

Preface

Welcome to *Psychological Treatment for Patients With Chronic Pain*, a book in the Clinical Health Psychology Series published by the American Psychological Association. This book provides psychologists, trainees, and other health care professionals with information on the critical role of psychology in the experience of pain and its treatment. Knowledge on pain psychology and treatment is bedrock for the clinical health psychologist. After all, pain is the most common health complaint and reason people seek medical care for a variety of health reasons (Schappert & Rechtsteiner, 2008), and chronic pain is the most common chronic health condition in the United States. As you will learn, pain psychology is not just about helping patients cope with pain; rather, pain psychology treatment can reduce pain intensity, alter the trajectory of pain, improve the outcomes of medical treatments, and help patients with pain live more functional and meaningful lives.

A little bit of background about me and how I came to be a pain psychologist. I am a clinical professor in the Department of Anesthesiology, Perioperative and Pain Management at Stanford University School of Medicine. I received my doctorate degree in clinical psychology from the University of Colorado at Boulder. My doctoral studies included zero training in pain, as is commonly the case in graduate clinical psychology programs in the United States. However, I was fortunate to receive my clinical internship training at the Tucson Veterans Affairs (VA) Hospital, where I learned about chronic pain and how to best treat it. I recall starting

my internship and working with veterans who had severe chronic pain. I wondered how I could possibly help with their physical pain—it triggered a sense of helplessness in me that is not uncommon to many mental health professionals who lack training in pain. Feelings of helplessness or discomfort about chronic pain are simply information that knowledge and skills are needed. You will learn, as I did, that there is much you can do to alleviate the suffering associated with physical pain.

After my Tucson VA internship I did a postdoctoral fellowship at the Johns Hopkins University School of Medicine in the Department of Physical Medicine and Rehabilitation and in the Bloomberg School of Public Health, where I received advanced pain training in severe medical conditions. At Hopkins, I treated patients after amputation, severe spinal cord injury, and catastrophic burn—conditions that typically involved intense pain, major life adjustment, and psychological distress.

I have been treating patients with pain for 15 years, mainly in academic pain clinics at Oregon Health & Science University and at the Stanford University School of Medicine in California. My work in the field extends beyond patient care to leadership, education, research, and authorship to have a broader impact on chronic pain treatment across multiple disciplines of health care. My past pain leadership roles include serving as the 2012 president of the Pain Society of Oregon and as cochair of the Pain Psychology Task Force at the American Academy of Pain Medicine. I am current cochair of the Behavioral Medicine Committee at the American Academy of Pain Medicine, and also serve on their Opioid Advisory Committee. I have coauthored or advised on the development of national pain treatment guidelines and resources for the American Pain Society (2016), the American College of Occupational and Environmental Medicine (2017), and the American Chronic Pain Association (2015, 2017).

As principal investigator for nationally funded pain research, I work with colleagues to investigate psychological treatments for chronic pain and their ability to reduce the use of prescription opioids and to prevent post-surgical pain (National Institutes of Health, Patient-Centered Outcomes Research Institute). Outside of Stanford, I develop pain psychology treatment programs for major health care systems and consult with agencies and groups wishing to create a clinical cultural transformation in the treatment

of pain by integrating pain psychology treatment into primary care and specialty pain clinics. My consulting and national advocacy work have centered on education and training about pain psychology and advancing the presence of psychology in the field of pain medicine and health care in general.

