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Daniel Carlat, MD
Editor-in-Chief

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IN THIS ISSUE

Focus of the Month:
Pain Management

Learning Objectives
After reading these articles you should be able to: **1.** Apply specific cognitive behavioral therapy (CBT) techniques to assist patients struggling with chronic pain issues. **2.** Describe some of the ways practitioners can treat patients with pain and psychiatric issues. **3.** Summarize some of the current findings in the literature regarding psychiatric treatment.

Managing Pain: A Cognitive Behavioral Therapist's Approach

John D. Otis, PhD
Associate Professor of Psychiatry, Boston University School of Medicine, Boston, MA
Author, Managing Chronic Pain: A Cognitive-Behavioral Therapy Approach

Dr. Otis has disclosed that he has no relevant financial or other interests in any commercial companies pertaining to this educational activity.

As a clinical psychologist with a specialty in chronic pain management, I am often referred patients with both chronic pain and psychiatric issues. Many of these patients see a psychiatrist and a therapist, and are taking with both psychotropic and pain medications. The referral is often made because there is a sense that psychological issues are complicating the

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In Summary

- CBT can help patients with chronic pain issues to identify and restructure maladaptive automatic thoughts.
- In addition to cognitive restructuring, patients can help manage their chronic pain by using proper breathing techniques, increasing activity, and avoiding social isolation.
- In pain management CBT, patients learn how the "Cycle of Pain" components (pain, distress, and disability) have ultimately worsened their pain.

Q&A With the Expert

Evaluating and Treating Pain in Psychiatric Patients

Michael Robert Clark, MD

Associate professor & director of the Chronic Pain Treatment Program at The Johns Hopkins Hospital in Baltimore, MD

Dr. Clark discloses that he has been a paid consultant to Collegium Pharmaceutical Inc. and Depomed, Inc. Dr. Carlat has reviewed this article and has found no evidence of bias in this educational activity.

TCPR: Dr. Clark, recently a local pain clinic asked me if I wanted to do some psychiatric consultation there. I ended up declining, partly because I really didn't know what I was supposed to do as a psychiatrist working in a pain clinic. Can you provide some insight?

Dr. Clark: I think psychiatrists are being underutilized in chronic pain management, because many of the things that people with chronic pain are dealing with are psychiatric problems. Pain patients have tremendously high rates of major depressive disorder which is undertreated and underdiagnosed. Many clinicians assume that the depression is a reaction to living with chronic pain, but in fact it's often the other way around. These people have high rates of family histories of affective disorders; they have prior episodes of depression themselves. And having depression puts you at about two to three times the risk of the general population of developing a chronic pain syndrome (Larson SL, *Psychol Med* 2004;34(2):211–219). In addition, most of the medicines that you would use to treat affective disorders, such as antidepressants,

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patient's pain management.

In this article, I'll describe how psychologists conceptualize the treatment of chronic pain and provide some tips for how you, as a busy prescriber, can leverage some of the successful techniques I use with my patients.

I'll start by introducing a case of a veteran who is typical of my practice (I have altered the details to preserve confidentiality).

Martin C. is a 37-year-old U.S. veteran who was honorably discharged three years ago after four tours of duty in Iraq and Afghanistan. During his last tour, he sustained multiple injuries after an improvised explosive device detonated in close proximity to his Humvee. Three years later, he suffers from chronic low back pain and shoulder pain, and has been diagnosed with both PTSD and depression. He is taking milnacipran and prazosin for his psychiatric symptoms, and hydrocodone as needed for chronic pain. His referring psychiatrist says that Martin has partially responded to his meds but is still depressed and not very active. I am asked to help Martin learn some cognitive behavioral skills to manage his pain more effectively.

