SPS NEWS

The Official Publication of The Southern Pain Society

June 2008

New Kids on the (Pain) Block

Leanne Cianfrini, PhD

I've been fortunate over the past year to supervise three excellent clinical psychology graduate students for clinical practica and dissertation data collection at our pain clinic. They've conducted intake evaluations, developed treatment plans, participated in multidisciplinary team staffings, and followed our patients for counseling and medication monitoring. I'm proud that they are all heading to excellent predoctoral internships in southern states.

I thought it might be productive to share brief highlights of their doctoral dissertation abstracts as examples of the work we can look forward to from some young professionals in our field. I also asked them to comment on, from their fresh perspective, their venture into the specialty of pain research and treatment.

Effects of Catastrophizing and Acceptance on Functional Interference in Persons with Chronic Pain: Laboratory Findings, Subjective Reports, and the Moderating Role of Acceptance.
-- Elizabeth J. Richardson, MA, University of Alabama at Birmingham

The aims of the study were to examine the effects of catastrophizing and acceptance on task performance during laboratory-induced ischemic pain as well as on depressive symptoms and self-reported pain interference with daily activities. A secondary aim was to investigate the degree to which laboratory performance corroborated self-reported daily functioning. Sixty-seven patients with low back pain status post lumbar surgery completed questionnaire measures of catastrophizing, acceptance, pain interference, and depressive symptoms. Participants underwent an ischemic pain induction procedure during which a cognitive task of attention (a color-word inhibition task) was administered. Acceptance was a significant and stronger predictor than catastrophizing for task functioning during induced pain and also self-reports of day-to-day pain interference. Conversely, catastrophizing was a stronger, significant predictor of pain ratings during ischemic induction and also of self-reported depressive symptoms. Results indicated a moderating role for acceptance on the relationship between catastrophizing and task performance during laboratory-induced pain, such that higher levels of acceptance were associated with better performance in the presence of catastrophizing. Lastly, a modest relationship was found between observed laboratory and self-reported interference from pain on functioning. Results suggest that exclusive focus should not be placed on either catastrophizing or acceptance; both constructs appear to contribute to important, but different, outcomes. Pain acceptance appears to attenuate the negative impact of catastrophizing on task functioning.

Ms. Richardson will be attending internship at the University of Florida Health Science Center.

Chronic Pain and Spousal Interactions Laura Pence, MA, University of Alabama

Researchers have recognized the association between spouse responses and patient *pain*-related variables, but have only recently begun to examine associations with spouse responses to patient *well behavior*. The primary aim of this study was to test associations of perceived facilitative responses and perceived negative responses to patient well behavior with pain-related outcomes (e.g., patient pain behavior, interference, pain severity, disability, and depressive symptoms). The second aim was to examine the role of marital satisfaction and catastrophizing in these associations. Perceived facilitative responses to well behaviors were related to fewer depressive symptoms, and perceived negative responses to well behavior were associated with greater reported disability. Also, there was a significant interaction between facilitative responses to well behaviors and catastrophizing, such that facilitative responses to well behaviors were more strongly (inversely) related to disability in persons who are low on pain catastrophizing. The current results help expand models of spouse responses to include responses to well behavior. Moreover, the results suggest that multidisciplinary treatments for chronic pain management could be improved by teaching spouses of persons with chronic pain to modify their responses to patient well behavior. *Ms. Pence's internship is with the VA Maryland Healthcare System:* "Observing the clinic's model for how psychologists and physicians can work collaboratively **Continued on page 6**

Mission Statement

The Southern Pain Society is a regional section of the American Pain Society and endorses and supports the mission and goals of the American Pain Society. The Southern Pain Society's missions are to serve people with pain by advancing research and treatment and to increase the knowledge and skill of the regional professional community.

SPS Board of Directors
President: Daniel M. Doleys, PhD
President Elect: Todd Sitzman, MD, MPH
Immediate Past President: Benjamin Johnson, MD, MBA
Treasurer: John Satterthwaite, M.D.
Secretary: Jonathan Cole, PhD
Directors
Ike Eriator, MD, MPH
Leanne Cianfrini, PhD
Eduardo Fraifeld, MD
Joseph Holtman, MD, PhD
Executive Director: Lori H. Postal, RNC, MHA

Committees and Chairs
Awards: Joseph Holtman, MD, PhD
By-Laws: vacant
Districting: Daniel M. Doleys, PhD
E Communications: vacant
Finance: John Satterthwaite, M.D.
Membership: vacant
Newsletter: Ike Eriator, MD, MPH
Nominating: Benjamin Johnson, MD, MBA
Public Affairs: Eric Pearson, M.D.
Professional Education: vacant
Program: Benjamin Johnson, MD, MBA

SPS News Editorial Board
Editor: Ike Eriator, MD, MPH
Scientific Editor
Leanne Cianfrini, PhD

SPS News is the official publication of the SPS, provided quarterly to its members. SPS may publish material dealing with controversial issues. The views expressed are those of the authors and may not reflect those of the SPS. No endorsement of those views should be inferred unless specifically identified as the official policy of the SPS. Submissions are welcomed. Publication is based on editorial judgment as to quality of material, timeliness, and potential interest to members.

