The International Association for the Study of Pain (IASP) defines **PAIN** as, “an unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage”, and thus recognizes both a sensory as well as emotional-affective component to pain. The “**ouch**” is a result of the nocioceptive volley relayed from the periphery into the CNS with the first synapse in the dorsal horn of the spinal cord, which crosses and ascends the spinothalamic tracts to the second synapse in the thalamus before relay into the somatosensory cortex. In contrast, the emotional aspect of pain ascends primarily from the spinoreticular tracts to poly-synaptic connections in the reticular formation of the brainstem before ramifying diffusely into the limbic system with subsequent projection to the cortex resulting in the “**yuck!**”. Acute and chronic pain are quite different. While proper processing of acute pain is essential to survival, in contrast, there is no tissue damage which can be demonstrated in CNMP to explain the painful experience, and thus there is “**hurt without harm**”. Physiologically, the process of abnormal and augmented sensory processing is known as ‘nonnociceptive pain’ (NNP) and increasingly understood at the structural and molecular level which results in ‘wind-up’ and ‘up-regulation’, which in turn results in central sensitization with ‘expansion of receptive fields’. Simultaneously, dysfunctional adaptation out of proportion to objective findings is often seen associated with unresolved emotion, anger, abnormal stress reaction, anxiety, depression, emotional lability, behavioral issues, anhedonia, impaired memory, and insomnia which is counter-therapeutic. Additionally, delayed recovery is accentuated in many Workman’s Compensation and medical-legal cases. The longer CNMP persists, the less likely recovery will ever occur, and thus the importance of early detection and intervention. Conceptually categorizing pain into three phases is useful- **ABCs: Acute, Budding chronic and Chronic**

**A-** Early and aggressive treatment of acute and post-operative pain is very important in preventing development of CNMP particularly when allowing early remobilization and functional activity. It is important to identify ‘**red**’ flags and high risk for delayed recovery including nonorganic features with symptom magnification syndrome and pain behavior, medical-legal entanglement, low socioeconomic and/or educational level, especially in the presence of a learning disability, singular work history, particularly when only heavy labor, job dissatisfaction, history of alcohol and/or drug problem, anxiety and depression, or any psychiatric co-morbidity.

**B-** Through work-up is necessary to rule out missed pathology, but it is important to remain focused on maximizing physical function and positive psychological adaptation. Avoid passive therapy which contributes to musculoligamentous contracture, muscle atrophy and deconditioning perpetuating the cycle of dependence. Centrally acting drugs including opioid analgesics, tranquilizers and muscle relaxants which tend to lose efficacy after a few weeks and risk habituation should be withdrawn if possible. Facilitate return to work A.S.A.P.

**C-** Chronic Pain Syndrome can develop quickly, even within weeks, and thus is best defined by presenting psychosocial determinants rather than the time since injury. It is best managed by an interdisciplinary team which typically involves physical, occupational and recreational therapy, vocational rehabilitation, behavioral psychology, biofeedback, rehabilitation nurse and psychiatrist. After assessment, the team works with the patient to implement a comprehensive rehabilitation plan with the goal of empowering the patient to be successful with return to a more normal lifestyle within the family setting and workplace. Non-pharmacologic treatment is emphasized. Essentials of a Cognitive-Behavioral approach include: the ability to think and behave adaptively in order to facilitate positive emotional experiences, and to utilize adaptive thoughts and actions to decrease emotional suffering. The goal is to make the quality of life a cognitive experience, independent from the pain problem, an affective experience.