Cognitive behavioral therapy (CBT)

Most of you are probably familiar with basic cognitive behavioral therapy (CBT) concepts. As a reminder, CBT focuses on teaching people ways to identify and change counterproductive automatic thoughts and maladaptive behaviors, and to replace them with more adaptive ones. For example, a typical automatic thought in a patient with depression might be "I'm a failure." In CBT, we help patients become aware of such cognitions, teach them to examine the evidence that supports the thought, and to generate alternative thoughts that are more balanced and adaptive. If therapy is successful, a patient will be able to recognize automatic thoughts as they occur, and counter them with more realistic thoughts. Over time, the adaptive thoughts become stronger and take the place of those that have been causing distress.

How does CBT work in pain management?

When I meet a new patient, I often start by taking out a sheet of paper and drawing the "Cycle of Pain," which includes pain, distress, and disability (see figure below). The essence of this vicious cycle is that chronic pain can lead to negative automatic thoughts, insomnia, and isolation, all of which contribute to distress/depression.

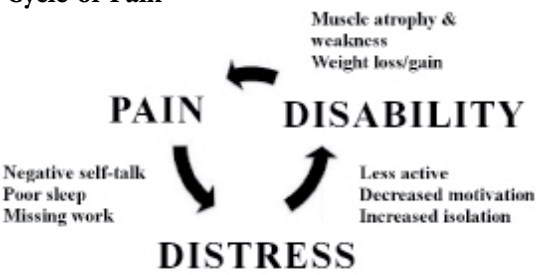
Typical examples of maladaptive thoughts in pain patients include "I'm worthless to my family because I can't work," "I could have done so much with my life," "This is never going to get better," or "I'd better not be too active or I'm going to be in more pain." Such thoughts lead not only to depression, but also to isolation and inactivity. Patients may isolate themselves to avoid others, in part because they get tired of hearing questions like, "Why aren't you working? You look fine to me." Less activity may lead to muscle atrophy and weight gain, both of which can aggravate the original pain condition. The decreased activity and deconditioning lead to more pain.

In my experience, patients with chronic pain will recognize this cycle and will be able to acknowledge that it has affected their lives and worsened their pain.

Evaluating pain

Returning to Martin, at our first meeting I conducted a typical comprehensive pain assessment assessment: I evaluated the location and quality of his pain, as well as his pain triggers, and took a standard psychiatric history. When I asked him about any strategies he had learned to cope with his pain, Martin responded, "I guess there's really nothing I do but sit down, rest, and play video games to distract myself." He used to enjoy fishing and photography, but he felt that his pain made those hobbies impossible to continue. He said he thought that life was passing him by. When I asked Martin, "Have you ever noticed a connection between your mood and pain?" he responded that he had, and that in particular the pain caused him to have a "short fuse" with everyone around him. He also realized that he had lost his motivation to take the steps necessary to return to college and develop a new career.

Cycle of Pain



Based on my assessment of Martin, there were several areas that were clear targets for intervention. First, Martin was depressed due to his tendency to engage in negative and catastrophic thinking about his future and his withdrawal from reinforcing activities. He needed to learn adaptive ways of addressing his negative thoughts, to get involved in activities that would bring happiness

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back into his life, and to make a plan to move forward with his educational interests. Second, Martin had a difficult time doing things at a slower pace. This is quite typical of people in the military, who are trained to not stop a job until it is complete. On a typical day he would spend hours playing *Call of Duty*; however, if he had a day when he was experiencing less pain, he would try to accomplish everything on his "to-do" list only to find himself in greater pain the next day.

Creating a treatment plan

Once I conduct an initial assessment, I work with the patient in coming up with a treatment plan. This typically involves the following elements:

1. Developing several overall goals for therapy and creating a strategy for goal achievement. This is done by setting small achievable goals each week that gradually move patients toward overall goal accomplishment.
2. Teaching patients how to relax by noticing how they are breathing, how they are feeling, and what they are thinking. This is accomplished using diaphragmatic breathing, visual imagery, and progressive muscle relaxation.
3. Replacing negative automatic thoughts with more realistic thoughts. This is also known as *cognitive restructuring*. My technique involves using a "restructuring sheet," which is a page divided into several columns that require patients to write down their thoughts, feelings, evidence for and against a thought, and an alternative thought based on the actual evidence. Although these sheets initially require effort to complete, eventually they become unnecessary because patients learn to restructure thoughts in their heads.