Editor's Desk

Ike Eriator, MD, MPH

The institute of Medicine (IOM) in its "Priorities for national Action: Transforming Health Care Quality, list improved pain management as one of the top 20 chronic medical problems that national and private healthcare organizations should focus on, in order to have the broadest impact on patients, families and communities. Pain is a leading public health problem and a significant source of personal and family suffering across different cultures and geographical boundaries. The review article in this issue of your Newsletter again highlights this clear and present danger. Assisted suicide, substance abuse, narcotic regulation, alternative therapies, disability and compensation issues are all strongly related to pain and pain relief. Employment outcomes in people with chronic pain are consistently poor. The largest numbers of people turning to alternative medicine today are patients with pain.

The world of pain is constant and at the same time, rapidly changing. It is said that in times of change, learners inherit the earth; while the learned find themselves beautifully equipped to deal with a world that no longer exists In essence, the educated person is the person who knows what it is today, not the person who knew what it was yesterday. The evil that is in the world almost always comes of ignorance, and without understanding, good intentions may do as much harm as malevolence. Learning and equipping ourselves are the fundamental prerequisites for the pain profession. History will not be kind if we do not help our community, state, nation and the world to strike the appropriate balance between ensuring that people in pain get appropriate relief and ensuring that public health problems like addiction do not skyrocket on account of pain practice.

The **Essentials of Pain Medicine** coming up (September) in **New Orleans** is geared to provide updated information regarding chronic pain pathophysiology, pharmacology, assessment, treatment, rehabilitation and other pain related topics. It will help to equip us with the tools we need for managing the pain patients in the medical and public health environment of today. Pain denies patient the quality of life. We may not yet be victorious over many diseases causing pain, but it is hopeful that, well equipped, we will be able to conquer a significant amount of the pain associated with these diseases.

So, we look forward to seeing you in New Orleans. All the best as we strive to improve the lot of that most desolate of mankind – the patient in pain.

President's Message

Daniel M. Doleys, PhD

The arena of pain management and pain research has suffered a great loss recently, one that will impact patients and practitioners alike. Dr. Samuel Hassenbusch, one of the strongest supporters and most ardent advocates of pain management and research, succumbed to cancer in February 2008. His bravery during his battle with cancer is a testimony to the greatness of the man. He openly shared his personal experiences with the public and the media in an effort to raise awareness and understanding.

I knew Sam, as many others did, as one committed to the staunch application of scientific methodology in pain research. His studies with animals and humans spanned three decades. He helped to propel our understanding of neuropathic pain, in particular Complex Regional Pain Syndrome, to the 'next level'. He pioneered efforts to bring forth new and safe pharmacological treatments. Sam devoted untold amount of time addressing economic issues on a national level, including reimbursement and coding, in an effort to aid patients and clinicians. Possessing great intellect and drive, he was one of the most compassionate and giving persons I have met. He strongly believed in the multidisciplinary model and had a unique way of making everyone's involvement and contributions seem necessary and appreciated.

I had the pleasure of being on several faculties with Sam at week-end cadaver courses training fellows and experienced clinicians in the basic and advanced application of implantable technology for pain management. Sam had the remarkable ability to address every question as an important one. He made complex and complicated topics understandable. Somehow, despite a very busy schedule, he always seemed to have time to present at educational meetings, especially those organized by colleagues.

Sam's humanity, passion, scientific contributions, and friendship will long be remembered.

In the midst of preparing this note honoring Sam, I became aware of the sudden illness of a long-standing colleague and member of the Southern Pain Society (SPS), Dr. C. Paul Perry. Dr. Perry was the driving force behind the development of the International Pelvic Pain Society (IPPS). He was a past president of IPPS and continued as chairman of the board. Paul's compassion for those suffering with pelvic pain, many of whom are young women, was uncommon. He always made time to see 'one more' patient and give them his full attention. Much of our understanding of the complexities of pelvic pain and its treatment has emerged directly or indirectly from his efforts. The thoroughness of his examination should serve as an example to us all. He was a firm believer in the biopsychosocial model and multidisciplinary approach to treatment.

His passing in May 2008 from a rare form of cancer within months of the diagnosis left all of us who knew him in shock. The outpouring of affection and prayers for him and his family came from all over the country and the international community. Throughout his ordeal, he maintained his concern for others and his deeply held spiritual commitment. He will be sorely missed by those of us in this region of the country that depended so heavily upon him and by the pain community at large. We should all be compelled to carry on his legacy of devoted patient care.

