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The Post-Opioid Era: A Call to Medical Psychologists

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Abstract

The post-opioid era represents the climate that exists within pain management services since opioid analgesics are not considered first line treatment for chronic pain. For over a generation, the uses of opioid analgesics were prescribed to a level that contributed to what is now called “the opioid epidemic.” Chronic pain is a major public health problem that affects approximately twenty percent of the American adult population, let alone the excessive financial burden to the tune of approximately $560 billion annually. With this epidemic, the risks about opioid medications were not recognized initially, and in fact notably under-reported. A statistic that represents the excess of opioids in American culture is that although we are five percent of the global population, we use eighty percent of the world’s opioid supply. There is now a generation of patients who have been introduced to opioids and are conditioned to expect pain relief even when the benefits of the medication cease. With the increase in opioid-related deaths over the past decade, clinical and legal guidelines have been developed to define the appropriate use of these agents. Since 2010, there has been a notable reduction in opioid prescribing. Patients who have been maintained on opioids have been deemed as either not appropriate for continued use, weaned from the medications, switched to non-opioid analgesics and confronted with the option of having pain-reducing interventional procedures. Those who have addiction-prone challenges or opioid use disorders are offered other agents to assist in their wean or taper.

Keywords: Post-Opioid Era; Chronic pain

Abbreviations: ACT: Acceptance and Commitment Therapy; DBT: Dialectical Behavioral Therapy; CBT: Cognitive Behavioral Therapy; IASP: International Association of the Study of Pain.

Introduction

The opioid epidemic is due to the over-prescribing of medical providers coupled with the biomedical focus on pain relief, rather than a balanced biopsychosocial perspective and practice. My work will look at the following concerns:

- How and why does the biomedical perspective minimize the psychological aspects of pain treatment;
- The barriers that have emerged that interfere with offering psychological pain services;
- How to integrate psychological interventions as first line interventions;
- Psychological interventions that are helpful for chronic pain management;
- Evidence that psychological services and barriers are addressed.

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The post-opioid era of pain management hopes to re-establish the essential place that pain and medical psychologists hold in their role of providing biopsychosocial assessment and treatment for chronic pain sufferers. Because chronic opioid therapy is restricted and not used for chronic non-malignant pain as first line treatment, it would be reasonable to consider that psychosocial treatment possibilities would be readily available and proliferating. However, there are many factors that complicate this process and limit or undermine the availability of psychological treatment.

The treatment of pain produces more visits to primary care providers than any other clinical issue. Chronic pain services within the biomedical arena, compounded by the additional referrals to orthopedic and interventional pain services, perpetuate a system that operationally is able to exclude psychosocial involvement. The inherent principles and values that have historically driven psychological treatment within the pain arena supports, trains and encourages patients to improve self-management and has essentially becomes a fiscal threat to the biomedical services industry. The industry perpetuates ongoing procedures that are best considered transient in their benefit for perceived pain relief. The overarching goal of pain management treatment is to have less pain from whatever method possible or to get rid of pain completely. Current psychological theory, in many ways, is counter to the fuel and intentions that perpetuate this industry. Liberal opioid analgesics are limited mostly to acute care and recognized as ineffective for chronic pain management. The beliefs that have emerged for the last generation have conditioned patients to believe that pain relief is possible, if not a right, even though chronic opioid therapy contributes to more complications and health risks, and in many cases, even more pain (hyperalgesia).

