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THE SAN DIEGO PSYCHOLOGIST

The Official Newsletter of the San Diego Psychological Association

In this issue

President's Corner

by Annette Conway, Psy.D.

Welcome to the first quarter of The San Diego Psychologist! Our Editor, Dr. Gauri Savla, and the SDPA Board, continue to receive positive feedback from the membership about the Newsletter's transition from a hard copy to an online publication. I want to personally thank Gauri for her hard work, skills, and professionalism in accomplishing this large task. It takes many hours of creating content, laying out and formatting the articles, editing, and proofreading, before each issue of the Newsletter is published. I encourage you to leave your comments and questions directly on website, as well as to consider submitting your articles. We had an unusually low response rate for the call for articles for this Winter 2017 issue. The Newsletter will only be a success with your continued collaboration and support.

As the new President of the SDPA, I would like to draw your attention to the new and exciting changes and activities taking place in our organization. You may have noticed that the SDPA Board has taken steps toward a structural reorganization over the past year. Since July 1, 2016, we have been able to reduce administrative expenses by 25% in hiring contract office staff and volunteers. This restructuring has lessened the burden of fundraising, while continuing to offer SDPA members the programs and other benefits they deserve. In addition, new leadership positions have been filled by students and early career psychologists on the Board and within our committees. Fifty percent of the 2017 Board is comprised of early career psychologists.

In other news, we have a new part time office assistant, Tami Magaro, who has a background in accounting, administration, and website design and management. We are excited to have her. The Public Education and Media

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The San Diego Psychologist

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Committee (PEM) is vetting the soon-to-be-hired publicist in order to “brand” the SDPA so that it is more visible within the community. The Diversity and LGBTQ Committees continue their efforts in increasing diversity and inclusivity within the SDPA and the community at large. The Government Affairs Committee keeps members up-to-date on issues that are vital to the psychology.

We are also looking forward to hosting several upcoming events: The annual SDPA party is on April 29, 2017 at the Karl Strauss Brewery in Sorrento Mesa. In our ongoing commitment to serve our members, SDPA has partnered with the San Diego Psychiatric Society, San Diego Child and Adolescent Psychiatrists, and the San Diego Chapter of Marriage and Family Therapists (CAMFT) for its second annual Critical Issues in Child and Adolescent Mental Health Conference. The conference will take place on March 11, 2017. For more information and to register, visit www.cicamh.com. The Ethics Committee is offering a CE workshop titled "Being Prepared for the Unexpected: Practice and Ethics of Preparing Your Professional Will” on May 13.

The Fall Conference this year will be held on October 14, 2017; it is being spearheaded by the CE Committee Chair, Dr. Mary Mulvihill, who has has been exploring new ideas for presenting up-to-date information. The Fall issue of the Newsletter will focus on the theme of the conference, which will be announced in the next few months.

The current issue of the Newsletter focuses on Pain and our role as mental health professionals in treating clients with chronic pain. Chronic pain and the management of the pain is a complex problem, and the most common reason individuals seek medical advice. According to the APA, approximately 100 million adults in the United States suffer from chronic pain, which is the leading cause of disability. The psychological repercussions are numerous: depression and anxiety, withdrawal from productive activities, social isolation, loss of self-esteem and purpose, loss of energy, the fear of being labeled “crazy” or that the pain is “all in my head,” enforced dependency, and the misuse and addiction to opioids. This issue addresses the pioneering and integrative approaches to the problem associated with improved functioning and decreased psychological distress. It is hopeful to read about the advancements and the "out-of-the-box" strategies that are being researched and introduced as effective coping tools for pain relief.

You are welcome to contact me with your questions and suggestions via email (drconway@helptherapist.com) or via phone (858-342-0948).

Sincerely,
Annette Conway, Psy.D.

Editorial

by Gauri Savla, Ph.D.

Dear SDPA members and guest readers,

Welcome to the first issue of the 2017 *San Diego Psychologist*! We have a new President of the *SDPA*, Annette Conway, Psy.D., and a new Board of Directors. I have thoroughly enjoyed working with Annette so far, and am looking forward to our continued collaboration. Before I introduce the current issue and people who contributed to it, I would like to thank Ellen Colangelo, Ph.D., the outgoing President for her grace, kindness, and wisdom. I am grateful to have had her guidance as I navigated my first year as the Editor of *The San Diego Psychologist*.

The theme of the *Winter 2017* issue is *Pain*. When Annette and I discussed our plans for the Newsletter late last year, we mutually agreed that one of the topics of focus would be on the role of psychotherapy in treating patients with chronic pain. As psychotherapists, most of us have encountered patients with comorbid psychiatric disorders and chronic pain, with latter typically preceding the former. As a geriatric psychologist in private practice, I find that 60% of my current patients suffer from chronic pain. Indeed, all four of the articles that make up this *Pain* issue mention that chronic pain affects more people in the United States than diabetes, heart disease, and cancer, combined. That is roughly about 100 million Americans and counting. Pain is all-consuming, intractable, and in most cases, invisible. It requires that the sufferer embrace a "new normal," i.e., a life irrevocably changed by pain.