The absence of these two pioneers and members of SPS demands that the rest of us redouble our efforts in advocating for our patients and advancing pain research and treatment especially in the broader social and political contexts.

In addition, it is with great sadness that we note the passing of Dr. Hugh Rosomoff on June 5th. Dr. Rosomoff was one of the founders and the first president of the Southern Pain Society. His leadership and inspiration will long be remembered. Our sincere condolences and prayers go out to his wife Renee and all the Rosomoff family. A more detailed tribute will appear in the next SPS Newsletter.

Newsletter Submissions

All submissions to SPS News should be typewritten and double spaced with title and name of author(s). The article should be copy-ready. Please include short biographical information.

Submission Deadlines
Winter edition-November 1; Spring edition-February 1; Summer edition-May 1; Fall edition-August 1. Please submit your articles to lpostal@southernpainsociety.org or to our editor ieriator@anesthesia.umsmed.edu

People Living with Chronic Pain: Who Are They?

Ann Quinlan-Colwell,MSN, RN, FAAPM

Ann Quinlan-Colwell is currently a doctoral student at UNC Greensboro. Her research focus is the relationship between chronic pain and anger. She works as a Clinical Nurse Specialist in Pain Management at New Hanover Medical Center in Wilmington, NC. In addition to being certified in pain, holistic nursing and stress management, she has worked with patients in geriatric, psychiatric, correctional, public health and hospice areas of health care.—Editor

Chronic pain persists past the normal healing time, no longer conveying a cautionary message of trauma[1] It becomes, as Bond & Brevik[2] wrote, a "specific health care problem" and "a disease in its own right" (2004, p. 2). It signifies pathological alterations that are manifested physically and psychosocially (Bond & Brevik, 2004). Chronic pain results in limitations of function and physical activities with impaired quality of life and an increase in health care utilization[3] . It directly and indirectly affects individuals of both genders[4], all ages[4,5], and ethnic groups[6,4]. While it affects individuals in all socio-economic groups, there is an inverse relationship with socio-economic markers. Prevalence has been reported to be higher among those with less education and lower incomes[7]. It is estimated that 90% of all Americans frequently experience pain and one third to one half will suffer with chronic pain[1,8]. While cancer and headaches, each account for less than 10%, musculoskeletal/joint and neck/back pain each account for at least 30% of chronic pain[2].

The American Pain Society estimates that there are fifty million Americans currently living with chronic pain and they represent the largest segment of all individuals who live with a long term disability[1]. In 1996, it was estimated that the economic burden of people living with chronic pain (PLWCP) was $150 billion per year (US Census Bureau). Treatment of chronic pain averages more than thirty-five thousand dollars per person per year ranging from a low of $1,380 to a high of $97,570[9] .

Characteristics of PLWCP are challenging to capture. This is partially because chronic pain results from many etiologies. The origin can be a genetic disorder such as sickle cell disease[10] or osteogenesis imperfecta[11]. It is intrinsic in some diagnoses such as fibromyalgia and rheumatoid arthritis[12]. It can be a sequel of traumatic injures, chronic illness, surgeries, cancer, and with the osteoarthritic changes of aging[1].

While it is easy to portray PLWCP as being primarily the elderly, this is not true. In 2005, the U.S. Census[4] (2008) collected information from individuals over 18 years who experienced pain in the lower back, neck, face, jaw or had migraine headaches that lasted at least one full day during the preceding three months. Of the 217,774 people who reported such pain, a significant majority (110,431 or 51%) were between 18 and 44 years with the second largest group (72,296 or 33%) between 44 and 64 years. Similarly, of the 39,736 U.S. citizens who reported a disability, 22,789 (57%) were between 16 and 64 years of age while 14,062 (35%) were over 65 years.

Among the 215,349 individuals who reported ethnicity and pain, the vast majority (180,477,or 83.8%) were white followed by 24,817 (11.5%) black or African Americans. The third largest group was the Hispanic or Latino's (27,770 or 12.9%) with Mexican/Mexican Americans accounting for 17,163 of these. American Indian and Alaskan Natives followed with 18,446 (8.6%) reports. There was less variability when chronic pain was considered from a gender perspective. There were 112,855 (or 52.4%) reports of pain by women which was only slightly greater than the 104,919 (48.7%) reported by men.

Considering the total numbers, the cases of low back pain (61,965 or 29%) were more than double either migraine (32,826) or neck pain (32,294 or 15%) and significantly more than pain in the face or jaw (9,639 or 0.04%). This enhanced frequency of low back pain continued through all subgroups of age, gender and ethnicity[4]. *Personal characteristics of PLWCP involve all realms of their lives[13].* and signify the extensive impact it has. While the experiences and subsequent traits are specific for each individual, general similarities have been identified[14].