In a recent Yahoo News publication that asked, “Why are Americans in so much pain?” a question prompted by the fact that with five percent of the global population, Americans use about 80% of the world’s global supply of opioid prescriptions. What has contributed to this imbalance and clinical practice is complicated and multi-faceted. The amount of opioids used in the American culture has been influenced by practices reinforced by the pharmaceutical industry, the industry that distributes such medications and the medical practices of not only pain specialists, but also primary care providers (physicians and mid-level practitioners) who liberally provide such medication as first line treatment. Since the introduction of and marketing associated with OxyContin, one of the major opioid medications introduced by Purdue Pharma in 1996, we now have a twenty year history of liberal availability and a culture of psychological and physical dependence. OxyContin has been identified as the “tool” of choice for controlling pain [1]. This has been predicated on the belief that pain is not to be tolerated and that medications have been designed “to get rid of pain.” The major problem with this thesis is that, although the desired benefit of pain treatment is to be rid of pain, the many interventions used for this process are at best marginal in achieving this goal and benefit. Clinical evidence notes on average 25 to 30% of pain relief is obtained with opioids [2]. The relief obtained by the many pain interventions available is limited and partial. Patients, however, are not informed that the outcome of treatment will likely be temporary, and, although there may be a lessening of pain, the actual clinical benefit is no more than what is obtained from psychological interventions that do not offer risks [3]. Opioids are effective for short-term relief following surgical intervention and medical procedures. The World Health Organization and other health organizations have elevated practices that reinforce a graded pain treating and relieving process that proposes treatments for varying levels of pain severity, with opioids identified as appropriate treatment for moderate to severe pain [4].This “ladder approach” has contributed to the perceived need for something stronger, greater and more effective for severe pain. This tenet has influenced patients to expect higher doses of more potent medication, perpetuating the belief that there is something that will “take the pain away.” Earlier opioid practice also encouraged that titrating to higher doses would not contribute to risk, misuse or addiction. This belief is reinforced by medical practice and the often repeated expectation associated with subjective pain rating. With zero meaning “no pain” and ten,” the most excruciating pain,” patients seek the lowest possible number and whatever intervention will bring it to fruition is pursued. What this evaluative exercise does not take into consideration is that the patient’s psychological status and perceptions of pain are not part of the equation. The exercise is purely subjective and is influenced by the patient’s history, cognitive structure and personal coping strategies. For many, current practice does not assess the patient’s psychological architecture and, in so doing, further reinforces that there is an industry that can get rid of pain. Now that opioid medications have failed to provide the promised relief, the graded system becomes impotent if not irrelevant. Addressing chronic pain requires comprehensive treatment that encompasses psychological intervention. This option can no longer be dismissed or avoided.

When considering medical interventions, it is essential to know what the underlying goal and intention is associated with treatment, primarily what is reasonable and

possible. When chronic opioid therapy was available as first line intervention, it also contributed to an unrealistic if not inaccurate belief about what was clinically possible. For many, various pain interventions and procedures were offered either for analgesic benefit or for diagnostic clarification. This is one of the aspects that can become blurred in treatment if the full spectrum that contributes to chronic pain is misrepresented, unacknowledged or not explained. It is reasonable to expect that pain is notably diminished when using opioids to treat an acute injury. When the complexity of the condition is chronic, it is also far more likely that cognitive, emotional and life quality issues are present. Getting rid of pain cannot be the overarching goal of treatment. Cognitive researchers have offered that, when the treatment focus is set on having less pain, such a focus cements the reality and consequence of having more pain [5]. Since the option of having opioids for chronic pain is not currently considered first line treatment, it is appropriate to educate consumers of this reality and to not reinforce the idea that, if only opioids were offered, pain would be adequately addressed.

Endorsing the biopsychosocial approach to pain requires acknowledging the influence of thoughts, emotions and behaviors. This is where pain and medical psychologists are most useful. The challenge is how to access this service and how to minimize the stigma and fear associated with integrating psychological care. A referral to medical or pain psychology can be made at any time. However, earlier in treatment is best and particularly not at the end when all other treatments have failed. It is also essential to recognize that patients have abilities and strengths to address pain from their history and capacity already defined by life events and from learned coping strategies. These are skills learned and integrated, not necessarily associated with medical options. A patient can claim, define and access these abilities without the intervention with a medical provider.[10] Pain is a common human experience but culture defines methods for coping. It can be argued that medical intervention as part of the pain-relieving industry may interfere with the innate and even learned skills of pain management and tolerance. Since primary care providers are often the first to address a pain complaint, it would be helpful if they would refrain from the conditioned response of seeking first and foremost a pill remedy; this only reinforces the potential abuse of opioids and fails to offer integrated care. Tapping into how patients cope, react and believe about their pain is central to treatment and to life quality [6]. The Veteran's Administration understands this approach. As noted, "Veterans Affairs, meanwhile, is taking steps to reach out early to chronic pain patients, often through their primary care physicians, to coax them into increasing physical activity, sitting through cognitive behavioral therapy, and meditating" [7].