Applying a treatment plan

Once I developed my case conceptualization, here's how I proceeded with Martin's therapy. In our first session, I made sure that Martin understood the connections between his thoughts, feelings, and behaviors and his pain. Unless patients agree with the treatment rationale, in my experience they often will not return.

Another activity I did with Martin, which I typically teach to my patients, is relaxation using diaphragm breathing. This technique serves two purposes: it teaches patients a useful skill right from the start of therapy, and it helps them to begin to notice how their body feels in reaction to their thoughts. This intervention by itself can be very powerful.

Martin and I set some overall goals for treatment, including resuming his hobbies and looking into colleges. The plan was to gradually reintroduce those activities into his life in a safe way. For example, although his pain made it difficult for him to fish from a boat, we brainstormed less demanding ways to fish, such as from a bridge or the shore.

In subsequent sessions, I taught him about cognitive restructuring. Over the ensuing sessions, he completed these types of homework sheets and was eventually able to restructure negative thoughts on his own. For example, Martin reported that he often told himself, "My life is ruined now; I can't do anything," which made him feel frustrated and depressed. Using a restructuring sheet, Martin wrote down this thought and the associated emotions. Under "evidence for the thought," he wrote that his plans of having a military career were over, and he couldn't engage in sports like he used to. In the category of "evidence against the thought," he wrote that there are actually many things he can do, he has people who care about him, and he knows that he can learn new skills.

After reflecting on what he had written, Martin realized that there was little evidence to support his conviction that his life was "ruined." Next, I urged Martin to write down a positive coping thought based on actual evidence; he wrote: "Although there are some career paths that I'm not going to be able to take, and I may have to do some things differently, I know I can learn new skills and find a new direction for myself. When one door closes, another one opens." Martin commented that some of the thoughts he was having related to PTSD could also be challenged using restructuring.

In other sessions, we covered topics such as sleep hygiene, pleasant activity scheduling, and anger management. To discuss sleep hygiene, I typically use a patient education sheet, an example of which can be found on http://Painpsych.com/Pain-Resources. Pleasant activity scheduling is pretty much what it sounds like—we identified enjoyable activities that Martin could realistically perform and scheduled them into his week. Finally, anger management focused on helping him to identify thoughts that were contributing to anger, common triggers, and ways to be assertive but not aggressive.

Given his tendency to overdo it, Martin was taught to pace himself based on "time" and not "the job." The example I often give to patients is, "Think of your favorite athletes—do they play the entire game nonstop or do they take breaks?" I asked Martin to think of himself as an athlete who wants to give the best performance possible, which resonated with him.

By the end of therapy, Martin had a much greater ability to challenge negative thoughts. Most of the ones that had been troubling him in the past were no longer an issue; in fact, he described them as "spam." Martin was excited because he had selected a college and was enrolled in courses for the semester. While he had only managed to get his camera out a few times, he was fishing regularly and had made some new friends with the same interest. An important part of all of his progress was that he was pacing himself—he was thinking ahead and planning out what he needed to do in advance to set himself up for success. Martin still had chronic pain, and some days were tougher than others, but he was less depressed and more active, he knew how to talk to himself when he was in pain, and he was moving forward with his life.

Bottom line tips to use in your practice

While not all providers have access to a clinical psychologist with training in CBT for pain, there are several things that even busy prescribers can do to help patients.

1. Teach your patients the root CBT concept of the cycle of pain, using an

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mood stabilizers, and neuroleptics for augmentation, are the same medicines and almost identical algorithms for managing chronic neuropathic pain.

TCPR: What sort of evaluation should a psychiatrist do if asked to evaluate a patient with chronic pain?