Social factors can impact PLWCP extrinsically. Williams and Collins (2002) wrote that "the evidence reviewed indicates that large scale societal factors are the primary determinants of health status" (p. 420). They explained that in addition to establishing social group, risk factor exposure and access to health care resources are socially determined[15]. Factors such as residence, finances and ability to navigate the health care system notably affect the type of pain management available to the patient.

In smaller communities or underserved neighborhoods, there may not be access to providers specializing in pain management[16]). Pharmacies in many areas lack adequate supplies of opioid analgesics to fill prescriptions[16]. Such pharmacies are not limited to isolated areas. Morrison and colleagues (2002) surveyed 347 pharmacies in the New York metropolitan area and found that 176 did not have opioids to fill prescriptions while 122 could only fill part of an opioid prescription[17]. Sixty-six percent of the stores without opioids were located in minority neighborhoods.

Economic factors impact the health care of PLWCP from several perspectives. While some individuals are able to manage chronic pain such as arthritis with inexpensive medications, for other PLWCP, medications can cost more than one thousand dollars per month. Often there is no insurance coverage for these costs[18]. Chronic pain may limit employment with resultant financial constraints and losses[19,20]. Personal financial loss is stressful, impacting the standard of living, personal goals, family relationships[21] and health care options.

In 1996, Earman and colleagues[22] found that the average cost

of a work related back injury, through resolution of the case including treatment, was $41,727. They reported that for the 157 cases they reviewed, the total cost was more than $6.5 million. They compared this to a total annual cost of work related back injuries in the United States of more than $50 billion. Even when the cause of the pain is not work related, the cost of lost work days and benefits is significant [23].

In a selective review of 75 multi-national studies that involved employment outcomes among disabled individuals who were categorized in six groupings, the pain was more closely correlated with work status than with physical limitations among PLWCP. Reports of pain tended also to be greater among PLWCP who were involved in litigation and those who had received compensation benefits for longer periods of time. From a national perspective, the estimated cost of treating PLWCP ranges from $100 to $150 billion and the cost of lost work hours for painful conditions is reported as another $61.2 billon per year[9]. Chronic pain is not just a symptom, as Bond & Brevik[2] noted it is a health care problem that affects the individual person both socially and financially while having an appreciable economic impact on society.