Western medicine has mostly endorsed, through reductionism shaped by the history of infectious disease interventions, a design meant to get less of or eliminate whatever sickness, disease or complication patients report. That path was what influenced dealing with infections and unwanted diseases and also what fueled medications for depression, anxiety, mood instability and chronic pain. Similar to the current opioid epidemic were the challenges associated with the introduction and use of anti-anxiety medications in the 1950's. Following the success of Librium to address anxiety, further research led to the development of another anxiolytic, that being Valium (trade name), also known as Diazepam. Due to its popularity, it became the most widely prescribed medication between 1969 and 1982. In 1978, sales peaked with more than 2.3 billion pills sold that year. It was known during this time as "mother's little helper" and then became more widespread within the rock and roll culture after being endorsed by the Rolling Stones. Even though Valium has been described as dangerous, habit-forming and over-prescribed, it remains one of the most widely prescribed psychoactive drugs in the United States. The intended purpose of this medication was to get rid of anxiety and the tensions, thoughts and sensations associated with fear, worry, stress and inner turmoil. The desired impact of the medication was a worthy endeavor. Gatchel, a pain psychologist and researcher at the University of Texas, Arlington notes "in the past, pain was viewed just as a physical issue, and the thought was, if you cut something out, the pain will go away but lo and behold, it doesn't in many cases, and sometimes the pain gets worse" [8].

In 1996, bolstered by the false claims of research from pain neurologist Russell Portenoy and others, opioid medications which had been mostly used for acute surgical intervention and end of life or palliative care, were determined to be appropriate for chronic non-malignant pain [9]. The doors were opened wide for pharmacological marketing opportunities, driven by the belief that medications and in many circle, a cure, had finally been developed to get rid of chronic pain.

The combination of unrealistic hopes, quick and dirty solutions and excessive prescribing fostered a perfect storm that makes the opioid epidemic our most significant public health crises. There have been more deaths associated with the opioid epidemic than the AIDS epidemic. With the core of medical training and practice fueled by a history of infectious disease reduction, it made sense that, within such a construct, getting rid of anxiety,

depression and even chronic pain seemed appropriate and plausible.

In a 2015 paper from the New England Journal of Medicine, two esteemed pain physicians and researchers, Jane Ballantyne and Mark Sullivan, courageously suggested that, quite possibly, the wrong metric for measuring pain (reducing pain severity) is not where the focus should be [10]. Instead, "a willingness to accept pain, and engagement in valued life activities despite pain, may reduce suffering and disability without necessarily reducing pain intensity" [11].

This, of course, is counter to what our culture and medical community promotes, recognizing the intense conditioning that has influenced opioid practice and use. Beliefs have developed that reinforce such thoughts as, "There must be a medication that can take my pain away" and "if I complain loudly enough, there will be a physician who will eventually give me what I need."

Since 1999, a leading cognitive and behavioral science has emerged called Acceptance and Commitment Therapy (ACT). From this trajectory, another prolific cognitive intervention emerged, Dialectical Behavioral Therapy (DBT) from the work of Marsha Linehan, Ph.D. These acceptance-based interventions have shown that, by investing in greater awareness and willingness to experience rather than avoiding difficulty or unwanted challenges associated with either emotional dysfunction or chronic pain, that greater ability for relating to and living with the challenges mindfully becomes possible [12]. The skill of living with the perceived difficulty mindfully (with full awareness) allows the patient to ultimately be able to accommodate and respond compassionately rather than engage in a perpetual struggle [5,11]. This therapy is not focused on having less of something undesirable. This is a courageous direction and, since 2012, ACT has been fully endorsed by the American Psychological Association as an effective treatment for chronic pain. Integrating this treatment direction is a challenge when working in the biomedical industry that pursues a path of seeking less pain [13].