Dr. Clark: Well, in general, you should be doing the same kind of evaluation that you would do with any other patient. A couple of special areas of emphasis are the mood disorders and substance use disorders. To do a good evaluation, you have to understand something about the subjective experience of a patient with chronic pain. Chronic pain is poorly understood, difficult to cure, and frustrating to both patients and health care practitioners. As a result, patients with chronic pain find themselves in a world apart. They are isolated from family and friends and become trapped in the realm of the doctors, insurance companies, case managers, and even quacks. As patients struggle to find relief, they lose their lives.

TCPR: So it's key to make sure that these patients feel you are on their side?

Dr. Clark: Absolutely. You have to have an alliance. You have to demonstrate that you're thorough, that you know your field, and that you are interested in taking care of them. And then you have to begin a discussion with them about what you think might be contributing or causing their pain, such as depression or side effects of medications. For example, chronic opioid use often causes a host of problems in patients, including cognitive impairment and a hyperalgesic state.

TCPR: What is a hyperalgesic state?

Dr. Clark: The hyperalgesic state is a clinical phenomenon where you see somebody getting more severe and more generalized pain as the dosage of opioids is increased.

TCPR: Interesting, and do you have a hard time convincing patients that this is a problem that they have?

Dr. Clark: It depends on the person. Most people are skeptical, but now that they're hearing more about opioids in the news and online, there's a little bit more willingness to hear more about it. The biggest thing that we're trying to overcome is somebody saying, "If I'm in this much pain on these medicines, how can I not be in more pain off these medicines?"

TCPR: I assume that many patients may not recognize cognitive impairment as a side effect of long-term opioid use. How do you address this?

Dr. Clark: It's really helpful to have a family member with the patient when you're discussing cognitive impairment. I usually say something like, "Often, after people have been on these medicines in these kind of combinations for a while, not only do they become tolerant to some of the side effects, but they don't recognize how the medicines are affecting them. And you must have noticed that you're not quite as attentive as you usually are; you're more forgetful; you don't have the same kind of motivation and interest in things; you tend to spend more time doing less, and your usual kind of get-up-and-go for projects is gone." And usually it's the family member who is sitting there—the partner or a son or daughter—who starts nodding their head and saying, "Oh, yeah, he's not the person he used to be. He forgets all kinds of stuff. He's always kind of nodding off even though he says he doesn't sleep." That's where you can say, "Do you recognize any of these things?" and they'll say, "Yeah, my wife has been telling me this for months, but what can I do?"

> **"[Patients] have to be willing to make changes and accept ... treatment that is focused on rehabilitation as opposed to comfort. And often that's a paradigm shift for [them], when I [say] we are not going to be focused solely on making them comfortable, but that we're going to work on all the causes and contributors to their pain."**
>
> Michael Robert Clark, MD

TCPR: So once you have that alliance going and the patient realizes you are both on the same side, you can begin talking to them about treatment?

Dr. Clark: Right. They have to be willing to make changes and accept a course of treatment that is focused on rehabilitation as opposed to comfort. And often that's a paradigm shift for patients, when I tell them that we're not going to be focused solely on making them comfortable, but that we are going to work on all the causes and contributors to their pain, whether it's depression or another underlying pain problem. I'll say something like, "There are a tremendous number of people who have these very same problems who are able to be more functional than you, and we will help you transform yourself into one of those people."

TCPR: What do you mean by "rehabilitation" in the context of chronic pain?

Dr. Clark: Rehabilitation has to do with being productive and functional, with a higher quality of life: to move from a model that is a palliative care one—"Give me medicine until I'm comfortable; take my pain away; fix me, and if you can't fix me, help me get disability." And that's where a lot of our patients are trapped. You want to say, "Look, you can actually do more despite what's wrong, and there are better and more specific treatments than what you're receiving. There are things that we can do that will ultimately decrease your pain and help you to have more motivation to do productive and functional things in your life."

TCPR: Can you give us an example of a patient who's responded to that message? I mean, it sounds great, but convince me that it actually works.