References

1. (Berry P H Covington E C Dahl J L Katz J A Miaskowski C 2006 Pain current understanding of assessment, management and treatments)Berry, P. H., Covington, E. C., Dahl, J. L., Katz, J. A., & Miaskowski, C. (Eds.). (2006). *Pain current understanding of assessment, management and treatments*. :National Pharmaceutical Council.
2. (Bond M Brevik H 2004 Why pain control matters in a world full of killer diseases)Bond, M., & Brevik, H. (2004). Why pain control matters in a world full of killer diseases. In *Pain Clinical Updates* (pp. 1-4). Seattle, WA: International Association for the Study of Pain.
3. (Weiner D K Turner G H Hennon J G Perera S Hartman S 2005 state of chronic pain education in geriatric medicine fellowship training programs: results of a national survey) Weiner, D. K., Turner, G. H., Hennon, J. G., Perera, S., & Hartman, S. (2005). The state of chronic pain education in geriatric medicine fellowship training programs: results of a national survey. *Journal of the American Geriatric Society, 53,* 1798-1805.
4. (Us Census 200803 Number of Persons With a Disability by Age Group and by State: 2005)US Census. (2008, March). *Number of persons with a disability by age group and by state: 2005*. Retrieved April 12, 2008, from US Census Bureau Web Site: http://www.census.gov/compendia/statab/tables/08s0180.pdf
5. (McGrath P J Finley G A 1999 Chronic and Recurrent Pain in Children and Adolescents: Progress in Pain Research and Management (Vol. 13))McGrath, P. J., & Finley, G. A. (Eds.). (1999). *Chronic and Recurrent Pain in Children and Adolescents: Progress in Pain Research and Management (Vol. 13)*. Seattle, WA: IASP Press.
6. (Green C R Anderson K O Baker T A Campbell L C Decker S Fillingrim R B 2003 unequal burden of pain: confronting racial and ethnic disparities in pain)Green, C. R., Anderson, K. O., Baker, T. A., Campbell, L. C., Decker, S., & Fillingrim, R. B. (2003). The unequal burden of pain: confronting racial and ethnic disparities in pain. *Pain Medicine, 4,* 277-294.
7. (McBeth J Jones K 2007 Epidemiology of chronic musculoskeletal pain)McBeth, J., & Jones, K. (2007). Epidemiology of chronic musculoskeletal pain. *Best Practice & Research Clinical Rheumatology, 21,* 403-425.
8. (Woods Smith D Arnstein P Rosa K C Wells-Federman C 2002 Effects of integrating Therapeutic Touch into a cognitive behavioral pain treatment program)Woods Smith, D., Arnstein, P., Rosa, K. C., & Wells-Federman, C. (2002). Effects of integrating Therapeutic Touch into a cognitive behavioral pain treatment program. *Journal of Holistic Nursing, 20,* 367-386.
9. (Turk D C Burwinkle T M 2005 Clinical outcomes, cost-effectiveness, and the role of psychology in treatment for chronic pain sufferers)Turk, D. C., & Burwinkle, T. M. (2005). Clinical outcomes, cost-effectiveness, and the role of psychology in treatment for chronic pain sufferers. *Professional psychology: research and practice, 36,* 602-610.
10. (Edwards C E et al 2005 A brief review of the pathophysiology, associated pain, and psychosocial issues in sickle cell disease.)Edwards, C. E., et al. (2005). A brief review of the pathophysiology, associated pain, and psychosocial issues in sickle cell disease. *International Journal of Behavioral Medicine, 12,* 171-179.
11. (Glorieux F 2001 disease of the osteoblast)Glorieux, F. (2001). A disease of the osteoblast. *Lancet, 358,* S45.
12. (Provenzano D A Fanciullo G J Jamison R N McHugo G J Baird J C 2007 Computer Assessment and Diagnostic Classification of Chronic Pain Patients)Provenzano, D. A., Fanciullo, G. J., Jamison, R N., Mc Hugo, G. J., & Baird, J. C. (2007). Computer assessment and diagnostic classification of chronic pain patients. *Pain Medicine, 8,* S167-175.
13. (Gatchel R J Peng Y B Peters M L Fuchs P N Turk D C 2007 biopsychosocial approach to chronic pain: scientific advances and future direction)Gatchel, R. J., Peng, Y. B., Peters, M. L., Fuchs, P. N., & Turk, D. C. (2007). The biopsychosocial approach to chronic pain: scientific advances and future direction. *Psychological Bulletin, 133,* 581-624.
14. (Franz C Paul R Bautz M Choroba B Hildebrandt J 1986 Psycosomatic aspects of chronic pain: a new way of description based on MMPI item analysis)Franz, C., Paul, R., Bautz, M., Choroba, B., & Hildebrandt, J. (1986). Psychosomatic aspects of chronic pain: a new way of description based on MMPI item analysis. *Pain, 26,* 33-43.
15. (Williams D R Collins C 2002 U.S. socioeconomic and racial differences in health: patterns and explanations) Williams, D. R., & Collins, C. (2002). U.S. socioeconomic and racial differences in health: patterns and explanations. In T. La Veist (Ed.), *A public health reader: race, ethnicity and health* (pp. 391-431). San Francisco: Jossey-Bass.
16. (Palos G A Ashing-Giwa K T 2007 importance of community and culture int he comprehensive management ofpain)Palos, G. A., & Ashing-Giwa, K. T. (2007). The importance of community and culture in the comprehensive management of pain. *The American Academy of Pain Management: the Pain Practitioner, 17*(2), 10-19. **Continued pg 6**

Continued from page 1 has energized my aspirations for a career in integrated health care. I've been particularly impressed by the staff's ability to communicate openly and mutually respect opinions and contributions across disciplines. I have also enjoyed seeing that a busy clinic can truly apply knowledge from the pain literature to understand and treat patients. Working in the clinic has also alerted me to real world issues related to treating pain in a multidisciplinary setting that are not typically addressed in classroom and research training opportunities. For example, I have learned about the practical and ethical constraints related to working with patients receiving opiate pain medications. Further, I was struck by the limitations that people with serious mental illness have on their ability to participate in specialty pain care, even at a clinic with psychologists on staff. My experience at the clinic has been extremely valuable to my career as a health psychologist because it helped me appreciate the rewards of working in a multidisciplinary setting and showed me the issues that future psychologists are challenged to resolve."

Ethnic differences in cognitive strategies for managing pain.
-- Regina McConley, MA, University of Alabama at Birmingham

There is consistent evidence of ethnic group differences in pain response studied in both clinical and laboratory settings. However, few studies have assessed the efficacy of interventions to reduce pain across ethnic groups. We evaluated the effects of of two brief cognitive strategies, sensory focus and distraction, on measures of pain tolerance and ratings of the intensity and unpleasantness of pain evoked by the Cold Pressor Task (CPT). Participants included 58 healthy university students (36 African American, 22 Non-Hispanic White), randomly assigned to the sensory focus or distraction training groups. Repeated measures ANOVAs were used to assess differences in tolerance, intensity, and unpleasantness for pre-training (CPT1) and post-training pain tasks (CPT2). A significant interaction for ethnicity, condition, and time was observed. Overall, Whites had higher average pain tolerances than African Americans (a difference of 56.4 seconds). African Americans in the distraction group had a pain tolerance increase of 26 seconds from CPT1 to CPT2, while pain tolerance declined by 8 seconds for African Americans in the sensory focus group. Whites in the sensory focus and distraction groups demonstrated a pain tolerance increase of 28.6 seconds and 7 seconds, respectively; these differences were not statistically significant. No ethnic group differences in intensity or unpleasantness ratings were found. Results suggest that interventions aimed at reducing pain may be more successful if they consider ethnicity as an important determinant of the pain experience.