The response to pain that reinforces the patient as primarily remaining a passive recipient of care, does not move the patient in directions such as re-wiring of the brain, which is essential for gaining skill at addressing the harm-alarm messages associated with pain. The re-wiring process is a skill learned by integrating methods associated with repeated practice of the relaxation response. Transient relief interventions may be required at the time of acute injury. However, as chronic pain becomes more pronounced, the focus of treatment resides squarely in the hands of the patient who must find methods that improve their capacity for being with pain without catastrophizing or investing in a struggle.

With findings revealed by neuroimaging, we are well aware that the classic sensory "pain matrix" brain region is also involved with emotion and reward. Consequently, the intensity or perceived severity of pain becomes associated with emotional and psychosocial factors, not just nociception. This does not quite fit the current standard model of pain care. Rather, it supports a multi-modal approach where the primary goal of treatment is not just reduction in pain intensity. As Ballantyne and Sullivan state, "Multi-modal therapy encompasses behavioral, physical and integrated medical approaches. It is not titrated to pain intensity, but has a primary goal of reducing pain-related distress, disability and suffering. When it does that successfully, a reduction in pain intensity might follow or acceptance might make the intensity of pain less important to a person's functioning and quality of life"[10].

There have now been two generations of physicians and health practitioners who have been trained to promote pain control strategies that have been reinforced by an ideology promoted by the Joint Commission that pain relief is a right of treatment. With the latest legal clarification and guidelines from the Center for Disease Control and from various medical boards, the use of chronic opioid therapy has now been significantly modified. Depending on the specific state or jurisdiction, the availability and use of the medications has been altered. In addition, because of the number of accidental deaths associated with opioid overdose, combining the use of opioid with other agents such as benzodiazepines and sleep agents has been restricted, if not completely banned. Physicians have been forced to shift their investment in chronic opioid therapy, especially as first line treatment, and to seek other options. This is complicated, especially because of conditioned beliefs and practices as well as unrealistic expectations from patient's regarding the abolishment of pain.

Cognitive behavioral interventions have been a mainstay in interdisciplinary pain treatment for fifty years, well-established and empirically-based. They have also been under-used, minimized and complicated by lack of parity of services between medical and psychological treatment [14]. This if further complicated by insurance carriers that over- emphasize the value of medical interventions and downplay the need for psychological services and skill development. For a generation, patients have been conditioned to believe that "their pain was not in their heads," that their complaint was serious and their doctors have to do something about it." Their doctors did do something about it. Interventional pain services emerged,

pain psychologists exited from practice and chronic opioid therapy became the most serious public health crisis in history; the plague of the 21st century. The casualties are staggering and, in light of such, medical practice has been forced to change and encouraged to revisit tried and true clinical options. There are many factors that must be addressed that support greater access to care with appropriately trained pain or medical psychologists with cognitive behavioral skills provided without naiveté regarding biomedical services or medications. Beth Darnall, one of the leading pain scientists, theorists, clinical psychologist and professor at Stanford University Department of Anesthesiology, Perioperative and Pain Medicine simply notes, “Too often, pain is treated as a purely biomedical problem. It is a biopsychosocial condition” [15].