I was reading George Orwell's *"1984"* recently and one quote from the book especially jumped out at me: "Of pain you could wish only one thing: that it should stop. Nothing in the world was so bad as physical pain. In the face of pain there are no heroes." I found myself saying, "But there *are* heroes. I see some of them in my office every week." (I also beg to disagree with Mr. Orwell about his statement on physical pain; we know the devastating effects of psychological pain well in our profession.) I doubt there is anyone who suffers from chronic pain who does not wish that their pain would be gone; however, there are people who live valued lives despite their pain. Even those who merely *seek* psychotherapy because they are tired of their narrow, pain-centered lives are heroes. It is our job, as psychotherapists, to help them separate the reality of their pain from suffering on account of it. As I write this, I am acutely aware of the recent influence of the Acceptance and Commitment Therapy (ACT) bootcamp I attended a couple of weeks ago. I have been looking for new tools to help my clients with chronic conditions, and was intrigued by the ACT processes and principles and the evidence-based research supporting them. (I want to acknowledge that my curiosity about ACT was piqued as I edited the last issue of The San Diego Psychologist that focused on Mindfulness and Resilience; I want to sincerely thank Shoshana Shea and Jill Stoddard who both wrote excellent articles on ACT for the issue.)

As common as chronic pain is, we expected to receive an overwhelming response to our call for articles for this current issue. Unfortunately, we only received a small handful or articles, of which we selected two of the best ones. We solicited several more from experts in the field, from which we chose to publish two more articles. We reached out to physicians specializing in pain for their perspective on chronic pain management, but did not receive any positive responses.

So, four wonderful articles from five mental health professionals in San Diego make up the content of this Winter 2017 issue. Dr. Harpin and Ms. Gammon have written an excellent article giving a broad overview of the role of psychotherapy in pain management. It draws on Dr. Harpin's long career in pain research and practice, and we are fortunate to learn from his experience and knowledge. Dr. Tayer, who has now become a regular contributor to the Newsletter, has written a powerful article about her own experience with working with pain patients. As usual, it is evident that she pours her heart into her work. Similarly, Ms. Chester has written a thoughtful and personal article about her unique approach to treating chronic pain, as she draws parallels to grief therapy and Maslow's theory of Need Hierarchy. Finally, we invited Dr. Kangas to write about the use of medical marijuana by chronic pain patients, given its increasing popularity over opioid use in this population. Her concise article is well written and is full of great information.

The resources and recommended readings suggested by the authors have been separately compiled into the Resources page. Please check them out if you are interested.

Our Spring 2017 issue, which we are hoping to publish by the end of May, will focus on Couples/Family Therapy with Diverse Clients. We would be grateful if those of you who have experience working with LGBTQIA, ethnic minority, or refugee families would consider contributing to the next issue. Submission guidelines may be found on the website.

Please share your feedback in the comments below, or email me at TheSanDiegoPsychologist@gmail.com.

Thank you for reading.

Psychological Treatments for Chronic Pain

by R. Edward Harpin, Ph.D. & Taryn Gammon, M.A., B.C.B.

Introduction: Chronic pain is defined as pain that persists beyond the expected time of healing (Loeser, 1991). The Institute of Medicine (2011) estimates that 100 million Americans experience some form of persistent pain with an estimated cost to society of $600 billion per year. Jensen and Turk (2014) note that the prevalence of chronic pain now exceeds the accumulated rate of heart disease, diabetes and cancer. Gatchel & Oordt (2003) point out that chronic pain has multifactorial etiology that includes biological, psychological, social, and cultural factors. There is a wide array of biomedical treatments for chronic pain. However, the efficacy rates for these treatments have not been satisfactory (Chou et al., 2009; Turk & Theodore, 2011; Institute of Medicine, 2011) leading patients and their health care providers to seek other forms of treatment. This article will focus on psychological approaches to treating chronic pain.

Psychological factors: Psychological factors that may contribute to the experience of pain include mood, attention, quality of sleep, feelings of helplessness, depression, and anxiety, as well as beliefs about causation and ability to cope with or manage pain (Gatchel, 2004; Jensen & Turk, 2014; Williams, 2010) . The presence of psychological factors in chronic pain does *not* rule out the presence of biomedical factors; patients often interpret the identification of psychological factors to mean that the health care provider thinks that their pain is "all in their head" or, even worse, that they are "crazy." This may lead to wariness in trying psychological treatments that might be helpful in reducing and managing chronic pain.

Theory: The neuromatrix theory of pain posits that the perception of painful stimuli does not result from the brain's passive registration of tissue trauma, but from its active generation of subjective experiences through a network of neurons known as the neuromatrix (Melzack, 2001). May (2008) showed that changes in interacting areas of the brain that make up the "pain matrix" can differentiate chronic pain sufferers from healthy controls. The regions of the brain in this pain matrix include those identified in the affective, sensory, and cognitive elements of pain (Rainville et al., 1997; Luu & Posner, 2003; Jackson et al., 2006). These brain differences in patients with chronic pain are *not* believed to play a causative role in the development of chronic pain, but rather are the *result* of the chronic pain. These brain changes may negatively affect not only the patient's experience of the pain, but also the patient's ability to manage and cope with the pain as well as participate effectively in activities of daily living.