Dr. Clark: There have been quite a few studies over the years showing that multidisciplinary or interdisciplinary pain treatment is effective. One patient that comes to mind is a former military person who came to our program very depressed, intoxicated, and unable to function. He had sustained a horrendous injury while serving his country—very painful nerve damage that was being treated with intranasal ketamine and several different opioids as well as benzodiazepines. We gradually weaned him off all

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of those medications and treated him with a tricyclic antidepressant for his neuropathic pain as well as his mood. Ultimately, he was given a course of ECT because his depression was so severe. And he left our program pain free and on fewer medications. He went back to working full time in the family business and being a full partner with his wife in that endeavor.

TCPR: And that was due to a combination of the ECT for the depression and the tricyclic for both pain and depression. Any other medications?

Dr. Clark: He was also on a low-dose neuroleptic to augment the tricyclic and to facilitate sleep.

TCPR: Are there any specific medications that you find yourself turning to in these situations?

Dr. Clark: In my experience, the best medicines for neuropathic pain are the SNRIs and tricyclic antidepressants. So I use a lot of duloxetine, venlafaxine, and nortriptyline. If you're going to use a tricyclic antidepressant, you really need to check serum blood levels, and you need to aim for the high end of the therapeutic range. If you're using other medicines, you really should be willing to push beyond the usual dose—so 120 mg of duloxetine, 300–450 mg of venlafaxine. We also use a lot of anticonvulsants like Depakote and Lamictal—again, it's necessary to treat to therapeutic blood levels—so you use the same range that you would use for treatment of mood disorders or for epilepsy. The downside is the possibility of drug interactions, so you really have to make sure that you're tracking any over-the-counter medication use closely.

TCPR: We don't normally think of Depakote and Lamictal as being helpful for pain. Are you prescribing these both for pain and for whatever mood issues there are?

Dr. Clark: Yes. There are some nice statistical analyses that have looked at some of these agents in randomized controlled trials and have been able to show that most of these drugs have independent effects on pain and mood (Martinez JM, *Int Clin Psychopharmacol* 2012;27(1):17–26). Clinically, I can tell you I've had patients receive benefit for pain but not mood, and vice versa, with any given agent. It's very idiosyncratic who's going to respond to what, and it's challenging to know for certain whether it's a direct or indirect effect when it seems to work for both.

TCPR: Anything else you've had success with?

Dr. Clark: As far as neuroleptic augmentation, the medicine that's worked best for me and that I've seen the most dramatic results with is Zyprexa—2.5 mg to 5 mg at bedtime. There's also Geodon—20 mg to 40 mg in the morning—or Latuda, Saphris, or Abilify. Any of these can be helpful as long as you're monitoring the patient's metabolic status and their weight.

TCPR: There's also Lyrica (pregabalin) and Neurontin—are those helpful?

Dr. Clark: They can be in some people. They are a special class of anticonvulsants. They're calcium channel modulators, which don't really seem to provide any antidepressant or mood-stabilizing effects. They can sometimes be helpful with anxiety or insomnia, but are more limited in their use for neuropathic pain. Usually, by the time people come to see us, they've already tried those medicines.

TCPR: I imagine you must encounter resistance from some pain patients when you discourage opioids and suggest prescribing psychiatric meds. Some might think that you're implying that their pain is "all in their head." How do you address that concern?

Dr. Clark: You can say, "Look, it's important to understand at this point that you're not doing well: you've been trying things this way for years, if not decades, and it hasn't helped you. In fact, we see this a lot and can tell you that people improve when they get off of narcotic medications—their mood gets better, their sleep gets better, their pain gets better, and their thinking gets clearer. We expect that that's going to happen with you because we've seen it in thousands of patients. In addition to that, we think that your depression has taken on a life of its own. Of course, you're unhappy about being in pain and demoralized and frustrated, but we think it's gone to a new level, and that now you have a comorbid major depressive disorder because of the overlap in neurobiology of pain with the neurobiology of mood disorders. It makes perfect sense that these two things go hand in hand, and so both things have to be treated. And luckily a lot of the treatments are the same."

TCPR: What do you tell them about their treatment?