Cognitive Behavioral Therapy (CBT) and other non-drug treatments are underused for several reasons. Because of the fading of interdisciplinary pain services and two generations of medical providers who used chronic opioid therapy as first line treatment, many believed that the primary focus of treatment should be centered on pain severity and one’s response to procedures and medications, often without any awareness of assessing for life quality or improved functioning. It is not unusual that, when medical interventions fail, the patient is simply informed that there is nothing else that can be offered, and is typically dismissed, feeling hopeless, helpless and abandoned. When a chronic problem is treated as emergent because of the perceived need for pain reduction, time pressure and patient demands prompt ineffective temporary solutions often perpetuating frustration.

In a recent publication in the Journal of Psychiatric Practice from November 2017, Muhammad Hassan Majeed, MD and Donna M. Sudak, MD reiterate the benefit of providing Cognitive Behavioral Therapy either as a stand-alone treatment or with other non-opioid therapies. As noted, “CBT improves pain-related outcomes along with mobility, quality of life, and disability and mood outcomes. Compared with long-term use of opioids, CBT has dramatically lower risks and may, therefore, be worth pursuing.” Most importantly, Drs. Majeed and Sudak note, “Consequently, greater consideration must be given to the use of alternative therapies…..particularly CBT” [12]. In this seminal paper, it is recommended that patients with chronic non-malignant pain have a comprehensive evaluation that includes psychological aspects, along with education regarding the risks and benefits of any proposed treatment. Treatment alternatives with an emphasis on achievable and realistic goals are necessary. The central focus of treatment should include a reduction in suffering, which requires a shift in how one responds and thinks about his/her pain and personal experience, not just expecting a reduction in pain sensation. Being free from pain may not be a reasonable expectation or treatment goal. Rather, improved functioning possibly even with chronic pain is considered more appropriate.

There are barriers that complicate access for obtaining appropriate comprehensive care from pain or medical psychologists. In 2012, the American Pain Society endorsed the need for pain services to be provided from an interdisciplinary perspective [16]. This style of integrative care recognizes the importance and value of mutual power within the treatment paradigm between the medical, psychological and rehabilitative providers. From the beginning of treatment, thoughts, behaviors and emotions are identified as important and addressed concurrently, rather than after medical interventions have failed. Services are in collaboration and not sequentially offered when possible. The team of pain providers shares an inclusive philosophy, mission and purpose with shared objectives. The culture of this treatment approach reflects mutual respect and open communication. The blending of all involved disciplines helps create a common language, working together within a supportive work milieu. This is also the most effective approach for integrating biopsychosocial assessment and intervention. From the early definition of pain provided by the International Association of the Study of Pain (IASP), pain is a sensory and emotional experience. With the demise of chronic opioid therapy as first line treatment for chronic pain, it is essential to recognize that thoughts, emotions and behaviors influence the pain narrative. If treating pain severity was the most important consequence, opioid therapy was a realistic treatment. With the treatment evidence provided by the Cochrane Reviews, the benefit or lack of benefit from various procedures and interventional procedures has been clarified [17].

With the demise of interdisciplinary pain treatment, many organizations have substituted the interdisciplinary model with multidisciplinary services. Typically, the service offers interventional medical options and physical medicine or rehabilitative options provided by physical therapy; however psychological services are often not available. This is at times because the services of an appropriately trained pain or medical psychologist were not available, or because the biomedical model was deemed as more important, more profitable or adequate by the health system or insurance payer source. Insurance coverage is often a barrier. As noted, in a recent Mayo affiliated publication, “Insurance coverage is still a battle. Many plans will pay for medical treatments such as surgeries, pills, and steroid injections that can run $2000 apiece. They’re not as keen to cover therapy, massage and meditation. It’s much more efficient for insurers to pay for

a pill in a 15-minute office visit, Twillman said, instead of a pill, plus a psychologist, plus a chiropractor, plus acupuncture, plus yoga and massage. Slowly though, that's changing. In large part because of the opioid crisis" [18]. The treatment approach is usually hierarchical with a physician in the leadership role. Professional identities are clearly defined and team membership is secondary. The most subtle message communicated is that medical intervention does reduce a pain complaint, albeit transiently, and that the role of the physician is to control the patient's pain. Services by the various disciplines are provided in parallel rather than as integrated. The various disciplines communicate typically by reading documentation in the medical record rather than by coordinated purposeful discussions. When the pain complaint is not addressed as desired or the pain generator identified, the patient can go elsewhere, seek more medical interventions and avoid whatever psychological complications or misinterpretations that may interfere with improved coping. Without having a voice that understands, evaluates and treats psychological concerns, a bias exists that reinforces that medical aspects of pain are what is most important and treatable. The bias is real and demands awareness and action to change policy and practice.