Opioids: In an article discussing psychological treatments of chronic pain it is important to point out that patients with chronic pain are frequently treated with increasingly large doses of opioid pain medications such as hydrocodone and oxycodone for an extended period of time. These central nervous system depressant medications may interfere with cognitive functioning. They can also produce emotional effects such as irritability, which may interfere with social and occupational functioning. The development of opioid dependence is another risk of chronic opioid use.

Cognitive behavior therapy: A variety of psychological treatments are available for treating patients with chronic pain. One such treatment, with evidence-based support (Williams et al., 2012), is cognitive behavior therapy (CBT). CBT can target the cognitions, emotions and behaviors associated with chronic pain, such as, beliefs related to chronic pain that negatively affect a patient's functioning. For example, the belief that, "My life is ruined because I can't do what I used to do," might be reframed to, "There are other activities I can do that will meet the goals I had for my former activities." In a controlled study of CBT with chronic pain, Smeets et al. (2006) showed that change in pain beliefs was the mediator in improvements in pain intensity as well as disability status. The research has not shown strong evidence for long-term maintenance of the positive effects of treatment, suggesting that ongoing support might be helpful in maintaining the gains.

Acceptance and commitment therapy: Another psychological approach to treatment of chronic pain is Acceptance and Commitment Therapy (ACT). ACT for chronic pain is based on the theory that avoidance of pain and situations that might lead to pain results in lower quality of life, increased disability, and poor development of skills for coping with pain. Instead, ACT uses a mindfulness-based approach to teach acceptance of thoughts and feelings. A number of randomized controlled trials (RCTs) provide support for the effectiveness of ACT in coping with chronic pain (McCracken & Vowles, 2014).

Mindfulness-based stress reduction: Mindfulness-based stress reduction (MBSR) is another psychological intervention that has been used to treat chronic pain (Kabat-Zinn, 1982). Studies have shown improvements in pain ratings, other medical symptoms, psychological functioning, and decreased use of medical services. Cherkin et al. (2016) showed MBSR and CBT to be equally superior to Treatment as Usual (TAU) in treating chronic low back pain.

Interdisciplinary treatment: Due to the ever-increasing evidence for the multifactorial causation of chronic pain, interdisciplinary treatment is gaining increasing recognition as the gold standard for treating chronic pain (Institute of Medicine, 2011; Monson et al., 2012; Gatchel et al., 2014). Interdisciplinary treatment programs for chronic pain typically include medical monitoring, physical activity (e.g., physical therapy, exercise, yoga) and a psychological component (e.g., psychotherapy, biofeedback). Interdisciplinary programs commonly focus on teaching the patient pain self-management strategies, thereby reducing their dependence on health care providers.

Biofeedback: Biofeedback involves measuring a pain-related physiological parameter in a patient in "real time" and "feeding back" the measurement information to the patient and therapist via a computer with monitor. The purpose of the biofeedback is to facilitate the patient's ability to influence the physiological parameter being measured. Patients can learn not only to influence their physiology, but also to identify cognitive and situational triggers for changes in physiology. These triggers can then be addressed by the therapist in psychotherapy. The most common biofeedback modalities used in chronic pain treatment are electromyography (EMG), thermal (blood vessel constriction: BVC) and heart rate variability (HRV).

EMG biofeedback treatment is used to treat the chronic muscle tension that leads to chronic muscle pain. Electrodes are placed on the skin in the area of the affected muscles. Patients are then taught how to influence the levels of muscle tension and are able monitor their progress via the computer. Patients also learn that their muscle tension fluctuates as they experience different emotions, providing direct evidence for the mind-body connection. Evidence for the efficacy of EMG biofeedback is strongest for temporomandibular joint disorder (TMD), tension headaches, and migraine headaches (Crider et al., 1999; Schwartz & Andrasik, 2003). Clinical observation of benefit supports the use of EMG biofeedback in the treatment of neck and back pain as well as fibromyalgia, though the research evidence isn't strong (Mayo Clinic Health Letter, 2013).

Heart rate variability (HRV) biofeedback involves the use of paced breathing to increase self-regulation of the autonomic nervous system. Using external sensors, the patient's cardiac and respiration rates are measured and this information is displayed for the therapist and patient via computer with monitor. The patient is then taught to breathe at a rate of ten or fewer breaths per minute in order to induce a state of autonomic "balance." Autonomic balance can be described as a physiological state in which sympathetic activation is decreased and parasympathetic activation increased. It may be that this change in autonomic activity affects the previously mentioned "pain matrix" in the brain to reduce the patient's experience of the pain. Studies by Hallmann et al. (2011) and Schmidt et al. (2013), showed decreased levels of pain in patients with neck pain and TMD respectively.

Future directions: Although there have been many advances in the understanding and treatment of psychological components of chronic pain, there is still much work to be done, both in research and practice. A collaboration between researchers and clinicians is indeed warranted, in order to address the barriers to clinical improvement and to disseminate and apply the large body of research to clinical practice in a more impactful manner. For example, the first author (Harpin) has 40 years of clinical experience in chronic pain and a growing body of research that suggests that the way individuals with chronic pain relate to themselves may impact their functional impairment and how they respond to treatment. Often people with chronic pain judge themselves harshly for their pain conditions, and/or refuse to prioritize their self-care because of long-held beliefs about putting the needs of others ahead of their own. A treatment program has been developed at the Sharp Hospital's Pain Rehabilitation Program to address this need, incorporating evidence-based psychotherapeutic modalities as well as a novel focus on self-compassion.