Dr. Clark: Something along the lines of, "We're not necessarily going to just double the medicines that you're on because you have two disorders instead of one; we're just going to find a more sophisticated and tailored regimen for you. And I think once you see things improve, you'll find that you're capable of doing more and you'll have motivation to do more, and you'll be able to participate in the physical therapy that you need to get your body back in shape in the same way that after you've been kicked by the flu for a week, your body hurts and doesn't feel well and it has to kind of get going again. And you've had the flu for 10 years."

TCPR: I like that very much. It's a nice way to frame things so that patients understand the mind and body connection without feeling stigmatized. How do you handle the special circumstances surrounding disability insurance and litigation? Many practitioners are quite skeptical of patients seeking some form of compensation.

Dr. Clark: I think it's important to approach patients with the assumption that they would rather be healthy than sick. And, while patients may be seeking disability, workman's compensation, or pursuing other types of litigation, it's more likely they have become trapped in a system that is reinforcing the illness rather than that they are simply faking one.

TCPR: Can you explain how that happens?

Dr. Clark: In these cases, the incentives are in conflict. While the patient may want to go back to work and to a productive life,

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Research Updates IN PSYCHIATRY

Section Editor, Bret A. Moore, Psy.D, ABPP

Dr. Moore has disclosed that he has no relevant financial or other interests in any commercial companies pertaining to this educational activity.

BEREAVEMENT

Treating Complicated Grief: Grief-Focused Psychotherapy Is More Effective Than Citalopram

REVIEW OF: Shear M et al, *JAMA Psychiatry,* 2016;73:685–694; Study type: Randomized plabebo-controlled trial

Complicated grief (CG) is a relatively common response in those who have suffered the loss of a loved one. In DSM-5, it is listed in the section on conditions for further study, and it is called "persistent complex bereavement disorder." To meet the diagnostic criteria, your patient must have suffered bereavement for at least 6 months, and must have had at least 3 of a list of symptoms for 1 month. While there is some overlap with major depression, CG has core symptoms of yearning and sorrow and great difficulty accepting the reality of death. It's one of the more controversial proposed DSM disorders, with critics seeing it as medicalizing a normal human experience. Nonetheless, there has been a lot of research on how to help people with CG, and a specific psychotherapy, called complicated grief treatment (CGT), is clearly effective. But how does therapy compare with a standard antidepressant?

To answer this question, researchers recruited 395 individuals diagnosed with CG; the majority were women, the mean age was 53, and the mean number of years since the loss was 4.7. These patients were randomized to one of four groups: citalopram (n = 101), placebo (n = 99), CGT with citalopram (n = 99), and CGT with placebo (n = 96). The citalopram (CIT) was flexibly dosed with an average of 33.9 mg/day. Spanning 20 weeks, patients were assessed monthly with the Clinical Global Impression scale (CGI), which was the primary outcome measure. Secondary measures to assess depression included the self-report version of the Quick Inventory of Depressive Symptoms and a modified version of the Columbia Suicide Scale.

RESULTS

The main outcome measure was the response rate after 20 weeks, defined as "much improved" or "very much improved" on the Clinical Global Impression scale. Patients in the CGT groups did the best, whether the therapy was combined with CIT (83.7% response rate) or with placebo (82.5%). Adding CGT to CIT was more effective than CIT alone (83.7% vs. 69.3%), and CIT alone was numerically superior to placebo, but it didn't quite reach statistical significance (69.3% vs. 54.8%, p = 0.11). On a secondary measure of depressive symptoms, adding CIT to CGT did outperform CGT alone.

TCPR'S TAKE

CGT was clearly more effective for complicated grief than CIT. While CIT alone did not statistically outperform placebo, there is a factor that might have put the medication at a disadvantage. The 2011 FDA warning about high CIT doses causing EKG abnormalities was issued a year into the study, forcing researchers to decrease the maximum dose allowed from 60 mg to 40 mg. That led to a lower-than-planned CIT average dosing of 33.9 mg, which may have limited its efficacy.