The American Academy of Pain Medicine has represented physicians for years. However, it has recently opened its doors for medical and pain psychologists to obtain full membership. At their annual conference in March 2019 in Denver, they scheduled a day for psychologists to provide necessary training and to emphasize the importance of psychological intervention and presence in the organization. This was a symbolic gesture and represents that psychological assessment and treatment is first line treatment for chronic pain, and that whatever barriers exist or persist that interfere with accessing such comprehensive service, must be addressed.

As previously mentioned, the principles that acknowledge the structure and effectiveness of interdisciplinary pain management are proven. They have declined not because of ineffectiveness or lack of research evidence, but because of insurance, organizational and fiscal disparities. It is also because with the emphasis of pain treatment shifting toward interventional procedures and opioid analgesia reliance and minimizing of the biopsychosocial model of treatment; the purpose and function of medical or pain psychology was marginalized.

Not to belabor the fact, however I have worked in pain medicine related services for thirty years and have observed the transitions that reflect the full array of pain management ranging from interdisciplinary care to multidisciplinary care, multimodal care and unimodal care. The various treatment models are associated with the different methods practiced to offer psychological services. As clinical director at the Elliot Hospital in New Hampshire, we obtained CARF accreditation as an interdisciplinary pain program; all team members had a voice at the table with a collaborative message. Other interventional programs I have been involved with focused primarily on the profits obtained from billing procedures, while questions regarding improvement were irrelevant- there were no measures used to assess improved functioning outcome. Mid-level providers managed medications and psychological influences were not addressed or treated unless identified as psychiatrically co-morbid. Another organization, an interventional practice that provided repeat procedures, again, without outcome data. When psychological assessment was requested for opioid risk or for pre-surgical assessment related to the candidacy for trial of implantable devices, the clinical information was disregarded. The practice did four spinal cord stimulators each week, and the implantation took place no matter what the clinical risk data or psychological evaluation revealed. One of the other pain organization that I was recently involved with was aware of the range of IASP identified styles associated with pain treatment ranging from interdisciplinary to unimodal. During my interview, I gave the administration the white paper from the American Pain Society (2012) that defined interdisciplinary pain treatment (2012) [19]. In an introductory staff meeting, I asked what style of pain treatment would define their practice. One of the pain physicians, a trained intervention list, stated that the preferred style of treatment would be "interdisciplinary". Over a three year period, there was only one joint meeting. If there was shared information, I would take information to the two pain physicians. This practice was not mutual. They did not come to my office to share information. They practiced two days per week doing procedures typically doing 40 per day, and two days in clinic. Although they would say the practice was patient-centered, in actuality, patients were informed not to speak or ask questions at the time of injections or procedures so not to delay the practice or appointments. The marketing department designed and advertised the service as an interdisciplinary pain program. It was not.

The American Academy of Pain Medicine has recognized that medical psychology has a place at the table. How the voice is heard and integrated is one of the challenges. A team approach with mutual respect and expressed value is necessary in order to best facilitate integrative work. There are identified qualities that best represent how to effectively offer integrative pain management services. From Turk's paper regarding interdisciplinary pain

management, important attributes are noted regarding a well-functioning interdisciplinary pain team. As follows:

- Shared philosophy, mission & objectives
- Patient and family centered
- Working together for common, agreed upon goals
- Integrated, interdependent approach
- Mutual respect and open communication, often in a team meeting format
- Frequent and effective direct, clear and reciprocal communication amongst team members as well as with primary care providers and referral sources
- Quality improvement efforts are ongoing and the responsibility of all team members
- Collaborative approach to clinical care, education quality improvement and research
- Deliver evidence-based multimodal treatments [19]

The integrated style of treatment requires coordination, communication and collaborative involvement and all members are empowered to facilitate the required treatment goals and process. All aspects of the clinical matrix matter and such interdependent values limit patient splitting behaviors and the hierarchy that implies that the medical intervention is most important. It is typical for pain patients to dismiss or avoid psychological awareness, and in many ways it is often easier to express pain complaints that appear like acute injury in order to get medical attention, rather than integrating self-care skills that require practice or cognitive change. It is not unusual that by the time a chronic pain patient has seen a medical or pain psychologist, they have already been exposed to multiple treatments including medications, often psychotropic medication, along with a variety of pain medications. As previously mentioned, the role of the medical psychologist is trained and empowered to know the effectiveness of treatment, or lack thereof, including medications, surgical and interventional procedures. They are specifically trained to recognize how patient's beliefs, thoughts, emotions and behaviors influence outcome. Treatment outcome and expectations can contribute to greater co-morbid complications and reinforce the role psychologists play in the adjustment and acceptance process in pain management.

Although the availability of opioids is lessening in most practices, there are many patients who are maintained on chronic opioid therapy. How to manage opioid medications is as much a social issue as it was in the mid-1990s prior to the introduction of OxyContin. With the clinical pressures regarding opioid reduction that complicate patient care, for some patients, the idea of tapering off opioids prompts serious fear, anxiety and worry about pain and its impact. There are organizations that represent patients who protest about any consideration of reduction or availability of opioids. There is a national dialogue regarding the practice of tapering and transitioning from opioids to non-opioids. Addiction practitioners have entered the arena offering medication assistance in dealing with the withdrawal aspect of opioid reduction. For many pain patients, if included in the decision to wean and also concur that it is a necessary step and clinically sound, the wean is often uneventful. The role and involvement of the medical psychologist is necessary in the tapering process in order to assure the patient that adjustment is likely if the taper is slow and personal pain experience is respected. Treating pain patients embroiled in an opioid wean as psychologically weak or addicted often leads to divorce from the pain practice. The tapering process can be challenging and may require more counseling, patient education and time going at a slow pace to achieve the necessary wean.

The introduction or continued use of opioids requires an analysis of benefit to risk. It is not unusual for pain/medical psychologists to complete an Opioid Risk Assessment using validated measures to assess risks if to remain on the agent. There are several psychological tests used to help determine such a candidacy. Some of the measures identify and assess patient risk based on historical complications especially whether or not there has been a history of physical, sexual or emotional abuse, a history of alcohol or substance abuse and if already introduced to such agents, and if there is evidence of improved life quality. There are also measures that assess current use of opioids and their impact on daily functioning. The questions at hand are associated with an estimate whether the patient likely would misuse, abuse, divert or become addicted or not being able to remain within the tenets of an opioid agreement. Such as assessment may require interviewing family members or obtaining medical records to see if the patient is capable of maintaining such an agreement. There are several risk measures that are valid and useful in clinical practice. The most recent validated measure is the Brief Risk Questionnaire (2015).

Jones (2015) has identified further what is essential within the role of a medical/pain psychologist. In addition to offering pharmacological and treatment opinion, grounded in the integration of acceptance-based psychotherapeutic principles assist the patient with pain psychoeducation, integrating self-calming and parasympathetic responding, reframing catastrophizing thought and defining values based influences- this is the essence and purpose of medical psychology intervention. For many years, the use of cognitive-behavioral interventions has addressed ineffective thinking patterns along with teaching relaxation skills. The core principles identified by Jones (2015) are as follows:

- Chronic pain is more than tissue damage
- Pain gates affect how much signal gets to the brain
- Central processes influence how much pain is felt
- And how the pain is interpreted cognitively and emotionally (pain versus suffering)
- Behavioral interventions can be very helpful for chronic pain as is the full psychological spectrum [20].
- The essence of pain treatment whether it is interventional, psychological or surgical, recognizes the challenges moving from acute to chronic pain, mostly related to time duration, knowing that most tissues heal within three to four months. Even with multiple interventions, there is the possibility of experiencing ongoing pain and that the treatment may not provide what is desired. The wisdom of Sullivan and Ballantyne encourages to not primarily focus on pain relief, however after adjusting to loss and grief, with thoughtfulness and mindfulness techniques, move toward positions of acceptance and awareness that allow for a non-judgmental or reactive stance toward one's pain.

Summary and Conclusions

The conversation to address the opioid crisis demands a response from mutually valued participants. Medical psychologists stand ready to be an integral part of this conversation. Organizations, insurance payers, health systems and medical providers can be barriers or facilitators in enabling the conversation, creating an atmosphere that balances the policies and practices that influence access and service. Interdisciplinary treatment needs cannot be addressed without scheduled, organized and intentional conversation. It is not unusual for chronic pain patients to have co-pays for medical appointments, multiple weekly physical therapy appointments and also the costs associated with laboratory fees. It is also not unusual that appointments with pain or medical psychologists are secondary since psychological interventions are deemed less important. Not having the opportunity for an appointment because of fiscal constraints is also a subtle message of its lack of importance or less importance than other interventions.

Addressing psychological challenges requires investing in the acquisition of skills such as the relaxation response, and at this point, considered more difficult than just getting a new prescription. Resistance to psychological interventions becomes a treatment issue that can usually be tackled from a collaborative team approach when all team members recognize and support psychological needs. Behavioral interventions are important for helping a patient to become more active without heightened fear.

The solution is often not simply associated with pharmacological changes. For experienced psychologists and particularly medical psychologists, the hope was that, with opioid availability, functional status and life quality would improve. We know now that hope was misplaced. Caution and alternative therapies, along with non-opioid analgesics have become a less risky path to pursue. Medical psychologists are not naïve about pharmacological interventions and are willing to assist patients in learning the psychological skills that contribute to improved function and pain tolerance.

Darnall reminds us of the psychological challenges associated with chronic pain. Such challenges are not unusual with chronic pain, and as many as half of those suffering, experience co-morbid complications such as depression and anxiety. As stated, "Psychological disorders and pain frequently co-occur and psychological factors are underappreciated and undertreated in the context of pain" [21]. It is established that pain-CBT is an effective, evidence-based therapy for pain reduction, catastrophizing, depression and disability. It is not unusual for chronic pain patients to ruminate about their pain and life experiences, responding with a sense of helplessness and hopelessness while focusing on perceived difficulties. This is known as pain catastrophizing. We know that pain catastrophizing is the most powerful predictor for back pain disability one year after new-onset back pain. Pain catastrophizing is known to alter the structure of the brain and how it functions; priming pain responsivity and attention to future pain. This form of ruminating can be addressed by integrating cognitive-behavioral skills for self-monitoring and using effective calming strategies. Pain catastrophizing is known to complicate responses to medical treatment, various interventions and shape the brain toward greater pain sensitivity and distress. With exposure to CBT and with greater self-management efficacy, the complications and distress associated with such fearful thoughts can be modified.[9]

With the evidence and benefits shown from outcomes associated with pain-CBT, there is also particularly robust evidence that supports moving patients away from the struggle of overcoming chronic pain to greater willingness and acceptance of pain. Such willingness to accept and move forward in a meaningful direction in the face of pain makes patient action the central goal of pain treatment. As Sullivan and Vowles state, "Restoring the capacity for meaningful action is what transforms someone with chronic pain from a patient into a person" [16]. This is the essence of effective chronic pain treatment and psychological interventions are the tools that facilitate such a transformation.

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