Ms. McConley will be at the Southern Mississippi Psychology Consortium internship in Hattiesburg: "My rotations at the pain clinic gave me a sense of how a private practice operates, which was rarely emphasized throughout my academic program. Working with chronic pain patients has been both rewarding and challenging because of the complexity of the cases. I was surprised to learn the difficulties many patients have with obtaining insurance coverage for their adjunctive treatments (e.g., behavioral programs, biofeedback), even when empirical evidence demonstrates efficacy at least equivalent to medication or interventional procedures. My favorite part of working at the clinic was coordinating with the treatment team, because this enhanced both quality and continuity of care. I observed that patients generally responded positively to the integrated treatment approach, and I look forward to practicing in this type of setting when I finish my training. One unique opportunity that arose during my tenure at the clinic was attending the 2006 Southern Pain Society meeting. Participation in the meeting enriched my understanding of some of the unique stressors chronic pain patients face on a regular basis (e.g., fear of addiction, sleep problems, hyperalgesia). It was a valuable training experience and I look forward to attending this year's meeting in fall."

Although I personally dread "losing" these bright and enthusiastic students as they leave for internship, I'm excited to follow their inevitably bright careers in pain and rehabilitation psychology. As part of our thank-you token to them from our clinic, we provided them each with a one-year membership to the Southern Pain Society. We encourage them and all students embarking on their careers in our specialty to pursue opportunities for professional development and we hope they will continue to enjoy the membership and networking benefits available within the SPS organization.

Continued from page 5

17. (Morrison R S Wallenstein S Natale D K Senzel R S Huang L L 2002 "We don't carry that": failure of phamacies in predominantly nonwhite neighborhoods to stock opioid analgesics)Morrison, R. S., Wallenstein, S., Natale, D. K., Senzel, R. S., & Huang, L. L. (2002). "We don't carry that": failure of pharmacies in predominantly nonwhite neighborhoods to stock opioid analgesics. In T. La Veist (Ed.), *Race, ethnicity, and health* (pp. 463-471). San Francisco: Jossey-Bass.
18. (Shovein J 2001 Getting a grip on arthritis pain can be costly)Shovein, J. (2001). Getting a grip on arthritis pain can be costly. *Pain Management Nursing, 2,* 150-153.
19. (Karoly P Ruehlman L S 2007 Psychosocial aspects of pain-related life task interference: an exploratory analysis in a general population setting)Karolyn, P., & Rothmans, L. S. (2007). Psychosocial aspects of pain-related life task interference: an exploratory analysis in a general population setting. *Pain Medicine, 8,* 563-572.
20. (Saastamoinen P Leino-Arjas P Laaksonen M Lahelma E 2005 Socio-economic differences in the prevalence of acute , chronic and disabling chronic pain among ageing employees) Saastamoinen, P., Leino-Arjas, P., Laaksonen, M., & Lahelma, E. (2005). Socio-economic differences in the prevalence of acute , chronic and disabling chronic pain among ageing employees. *Pain, 114,* 364-371.
21. (Seaward B L 2004 Managing stress: principles and strategies for health and well being)Seaward, B. L. (2004). *Managing stress: principles and strategies for health and well being* (4th ed.). Boston: Jones and Bartlett.

The Pain Practice Corner

Lori Marshall, MD and Ike Eriator, MD, MPH.

Spotlight: Leanne Cianfrini, Ph.D.
Dr. Cianfrini is the newest member on the Board of Directors of the Southern Pain Society. She is also the scientific editor of the SPS Newsletter. Leanne is a psychologist in private practice in Birmingham, Alabama. She has been a member of the Southern Pain society since 2005.

SPS Interviewer: **What does your practice consist of?** I'm involved with a multidisciplinary chronic non-cancer pain management facility in Birmingham, Alabama comprised of three physicians, two psychologists, a physical therapist, a biofeedback technician, a vocational rehabilitation counselor, a clinical social worker, an in-house attorney, as well as medical and office support staff. We receive referrals for outpatient medical pain management as well as for our intensive 4-week residential day treatment program. We also have a busy pump refill clinic.

SPS Interviewer: **Tell us a little about your typical work day.** I may see a few new evaluations, which consist of a detailed interview, psychometric testing, and orientation to clinic policies and expectations. I may have several follow-up sessions, either for standard medication compliance monitoring and functional/mood status assessments, or cognitive-behavioral therapy for pain coping or mood management. In addition, I teach classes on topics such as stress management, anger management and assertive communication, sleep hygiene, and the pain-depression cycle. Finally, I may do some hospital consults for cognitive testing and feedback or counseling.