One of the co-authors of this article (Gammon, 2016) conducted a controlled trial of the outpatient interdisciplinary self-compassion-based intervention at the Sharp Pain Program. One-hundred-twenty-six patients participated in one of two mindfulness- and acceptance-based interventions. 1) (TAU) comprising behavioral therapy, biofeedback, and physical therapy; or 2) Therapeutic Self-Care (TSC), a structured 12-week group intervention in which TAU modalities were integrated within a self-compassion framework. Self-compassion, pain and depression were measured at baseline, and post-intervention. Both interventions demonstrated comparable statistically significant reductions in depression. Significant improvements in self-compassion and pain were observed only in the TSC condition, although the between-group differences in these domains were not significant. Additionally, improvements in self-compassion in the TSC group were significantly related to improvements in depression and pain. The results of this study suggest that self-compassion may be an important treatment target for individuals with chronic pain. Gammon's study reflects a much larger movement in the field to develop and assess integrative treatments for chronic pain that promote self-management of chronic pain and refine our understanding of which treatment approaches are most beneficial for which patients.

The Clinical Experience of Treating Chronic Pain

by Wendy Tayer, Ph.D.

Pain is a multivariate, multifaceted syndrome that presents in complex ways in outpatient psychology settings. Pain can be the result of a variety of illnesses or injury, including (but not limited to) sports injuries, rheumatoid arthritis, lupus, chronic fatigue, spinal stenosis, automobile or workplace accidents, and so forth. Often, the psychotherapist's office is the end of the line for pain patients after physicians and pain experts have not been able to alleviate or eliminate their pain through medical interventions. If you have ever treated patients with pain disorders, you know that they present with a range of emotional symptoms, including depression, anxiety, irritability, anger, resentment, guilt, sadness, and fear. These cases can be daunting and often challenge our strength, resilience, skill and boundaries as practitioners.

Pain affects more people in the United States than cancer, heart disease and diabetes combined. According to the Institute of Medicine of the National Academies, 100 million Americans live with chronic pain (The American Academy of Pain Medicine www.painmed.org/patientcenter/facts_on_pain.aspx#chronic). The economic burden of chronic pain is enormous: the cost of treating pain and the loss of work productivity due to disability and sick days ranges from $560 billion to $635 billion. These numbers are astounding.

The personal costs of living with pain are similarly staggering. In the behavioral medicine literature, chronic pain is defined as pain that is persistent and, at the same time, unpredictable. When I ask my pain patients if there is a pattern to their pain, they are hard-pressed to predict and anticipate their pain episodes; indeed, they often experience a sudden onset of pain during office visits, evidenced by their pain behaviors. The unpredictability of pain episodes interferes with the ability to plan one's life activities. Unexpected losses can negatively affect finances, relationships, work productivity, entire careers, ability to ambulate and/or exercise, and cognitive function, among others. Often, one's life focus shifts to the management of pain to the detriment of overall quality of life.

What is the physiology of a chronic pain episode? Pain signals start and continue to fire in the nervous system for weeks, months, even years. It is as if there is a malfunction in the body's pain signaling system. Some people can tie their pain to an accident or disease process while others experience pain with no apparent physical cause. According to the CDC, back pain is the most common pain complaint followed by headache/migraine, neck pain, and facial pain. Most chronic pain patients have more than one pain complaint or pain site. Adults with low back pain tend to fare worse in terms of mental and physical health than those who do not have pain conditions. They report severely limited physical activity and tend to experience severe psychological distress to a much greater degree than people without low back pain. Particularly disturbing is the fact that 20% of Americans complain of disrupted sleep 3-4 nights a week due to pain or bodily discomfort. According to the National Health Interview Survey in 2009, women in general are higher pain symptom reporters than men, and they report headache and facial pain at twice the rate of men.

How do chronic pain patients present in therapy?

There is no aspect of any of pain patients' lives that is not affected by pain. They are often referred by the primary care providers, pain doctors or other specialists because they appear to be depressed, irritable, anxious and/or adapting poorly to their pain condition. Most pain patients who engage in outpatient psychotherapy are or have been high functioning, bright, successful adults with careers and families or relationships who have experienced a sudden, dramatic shift in their lives due to their pain; often, it causes them to give up their job, livelihood, social life, travel plans, love relationships, and recreational activities such as sports and physical fitness. The degree and multifaceted nature of loss for this population is often palpable and overwhelming. Out of nowhere they are forced to rethink their personal identity, purpose, goals, and future at times in their lives when they otherwise would be at their prime in terms of productivity and activity. They come in with detailed stories to tell, asking to be heard, validated, supported, helped to rebuild their lives and redevelop their self-perceptions. It is a daunting task from a clinician's perspective.

What is my role as a psychologist?

