies showing that imaging results and pain correlate poorly and cannot be relied upon in isolation. Too often patients are told that their imaging or labs are normal and so there must not be anything wrong, without ever having hands laid on them.

Patient Dismissal and "Medical Gaslighting". Sometimes even the most well-intentioned doctors lack the ability to diagnose complex chronic pain. If the less well-intentioned can't figure it out, they may conclude that it doesn't exist, or maybe it's a psychological manifestation. Either way, they don't know how to help, and rather than acknowledging the possibility that someone else might be able to, they lead the patient to self-doubt and self-blame. Providers will sometimes misuse diagnoses like fibromyalgia, functional disorders, or psychiatric conditions because they lack the skillset to precisely diagnose and treat pain.

The Misuse of Opioid Therapy for Chronic Pain. Historically, doctors prescribed opioids without fully understanding the long-term consequences. Treating chronic pain with opioids can lead to tolerance, dependence and opioid-induced hyperalgesia, a maladaptive side effect whereby opioids make the body more sensitive to pain. Opioids also fail to address the mechanism of injury and often make chronic pain worse.

Harmful Mind-Body Paradigms. Pain has both physical and emotional components, and all pain is sensed by the brain. Pain can be modulated by techniques used by pain psychologists, and of course stress makes pain worse. Some providers, though, have taken this to the extreme of saying

that all pain is in the head, and therefore all pain can be treated by believing it doesn't exist. (True somatoform disorders exist and are quite rare.) Providers who adopt an all-or-nothing "mind-body" approach, attempting to convince patients that the pain is entirely psychological, can do great harm. The best comprehensive pain care includes pain psychology for the far-reaching effects of chronic pain and also identifies and treats any and all anatomic bases for pain.

2. Why is Complex Chronic Pain so rarely solved by modern medicine?

Treating Symptoms Instead of Root Causes. The general practice of pain management often focuses on near-term symptomatic relief. This may include medications or isolated procedures that temporarily reduce the pain, but fail to identify or correct the underlying problem causing the pain. For durable pain relief, the root cause must be identified, confirmed and treated through a process that leads us to understand the what, how, and why of the pain generation. Without addressing the underlying biomechanical, inflammatory, neurological and/or psychological dysfunction(s), as there are often multiple when pain becomes chronic, treatments rarely lead to robust, long-term healing.

Failure to Address Sensitization and Compensatory Cascades. Complex chronic pain is rarely just one isolated issue. It may have started that way, but with time the primary injuries, secondary compensations, and sensitization of the nervous system snowball. An ankle fracture may lead to an altered gait, which leads to back pain. Here, the entire cascade must be recognized and treated to reverse the process and

prevent progression Otherwise, repeated distress signals begin sensitizing the nervous system, which starts to pay more attention to the painful areas. Patients experiencing this present with a cloud of pain, and we must work to deconstruct and understand the current state.

"Cookie-Cutter" Treatment Algorithms. Pain is difficult to study. For research to be clean, a group of patients must have the same condition. With pain, even ten patients with a specific L4/5 disc herniation will each present differently and respond to treatment (or not) and heal differently. Applying the same treatment to everyone, regardless of their individual nuances does generally not produce good results, statistically or otherwise. For this reason, research studies for pain treatments rarely yield stellar results. From our point of view, the most effective treatment is tailored to each individual patient's specific pain picture, and addresses medical, physical and mental aspects as needed. A one-size-fits-all approach to complex chronic pain only succeeds for a very few.

Overtreatment and Rushed Interventions. Pain is exhausting. Doctors want to help suffering patients, and driven by a desire for a definitive, immediate result, some jump prematurely to procedures or surgeries. Bypassing the slower iterative, methodical diagnostic process required to map out the pain generators often leads to unnecess
ary treatments, setbacks, or suboptimal results.

3. Why can treating chronic pain take so long?

Chronic pain rarely develops overnight; it is the result of a slow, steady progression of dysfunction that builds up over years. To resolve it, we cannot rely on a "one-and-done" quick fix. Instead, we guide patients through an iterative journey of Discovery, Treatment, and Maintenance.

Chronic pain develops in layers. By the time a patient reaches the clinic, the pain is rarely one isolated problem. It typically begins with a primary mechanical dysfunction or injury. The body compensates by tensing muscles to guard and protect the unstable area, which leads to secondary layers of pain and altered movement patterns. Over time, repeated distress signals cause the nervous system to become sensitized. Sensitization amplifies pain signals and triggers fight-or-flight responses. We address all three layers: the primary source, the secondary compensations, and the often systemic sensitization.

Testing and Treatment. We work through targeted diagnostic blocks, temporarily turning off specific nerves or joints with local anesthetic to see exactly what pain goes away. Each test and treatment is a new data point that reformulates our understanding of the patient's body.

Healing cannot be rushed. Once the anatomic sources of pain are identified, the physical healing process itself requires patience.

Skipping steps or rushing to invasive interventions usually results in unnecessary delays, false leads, and suboptimal

outcomes. Enduring relief comes from taking the time to understand the what, how, and why of the pain and addressing each layer of the dysfunction.