SPS Interviewer: **How long have you been working in pain management?** I was involved in various pain research projects throughout my graduate medical psychology program, working primarily in a rheumatology department. I then focused on clinical pain management during my predoctoral internship and postdoctoral fellowship at University of Florida. I've been with my current practice since August 2005. So, I have been in the field of pain research and treatment for approximately 8 years.

SPS Interviewer: **Has your practice changed over time?** My personal practice, no – not yet. My clinic's structure and emphasis has essentially remained the same over time, and our behavioral philosophy and emphasis on functional restoration is what I really like about working here. The enrollment in our residential day treatment program has declined in the past decade which we correlate with the advent of interventional-oriented local pain clinics whose activities bring increased income to large medical facilities. Many worker's compensation referrals that once came to us have instead been diverted to those facilities. Once the interventions are completed, regardless of their efficacy, patients are often put at MMI, pain management is declared as completed, and the case is settled with the emphasis on minimizing future expenditures. Patients thus become "medicalized" and are less likely to participate in a functionally-oriented multidisciplinary program.

SPS Interviewer: **Tell us a few things you love about your practice.** I really enjoy our practice's comprehensive, mind-body approach to pain management and health care in general. We see a broad variety of patients with complex comorbidities, including neuropathic pain, traumatic brain injury, post traumatic stress disorder, and addiction issues. So…it never gets dull or routine. The complexity of our patient population keeps us on our toes and promotes team collaboration. It's an energizing and uplifting environment to work in.

SPS Interviewer: **Are there aspects of your practice that you do not like? How do you work around these?** Like many others, we have over-estimated the potential value of opioid pain medicines. We are returning to an emphasis on function versus reduction in subjective pain ratings as a primary outcome measure. For years, many of our psychoeducational and individual therapy sessions focused on the introduction and mastery of adaptive pain coping skills, such as distraction, positive self-talk, activity pacing, etc. Recent studies and our own clinical experiences suggest that patients who demonstrate 'acceptance' of chronic pain (e.g., willingness to give up the struggle to control or eliminate pain; also, the willingness to pursue activities despite pain) are more functional, productive, and have less associated mood symptoms than patients who are not willing to accept their diagnosis of chronic pain and who continue to search for a "cure" or a "quick fix". We are now incorporating acceptance training in our classes and therapies and we are measuring outcomes with relevant acceptance questionnaires in addition to the traditional approach of pain coping skills training.

SPS Interviewer: **Are there aspects of managing a pain practice that you wish you had known when you were starting out? If you had to do it all over again, what would you change about your practice?** I am just starting out, so I don't think I have enough wisdom yet to answer these. Hopefully I'll be able to look back in 25 years, happy with my choices, still excited about the field and my practice. I am learning so much from our clinic's director and my mentor, Dan Doleys, about the business end of the practice – the real life, day-to-day challenges of running a private practice clinic in today's economy and healthcare environment. I'm fairly confident that I'm getting started in the right direction.

SPS Interviewer: **How long have you been associated with the Southern Pain Society?** I joined SPS when I started this job in 2005, but really became involved and excited about it when our clinic co-sponsored the 2006 annual conference in Birmingham.

Continued page 8

SPS Interviewer: **What do you love about the Southern pain society?**

My first experience was with the 06 annual meeting, where I got to know the mission and scope of the society, the people involved, the quality of the speakers, and conference topics. In addition to the meetings, which I really look forward to every year, I now enjoy the networking opportunities across the south. I feel more connected to other pain practitioners in my discipline and other medical specialties who have a common goal of providing quality pain management.

SPS Interviewer: **What do you see as the future of SPS?**

I belong to several national pain- and psychology-oriented organizations, but it's important to belong to a smaller society that represents and reflects the unique issues faced as health care professionals in our own "neck of the woods". I would like to see SPS become more active in patient advocacy, national pain policy development, and regional public service. I hope we can recruit new members and corporate interest to help us reach our goals to advance pain research and treatment.

SPS Interviewer: **What do you feel is the biggest problem in pain care today? What do you see as the potential solution(s)? Where do you see pain as a specialty going in the next 5-10 years?**

I still get (perhaps naively) frustrated when health care costs interfere with medical or psychological care. Type or dosing of potentially effective medications, certain interventional procedures, number of counseling sessions, etc., are often dictated by or constrained by health care plans. Choices are restricted and freedom is limited, both for the patients and the treatment providers. We push as a field toward evidence-based medicine, pharmacological treatment guidelines and algorithms, and the importance of complementary therapies, but some of the most effective treatments are not covered by insurance carriers. I agree with Dr. Ben Johnson that we need to get involved on a political level, publish our treatment outcomes, patiently defend against the stigma surrounding certain aspects of pain control, and legitimize our specialty. This is the direction I'd like to see our specialty move toward in the next decade.