I work at the University of California, San Diego (UCSD), a giant healthcare system, where many of our patients are referred through the medical group. My background as a behavioral medicine psychologist has trained me to conceptualize chronic pain cases from a biopsychosocial perspective that is inherently holistic and multidimensional. Chronic pain patients often present to my office as the last resort after having exhausted standard pain treatment modalities; a subset of these patients are seeking therapy because a mental health visit has been deemed a condition of further treatment. In many cases, physicians sense that their patient has a psychological condition that is related to their pain syndrome; or they refer the patient for a psychological evaluation to aid in their decision-making about whether the patient is able to effectively manage or cope with a particular treatment. In some instances, physicians are not able to definitively diagnose the root cause of the pain and sometimes tell the patient and write in the chart that the patient has a psychosomatic disorder which necessitates a psychiatric evaluation. These patients, usually women, often leave these appointments in greater distress than when they arrived. I have seen many of these patients in my practice, who tend to be high functioning, insightful women who stay in therapy, are not interested in "secondary gain," and have a rare genetic or autoimmune disorder that is difficult to diagnose or does not meet full criteria for a common autoimmune disease such as MS or lupus. I have challenged their physicians' "patient-blaming" chart notes, and advocated for these patients in my own chart notes; I have also, on occasion, referred them to physicians and other allied health professionals who are empathic, open-minded, align with their patients and think broadly about their symptom presentations. Opioid dependence is another common occurrence with this population.

What does an initial visit with a chronic pain patient entail?

After obtaining written informed consent for psychotherapy, I typically ask for releases of information to collaborate with other treating practitioners as a team approach is optimal due to the complexity and variability of pain relief and treatment outcomes. (To that end, I also attend a monthly multidisciplinary pain management grand rounds meeting.) My working relationship with other treatment providers allows me to advocate for my patients who often are perceived as "difficult" or "demanding."

My first visit with a chronic pain patient entails a complete biopsychosocial history which includes a standard intake as well as questions about medical/health history, coping style/history, disability status, use of substances and medications for pain management, pain rating scale, observation of pain behaviors, existence of caregivers, and often a multidimensional pain questionnaire such as the McGill Pain Questionnaire. I pay special attention to consistency of pain complaints with medical history and pain behavior, pain ratings, degree of cognitive flexibility, psychiatric history and response to the initial interview as predictors of patient prognosis and therapy outcome. I also educate the patient about psychotherapy as a process of self-exploration and reflection in addition to pain as a challenging life experience, normalizing the patient's complaints.

What does psychotherapy entail?

Therapeutic alliance is crucial to successful psychotherapy outcomes in chronic pain patients, as are regular, weekly sessions and taking responsibility for the work of therapy. Pain patients often do not have partners or friends who understand their experience, or know how to respond or support them. A patient's premorbid level of self-worth often has plummeted, and they need a safe place to vent and reality-test their current cognitive-emotional response to their disabling pain. The therapist is one of the most potent sources of support in these patients' lives.

What treatment approaches are utilized and effective?

Empirical literature abounds with evidence supporting the efficacy of Cognitive Behavioral Therapy (CBT), operant conditioning, mindfulness and Acceptance and Commitment Therapy (ACT). CBT, owing to its long history, is supported by a large body of research; in particular, studies support the efficacy of problem-solving, therapeutic journaling, cognitive restructuring and operant conditioning for managing patient "catastrophizing" of their pain symptoms as well as pain-related fear responses to various stimuli. Although the efficacy of positive therapeutic alliance is well established in psychotherapy research in general, there are no studies examining this element specifically among chronic pain patients.

In my own practice, I strive to be present with my patients, and to create a non-judgmental and supportive space where they can safely express and work through their emotions and pain experience. My goal is to help my patients discover their own individual strengths and to thus empower those who feel greatly disempowered by their pain. If amenable, I practice meditation with them in order to facilitate acceptance and to reduce reactivity to their symptoms. Different approaches work for different patients; some merely want to vent and be heard, others want concrete coping strategies that they can practice at home. Regardless of technique, the ultimate goal is acceptance of this "new normal" and all that it entails; this process takes much time, commitment, patience, empathy, and attention. Therapy must be tailored to the individual patient, and usually is worthwhile and rewarding as most patients experience important changes in their expectations, view of themselves, ways of coping, reality testing, decision-making approaches, and reasoning abilities.

What are the common themes in therapy for chronic pain?

People with chronic pain struggle with what is often an invisible symptom or syndrome, and evident only via self-report and pain behaviors. A common theme among this population is their anguish about not being believed or acknowledged by others for having a pain condition. In fact, they frequently have to deal with insensitive comments such as "get over it," "push through it," "stop complaining," or even are openly confronted for having a handicapped placard and have to defend themselves to righteous strangers. These patients need empathy, and often, therapists are the only ones who will provide it to them. Simple interactions with loved ones or acquaintances become quandaries that must be addressed in therapy. To a chronic pain patient, the question, "How are you?" presents quite a dilemma: should he or she give a cursory response, i.e., "fine" or be honest about the fact that he/she feels miserable and/or exhausted?

Further, these patients are used to functioning independently and accomplishing a lot in a given day. They experience much difficulty lowering their expectations for their daily goals, pacing themselves because of their pain, learning to accomplish tasks in subsections due to limited periods of pain free functioning, not being able to make plans due to their pain and making decisions based solely on their pain level. Pain intensities vary for people; thus, on "good" days, people with pain tend to overexert because they desire a sense of normalcy and to meet their goals. However, as is often the case, they pay the price by finding themselves in increased pain, fatigue and anergia on the days that follow. This experience is demoralizing and literally, a painful reminder of their chronic condition.