A main focus of my clinical work (and research) involves helping patients reduce their need for and use of opioids. Historically speaking, many patients were prescribed opioids without being offered any alternatives. Often patients received no formal assessment of their psychological history or status prior to prescription—and therefore received no treatment for the psychological factors that were serving to amplify their pain and need for pain medication. I worked with patients who had been taking opioids for months or years who told me that opioids reduced their pain by only a small amount, though the side effects and consequences were large. People were coming to me seeking to learn ways to manage pain without opioid medication or at least less of it. Over and over I was giving the same information to patients one at a time—a highly inefficient process! To meet demand and reach a wider audience, I wrote two patient books (which are also appropriate for mental health professionals): *Less Pain, Fewer Pills: Avoid the Dangers of Prescription Opioids and Gain Control Over Chronic Pain* (2014) and *The Opioid-Free Pain Relief Kit: 10 Simple Steps to Ease Your Pain* (2016). Both books emphasize the role of psychology in the experience of pain and teach people what they can do to reduce their own pain and distress and how psychological skills can be used to reduce need and use of risky pain medications. In 2018, the patient workbook of the Chronic Pain Self-Management Program, an international treatment program, included a chapter that I authored on opioid reduction. In terms of professional education, I coauthored the seventh edition of the American Pain Society book *Principles of Analgesic Use* (2016).

LIVING A HEALTHY LIFE WITH CHRONIC PAIN

My public and mental health professional education efforts include a blog on pain psychology at *Psychology Today*. My research and public education continue to emphasize psychobehavioral treatment as a low-risk, evidence-based pain treatment pathway to reduce need for pain medication.

To help shore the gap for mental health professional and clinician training needs for psychological approaches to chronic pain treatment, I have delivered workshops on behavioral medicine for chronic pain for health care providers (physicians, psychologists, and other clinicians) in national and international venues, including the American Academy of Pain Medicine, the Institute for Brain Potential, and the Israeli Pain Association. Nationally, there is great need and desire to better understand psychological influence on pain and to develop systems that integrate evidence-based psychological treatments for pain into medical care pathways. The risk and side effect profile for psychological treatment pales in comparison to most pharmaceutical, medical, and surgical procedures. And psychological treatment can be as effective as many pain medications or procedures—sometimes more so. The interest in this space extends beyond national borders. In 2018 I presented on The Psychology of Pain Relief at the World Economic Forum in Davos, Switzerland, and my invited commentary on the need to integrate psychology into pain research and treatment was published in the international journal *Nature*.

Helping individuals with chronic pain learn to alleviate their suffering is deeply gratifying work. A common stigma about people with pain is that they are “difficult patients” or “hard to treat.” Broadly speaking, in many ways health care has failed people living with chronic pain. Numerous barriers prevent people from accessing the evidence-based, comprehensive pain care that they need. Paradoxically, patients may receive a lot of pain treatments and medical care, just not necessarily ones that are effective or right for them. Clinicians may label patients as difficult when treatment after treatment fails to improve their pain, and understandably patient distress increases.

PAMELA’S EXAMPLE OF HAVING PAIN OVERTREATED AND UNDERTREATED AT THE SAME TIME¹

Pamela is a 50-year-old woman with chronic low back pain. For the past 5 years she has received about 30 epidural steroid injections a year for her back pain—a lot of medical treatment. Pamela is not working. She has

¹This and all other case examples used throughout the book are fictitious or have been disguised to protect confidentiality.

underlying posttraumatic stress disorder and fear-avoidance behaviors, is deconditioned, and spends most of her day on the sofa or in bed. Some days she does not even get out of bed and get dressed for the day. Although Pamela is getting lots of shots and some pills for her pain, her psychosocial factors have never been assessed or treated. As a result, she remains distressed and feels trapped by her pain, unable to move forward with her life and toward the goals that are meaningful to her.

Pamela is an example of a common paradoxical phenomenon in which pain is overtreated and undertreated at the same time. Her pain is being undertreated because she is not receiving the type of pain care she truly needs. The key to best pain treatment is ensuring that a patient's pain is being treated in the way that is right for them. Almost always, the best pain care involves a comprehensive approach with careful attention to the patient's psychological needs.

I wrote this book to begin to address a gap created by the confluence of four important factors: (a) the striking prevalence of chronic pain, (b) the overlap between chronic pain and mental health factors and problems, (c) the emphasis of the biomedical treatment for pain yielding suboptimal outcomes and contributing to further patient suffering, and (d) a lack of psychologists and mental health professionals who are trained to effectively address pain in the therapeutic context with evidence-based strategies.