SPS Interviewer: **What general advice do you give to your patients?**

I think general stress management is a key factor in pain management. Our patients are educated about the physiology of stress and helped to modify their environments and/or perceptions and to learn relaxation skills to reduce stress responses that exacerbate painful conditions. We also encourage our patients to treat their chronic pain as a chronic disease, like diabetes, that can be managed long-term with several modalities (e.g., medications on a consistent regimen, education, changes in behaviors like diet and exercise). I believe that hope (e.g., for a quick fix) is fine and of course I want my patients to remain optimistic, but hope itself is not a plan. I encourage patients to limit all-or-nothing thinking, to not give up on all of their hobbies and daily responsibilities in response to pain interference, but instead to brainstorm and get creative about what they can still do to feel productive and have a meaningful life.

SPS Interviewer: **What advice would you give to pain professionals like you that are just starting out?**

Get involved! Meet your colleagues. Learn from other professional disciplines and pursue opportunities for professional development. Be patient. Read, read, read and then read more relevant journal articles. Learn how to market yourself and what you do. Seek personal development and find the balance early between career and home life.

SPS Interviewer: Thank you for taking the time to talk to us.

(Lori Marshall, MD is an anesthesiology resident at the University of Mississippi Medical center, Jackson, Mississippi).

New Members!

Welcome to the following new members to SPS!

Laura Pence, MA a psychology student from Washington DC

Regina McConley, MA a psychology student from Birmingham, AL

Elizabeth J. Richardon, MA, a psychology student from Birmingham, AL

Lori Hill Marshall, MD an anesthesia resident from Madison, MS.

Rochele G. Harris, PhD, Clinical Affairs Manager at Endo Pharmaceuticals from Atlanta, GA

Alan J. Ostrowe, MD, an interventional pain management specialist from Baton Rouge, LA

We are glad to have you all. Please let us know how we can serve you.

Southern Pain Society and Mississippi Pain Society
Annual Scientific Meeting:

ESSENTIALS OF PAIN MEDICINE

September 26-28, 2008
Harrah's New Orleans Hotel, New Orleans, LA

REGISTRATION FORM

Southern Pain Society and Mississippi Pain Society Annual Scientific Meeting: Essentials of Pain Medicine

September 26-28, 2008

PLEASE COMPLETE THE FOLLOWING AND MAIL TO: University of Louisville/ Continuing Health Sciences Education/ 511 S. Floyd St. /MDR Building, Room 111/ Louisville, KY 40202
OR REGISTER ONLINE AT: www.chse.louisville.edu/painsociety08.html
OR FAX FORM TO: 502-852-6300
QUESTIONS?: 502-852-5329

REGISTRANT INFORMATION:

Name & Degree ____

SS# (last four digits)_____ E-mail Address ______________________________

Address ____

City ________________ State __________ Zip ____________________

Day Telephone # ________________ Fax# ______________________

Profession ________________ Professional License # __________________

REGISTRATION FEES:

Southern Pain Society Member or Mississippi Pain Society Member:

- ☐ **Doctoral Level - $225**
- ☐ **Non-Doctoral Level - $175**
- ☐ **Students, Residents and Fellows - $100**

Non-Southern Pain Society Member or Mississippi Pain Society Member:

- ☐ **Doctoral Level - $245**
- ☐ **Non-Doctoral Level - $195**
- ☐ **Students, Residents and Fellows - $120**

METHOD OF PAYMENT:

☐ Check enclosed; payable to University of Louisville
☐ MasterCard ☐ Visa
Acct # ________________Exp. Date _______

Name on Card (please print)
____

Cardholder Signature **(required)**
____

How Did You Hear About This Conference:

Hotel rooms are available at Harrah's at a rate of $199 until August 26th. www.harrahs.com Use code SSPS098

If you are looking for alternative space, please contact the Doubletree Hotel 300 Canal Street, New Orleans, Louisiana, USA, 70130-1010 1-504-581-1300. Their rooms are approximately the same price as Harrah's.

Southern Pain Society

P. O. Box 5033
Cary, North Carolina 27512

Phone: (919) 303-3100
Fax: (866) 368-2700
info@southernpainsociety.org

Address Correction Requested

We're on the web!
www.Southernpainsociety.org

Corporate Members

Janssen

Lilly

Medical Learning Solutions

Merck

Medtronic

Pfizer

Call for Nominations

This year we have several leadership positions opened on the Southern Pain Society Board of Directors.

We are currently accepting nominations for the following 2 year positions:

President Elect
Secretary
Treasurer
2 At-Large

If you would like to nominate yourself or a colleague, please write to
Chair: Nominations Committee
Southern Pain Society
PO Box 5033
Cary, North Carolina 27512 or
Lpostal@southernpainsociety.org