Another common theme is the question of how one relates to one's pain condition/experience. Specifically, we discuss whether an individual is defined by his/her pain or whether it is something they "have." Exploration of this relationship can open pathways for more personal reflection and cognitive flexibility in the process of adaptation. These issues represent the most prevalent topics among this population group. There are other therapeutic topics which this article space does not allow but that are discussed readily in the pain treatment literature.

Addressing pain and its emotional repercussions is undoubtedly the main goal of therapy. However, also important is my role in mediating the relationship between my patients and their physicians. As I mentioned in an earlier section, chronic pain patients are often perceived as "difficult." For physicians whose ultimate goal is to "cure" their patients, chronic pain patients are an enormous challenge and reminder of the limits of modern medicine. Besides, these patients can be demanding, needy and sometimes present with irritability, impatience and cognitive deficits or lapses. As part of a multidisciplinary treatment team, my goal is to facilitate fruitful communication between my patients and their treatment providers. To that end, therapy can also involve teaching enhanced appointment preparation strategies (such as writing a list of questions, taking notes, affect and body language coaching, etc.) to patients so that they can communicate more effectively with their doctors and develop functional, goal-oriented working relationships with them.

What is the typical course of therapy? Treatment can range from participation in an Intensive Outpatient Program (IOP) or a six-week structured pain treatment group to years of individual psychotherapy, depending on many factors. In my experience, the need to be validated and understood is paramount in this population; also important, is the desire for hope and a functional future for these patients. Working with this population has challenged me to expand my repertoire of skills to help my patients, and also regularly tests my clinical skill set. I find that I am more present and compassionate as a result of my years of experience with chronic pain patients. It is ultimately humbling to know that as a clinician and an empathic human being, I have played such an important role in my patients' lives.

Treating Chronic Pain Patients Through a Grief Perspective

by Tracey Chester, Ph.D.

The American Academy of Pain Management estimates that approximately 100 million Americans are living with pain today. That number astonishingly exceeds the number of people suffering from diabetes, heart disease, and cancer, *combined*. Pain-management specialists are becoming increasingly aware that chronic pain is associated with depression and other mood disorders (in fact, 77% of pain patients report feeling depressed). This has resulted in more psychotherapy referrals of patients with co-morbid chronic pain and mood disorders.

Cognitive Behavior Therapy (CBT) is currently considered to be the standard of care for psychotherapy approaches to pain management; however, Acceptance and Commitment Therapy (ACT) has been receiving more attention as its effectiveness has been consistently demonstrated in clinical trials. In my own practice, I use both CBT and ACT with patients suffering from chronic pain, with varying degrees of success. Indeed, many of my patients have completed a 12-week CBT or ACT pain management group program prior to beginning individual therapy. Both modalities teach useful tools, but in my clinical experience, I have found that a successful outcome is limited unless the patient has been allowed to grieve the loss of his or her pre-pain functioning.

How can one change in a 12-week group program into a person who is able to adapt to the new experience of being unable to function in various aspects of life due to their pain? Compounded by the invisibility of their pain (many patients present visibly as healthy), they are often led by these treatments to believe they are suffering because of their negative thoughts. Indeed, recent research suggests that the efficacy of CBT is limited to improvement in mood immediately following treatment, but not in long-term pain and functional status. I propose that regardless of treatment modality, allowing the patient to grieve for the loss of their pre-pain self is essential for the ultimate success of that treatment. Guiding a patient through this grief is especially important when he or she understands for the first time that the acute pain they have been experiencing is now their new reality; it is now considered chronic pain. They have exhausted all means for a "cure," i.,e., they have failed multiple medication trials, undergone surgery, and have tried complimentary medicine without success. They have now entered a new stage in their treatment process: pain management. Acceptance of this stage requires giving up hope of a pain-free existence, and can be accompanied feelings of despair, hopelessness, anxiety, and/or anger. It is at this stage that they are referred to or seek help from mental health professionals.

Working with pain patients is personal to me; I am a chronic pain patient myself. My personal and professional experiences with pain management, along with my background as a grief counselor for the erstwhile San Diego Hospice and Elizabeth Hospice for five years have given me a unique perspective on pain. I have noted the striking similarities between losing a loved one and losing one's health to chronic pain. For example, the majority of people are shocked by the death of a loved one even when the latter has been ill for a long time; similarly, a person who has lived with pain for many years reacts with shock when he or she realizes that the pain will never completely go away. Viewing chronic pain it in this light can offer insight into what patients are experiencing. Furthermore, the invisibility and misunderstanding of their condition by friends, families and co-workers can greatly compound the feelings of grief.