4. Why are there so few good studies for chronic pain?

The Problem of Pain Inconsistency. No two patients present the same way. Medical studies frequently group patients with diverse, overlapping conditions, such as "low back pain", and apply a uniform, algorithmic treatment to all of them. This does not reflect the customized, diagnosis-first approach required in clinical practice. Chronic pain patients also frequently present with multiple comorbid pain generators. If a patient with both a lumbar disc herniation and facet joint arthropathy receives an epidural injection, any lingering pain from the untreated facet joint will be recorded in the study as persistent pain, mislabeling the epidural as a treatment failure.

Lack of True Placebo Controls. The placebo control for an interventional pain procedure must have no measurable therapeutic effect. Historically, studies presumed that saline and local anesthetic were placebo, but we have since come to learn that simply the volume of the injectate itself has benefit. Without an ineffective placebo, interventional procedures cannot be reliably tested.

Pharmacological research has a similar problem: long-term randomized controlled trials are scarce. Studies evaluating long-term opioid use, for example, frequently lack proper control groups, leaving us without consistent high-quality evidence. Many medications used for pain have been around

for decades, and without a patent to earn money, there is no financial incentive to spend millions of dollars on research.

5. Why is finding the right pain doctor difficult?

Treating Symptoms Instead of Diagnosing Root Causes. Finding a pain doctor who acts as a diagnostician is difficult. The general practice of pain management often defaults to temporary symptomatic solutions: finding a painful facet joint or a herniated disc on an MRI and injecting it to turn the pain off. Few providers take the time to ask the deeper questions: why did that disc herniate in the first place, how did the biomechanics fail, and what needs to be done to prevent the problem from returning.

Narrow Subspecialty Training. Even within the field of pain management, the physician's primary residency background (anesthesia, neurology, physical medicine and rehabilitation, emergency medicine, or psychiatry) heavily dictates their approach. A physician in a strictly spine-focused practice may lack the training to recognize how an unstable hip is the primary driver of a patient's back or pelvic pain. An anesthesia trained physician may not know how to perform a diagnostic ultrasound of the wrist.

Systemic gaps make it challenging to find a provider willing and able to look at the body holistically and perform the diagnostic detective work required. For those who do, it is a lengthy, expensive, and frequently exhausting journey, especially for the patient in pain who may not be able to commit the time or resources. The journey itself stresses the patient's already stressed body and mind, and many

who have already tried found recurrent disappointment. It becomes genuinely difficult to know which providers to trust and invest in for this journey.

6. What is the best way for a patient to find relief from chronic pain?

Finding durable relief from complex chronic pain requires moving away from one-size-fits-all algorithms and quick fixes. It requires engaging in the iterative pain journey: diagnosing the underlying drivers of pain, treating each layer of dysfunction in sequence, and then maintaining the gains over time. Chronic pain is individualized to each patient's specific mix of primary injuries, secondary biomechanical compensations, and nervous system sensitization. Relief comes from working through that mix layer by layer rather than masking the symptoms.

7. How will understanding the pain journey be helpful?

Understanding the pain journey is itself part of treatment. When patients recognize that healing is iterative, they understand that there is rarely a single quick fix. The diagnostic and treatment process takes time, and knowing this in advance prevents despair when setbacks or temporary flares occur. Fluctuations become data points that help the clinical team understand the body's mechanics rather than failures that suggest the treatment isn't working.

Patients who understand the journey become active participants in their own care. They track their symptoms with precision, ask more useful questions, and stay engaged through the time required to get the picture right. This shifts the locus of control internally: back to the patient, who has the greatest ability to affect healing.

The failures described in this part share a single cause: the work of understanding it was never done. That work has a definite algorithm, and the remainder of this book spells it out. The next section details pain in depth - what it is, how it works, and how it impacts those experiencing it.

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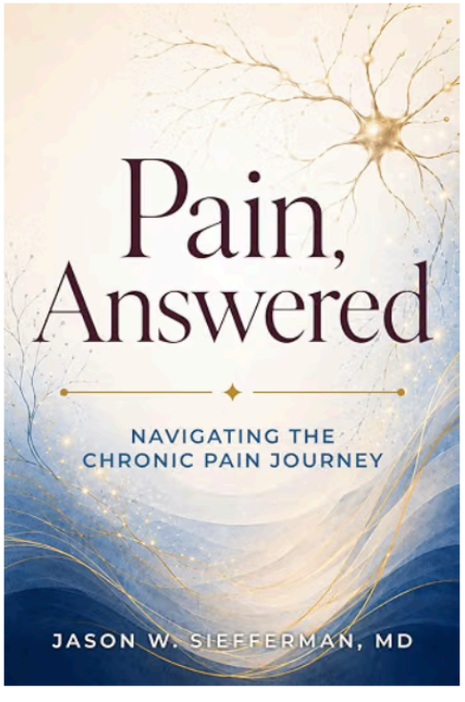

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Pain, Answered: Navigating the Chronic Pain Journey

by Jason W. Siefferman MD (Author) | Format: Paperback

Chronic pain is often not a fixed condition, but a signal that has not yet been fully understood.

For patients who have spent years moving through specialists, medications, and incomplete answers, *Pain, Answered* offers a different way forward. Dr. Jason W. Siefferman presents a diagnosis-first framework for understanding complex chronic pain as a layered condition shaped by injury, compensation, inflammation, muscle guarding, and nervous system sensitization.

Through an iterative clinical journey of Discovery, Treatment, and Maintenance, the book helps patients, families, and clinicians focus on what is driving the pain, how it developed, and why it has persisted.

Pain, Answered is a guide to untangling complex pain, building body literacy, and moving toward more durable, informed care.

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