The view of grieving put forth by J. Worden (Worden, 1991; 2011) is widely accepted by experts in grief counseling as the most comprehensive description of the grieving process, often referred to as Worden's Tasks of Mourning. The process includes (1) an acceptance of the reality of the loss, (2) experiencing the pain of grief, (3) adjusting to the environment with the deceased missing, and (4) withdrawing emotional energy and reinvesting it in other relationships. The most widely cited model of "the stages of mourning" is that proposed by Elizabeth Kubler-Ross, wherein a person sequentially experiences denial, anger, bargaining, depression, and acceptance, in that order. Kubler-Ross's model seems to more accurately describe the experience of patients with terminal illness rather than mourning. An important distinction in Worden's tasks of mourning and the Kubler-Ross model is that the former focuses on simultaneous processes while the latter describes sequential processes. Both models can be useful in guiding a pain patient process his or her emotions regarding chronic pain.

My proposed approach also takes into account Maslow's Hierarchy of Needs (Maslow, 1971; starting with basic physiological needs, followed by the need for safety, love/belonging, esteem, and self-actualization). It helps to understand many of the hurdles chronic pain patients have to overcome. How do they become their best selves? Most people struggle with this, without the basic health of body being compromised. For example, chronic pain can lead to loss of employment; this complicates the grieving process significantly, making it difficult to move forward and adapt to the new reality. Patients may suddenly find themselves struggling with *safety* (security of body, of employment, of resources, of the family, of health, of property). When *safety* comes up over and over through treatment, it can sabotage movement in other areas of life; *love/belonging*, *esteem*, and finally *self-actualization.*

Adapting the tasks of grieving to the experience of chronic pain

My own approach to pain management combines aspects of Worden's Tasks of Mourning, a version of Kubler-Ross's model adapted to the grief of chronic pain (Martin, J., 2015), and "Maslow's Hierarchy of Needs. I have found that presenting these "stages" to patients helps normalize their experience and works as a guide for treatment. I present the following summary to my patients:**Accepting the reality of the loss:** What is acceptance of chronic pain? Acceptance can be defined as a way of addressing an unchangeable situation or a life experience. It is not the same as defeat, helplessness, quitting, or resigning to a life of unhappiness, struggle, or misery. Accepting that you have pain (or that your pain is true and believable) is different than giving up all hope. Denying that your pain is not chronic may delay the grieving process, and in turn, delay adapting to this new life experience.

1. **Experiencing the pain of the loss:** Anger is a necessary stage in the healing process. Feelings of anger may seem endless, but they will begin to subside and make way for healing. Your anger may extend to your doctors, family, friends and loved ones. Thoughts such as, "This isn't fair! I didn't do anything to deserve this!" or "Just give me something that will make me feel better!" are common. Similarly, feelings of emptiness and grief are profound and seemingly endless; while sadness is a normal response to a life-altering situation, with chronic pain patients, it commonly turns into clinical depression. There is research indicating that depression that was pre-existing before the

occurrence of a stressful event, or brought on by the onset of the event yields similar functional changes to the human brain. Furthermore, functional neuroimaging studies have demonstrated that brain regions implicated in chronic pain are the same as the ones implicated in depression. As with depression, anxiety about the future in terms of financial security, medical bills, social expectation, etc. can be common. Professional help in the form of individual or group therapy, or even a peer-led support group can be a helpful way to cope with these feelings.

2.* Adjusting to a life with chronic pain*: Having a chronic condition is almost always accompanied by loss. Learning coping skills to manage the pain can help rebuild self-esteem and relationships. ACT can help with finding a way to live a fuller life despite the pain. CBT can help with restructuring negative thoughts to adaptive thoughts, .e.g., it can help eliminate thoughts that begin with "never," "should," or "always". This stage corresponds with Maslow's *Esteem* and *Love/Belonging*.

***3.* Moving Forward:** The final stage of adapting to a new life consists of reevaluating short and long term goals and what that means for the future. This involves setting daily goals that are realistic and redefining career and relationship goals so they are sustainable. For example, having a profession that is physically demanding will need to be replaced by one that is less so, and accommodates one's pain. Similarly, relationship roles and functions may need to be redefined, i.e., being a husband/wife/daughter/mother may look different than before the onset of the pain. Thus, defining what one can do versus cannot do can go a long way toward helping patients with chronic pain see the pain as only one aspect of a life that has meaning and purpose. This stage, thus, corresponds to Maslow's hierarchy of *Self-Actualization*. Self-Actualization is not easily attainable by anybody, but is especially by those with issues of *safety/security*. Chronic pain sufferers often have health issues, and can also have uncertain job or financial security. Refocusing one's energy from the losses to what is still possible can help them move toward a fuller life.

Medical Marijuana for Pain Management

by Julie Kangas, Ph.D.

The American Academy of Pain Medicine can trace back the use of cannabis as a treatment of pain for longer than recorded history. In 1996, California became the first state to legalize medical marijuana, but national legal prohibitions and the complex pharmacology of cannabis have slowed the progression of empirical evidence and standardization for clinical use. Despite the delays to research, there is evidence to suggest that 10-15% of people who attend treatment at a chronic pain clinic also use marijuana as part of their pain management. The number of patients using marijuana for pain grows when we consider how common it is for patients to self-medicate or decline to report use. In this article, I will answer common questions regarding the utilization of cannabis for pain management.

How does it work?

One difficulty in studying and standardizing cannabis for medical use is that there are more than 60 pharmacologically active cannabinoids in marijuana; therefore the exact mechanisms of its efficacy are still unclear. These many cannabinoids activate receptors in the brain, spinal cord, peripheral nerves, and immune system, explaining why it can be effective in treating both pain and inflammation. Different active components are beneficial for different types of symptoms. The two primary cannabinoids are tetrahydrocannabinol (THC) and cannabidiol. The THC component can produce euphoria and psychosis. Cannabidiol is not psychoactive, but it may have antianxiety and antipsychotic effects. This ratio between THC and cannabidiol is important for patients to know, and marijuana types are specifically engineered to hold different ratios.

What are the benefits of marijuana over other medications?

While marijuana does have side effects (discussed below) it can be used beneficially to reduce the more dangerous side effects of other medications for pain management. There is currently a national epidemic of opioid abuse, and patients may choose to use cannabis insteadof opioids or in addition to opioids. Cannabinoids do not bind to opioid receptors, so concurrent use is a safe option. Evidence suggests that using cannabis in addition to prescribed opioids can prevent tolerance and withdrawal from opioids as well as enhancing the effectiveness of both therapies. Even for milder pain or in cases where opioids are not prescribed, cannabis can replace non-steroidal anti-inflammatory drugs (NSAIDS) in order to avoid the negative side effects of gastrointestinal ulceration and bleeding.

What is the evidence of its efficacy?

Cannabis has been seen to be effective to varying degrees for several types of chronic pain. For example, neuropathic pain is typically a difficult kind of pain to treat because it is caused by damage to the somatosensory nervous system. Neuropathic pain is often compared to a dysfunctional alarm system. Where other pain would be compared to a fire alarm that is triggered by an actual fire that needs to be addressed, neuropathic pain is an unhelpful and annoying alarm that you can't turn off. Neuropathic pain is thought to be at least partially caused by a dysregulation of the body's endocannabinoid system, explaining why marijuana is seen to be a particularly effective treatment.

There is also evidence of cannabis being effective for chronic pain resulting from multiple sclerosis and paraplegia. Additionally, the many effects of cannabis beyond pain relief (e.g., euphoria, increased appetite) are especially beneficial for people with complex disorders such as AIDS or cancer. Musculoskeletal pain and migraine pain are less researched, but there is evidence that cannabis can influence the pain pathways of those disorders by reducing hyperalgesia, which is heightened pain sensitivity.

How can my patients use it in a safe and legal way?

Unfortunately there are only two FDA–approved, synthetic cannabinoids available in the U.S., dronabinol and nabilone, and these are approved only for reducing nausea. The benefit of an FDA-approved cannabinoid is that the doses are highly standardized and well understood. Most patients use botanical, rather than synthetic, cannabinoids for chronic pain, meaning there could be variability in the dosing and unknown side effects due the large number of pharmacologically active components. There are some preparations of cannabinoids available that are recommended for particular types of pain, e.g., for pain symptoms of multiple sclerosis, the American Academy of Neurology recommends off-label use of dronabinol (the FDA-approved preparation mentioned above) and nabiximols, a spray containing both THC and cannabidiol. Patients and providers can research the best types of cannabis for specific pain conditions.

Medical marijuana cards are available to patients with a doctor's recommendation for medical use, but because recreational use of marijuana became legal in the November 2016 election, patients may choose to use marijuana without obtaining a card. Benefits of having a card include looser restrictions on marijuana possession (e.g., 1 oz. in possession for recreational users vs. 8 oz. for card holders).

Unlike with alcohol, there is no standardized way of defining when someone is capable of driving after use of marijuana. A DUI can still be issued to someone who used marijuana before driving, if they do not demonstrate an "ability to drive with the caution characteristic of a sober person of ordinary prudence under the same or similar circumstances." Therefore a combination of subjective and objective data is taken into account, including the observed driving pattern, performance on behavioral sobriety tests, physical appearance, and a blood test confirmation of marijuana use.

What are the dangers, and how can I minimize risk?

It is important to note that many common mental health diagnoses are listed as contraindications to the use of marijuana for pain management in formal medical recommendations (e.g., see *JAMA* review in Recommended Reading) because "heavy" use of cannabis is seen to be related to future onset of depressive episodes, manic episodes, and psychosis. There are extreme limitations of the research, however, with differing definitions of what is considered "heavy use" and without randomized controlled trials that are able to comment on causation. Currently, all evidence is merely associations between cannabis use and poor mental health outcomes. The strongest caution is against the use of cannabis (particularly with high THC) for people with a strong genetic risk for psychosis.

According to the DSM-5, symptoms of cannabis intoxication include tachycardia, dry mouth, elevated appetite, red eyes and unusual fluid accumulation in the eyelids, and psychological and behavioral impairments, which can include anxiety and paranoia, along with hallucinations. Contrary to some patients' opinions/perceptions, marijuana is now widely accepted as addictive and has distinct patterns of withdrawal, with symptoms including: irritability, anger, sleep difficulty, anxiety, depressed mood, restlessness, headaches, fever, chills, sweating and abdominal pain. Of note, many patients see cannabis as beneficial for their sleep because it can be sedating immediately following use, however it is important to educate patients with sleep problems that insomnia is a primary symptom of withdrawal, and there is evidence that cannabis changes sleep architecture, reducing REM sleep and increasing sleep onset latency.