PRACTICE IMPLICATIONS

The bottom line is that while CGT is the treatment of choice for CG, adding an SSRI to this psychotherapy might provide a small efficacy boost for depressive symptoms.

Tales from the HISTORY OF PSYCHIATRY

Opium, an Ancient Psychotropic

Marcia Zuckerman, MD, director of psychiatric services at Walden Behavioral Care in Waltham, MA

Dr. Zuckerman has disclosed that she has no relevant financial or other interests in any commercial companies pertaining to this educational activity.

These days, opiates are primarily prescribed to treat pain. But there is a long history of using opiates to treat depression and other mental illness. Starting in the 700s, Arabian cultures used opium in mental hospitals in Baghdad, Damascus, Fez, and Cairo that also incorporated milieu therapy such as music, reading, and sexual stimulation. In the Victorian era, Thomas Sydenham popularized Sydenham's Laudanum, a mixture of opium, sherry, wine, and herbs. Laudanum, which was affordable at 20 or 25 drops for a penny, was used for depression and hysteria, as well as to soothe small children. (The laudanum that is currently available by prescription in the U.S., often known as "tincture of opium," no longer contains alcohol.) Many of the opium preparations were prescribed for women in response to problems with menstruation and childbirth, as well as "the vapours," a loose term that included hysteria, depression, mood swings, and fainting. As physicians began to appreciate the risk of addiction with opium preparations, they fell out of favor in the medical establishment, leading to regulation and, essentially, prohibition, in 1914 by the Harrison Narcotics Tax Act. Interestingly, the use of opiates to treat depression may have come full circle. Small research studies (eg, Bodkin JA et al, *J Clin Psychopharmacol* 1995;15(1):49–57) have shown a benefit for Suboxone, an opiate partial agonist-antagonist in treatment resistant depression, although the risk of addiction and misuse may outweigh the benefits.

CME Post-Test

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For those seeking ABPN Self-Assessment (MOC) credit, a pre- and post-test must be taken online at http://thecarlatcmeinstitute.com/self-assessment/

Below are the questions for this month's CME/CE post-test. This page is intended as a study guide. Please complete the test online at www.TheCarlatReport.com. Note: Learning Objectives are listed on page 1.

1. Using the "Cycle of Pain" model, maladaptive thoughts such as, "I know I'm going to be in more pain if I go out" contribute to which of the following outcomes? (LO #1)
   [ ] a. Anxiety [ ] b. Aggression [ ] c. Isolation [ ] d. Mania

2. According to Dr. Clark, one of the disadvantages to using anticonvulsants like Depakote and Lamictal for neuropathic pain is the possibility of drug interactions. (LO #2)
   [ ] a. True [ ] b. False

3. Which condition puts patients at approximately two to three times the risk of developing a chronic pain syndrome? (LO #2)
   [ ] a. Bipolar disorder [ ] b. Generalized anxiety disorder [ ] c. Epilepsy [ ] d. Depression

4. According to Dr. Otis, when developing a treatment plan for pain patients, what is the most effective way for them to achieve goals? (LO #1)
   [ ] a. Ask patients to set general yearly goals
   [ ] b. Ask patients to set weekly goals
   [ ] c. Ask patients to set goals according to their own time period
   [ ] d. Ask patients to set daily goals

5. In a recent randomized placebo-controlled trial, patients receiving complicated grief treatment (CGT) combined with citalopram showed 35% more improvement after 20 weeks compared to the patients receiving CGT and placebo. (LO #3)
   [ ] a. True [ ] b. False

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Expert Interview

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they are actually being paid, or more accurately, being reinforced for remaining in the sick role and exhibiting the behavior of disability. The patient is at the center of a complex web of factors that make it more difficult to become functional and independent. Patients often feel the risk of returning to work is too high—if they fail, the benefits they were receiving for having been injured or unable to work are gone.

TCPR: So you're saying that secondary gain can play an important part in maintaining the lifestyle of someone who has chronic pain.

Dr. Clark: Not exactly. It is true that illness behavior and disability can be reinforced by a system that does not necessarily have the patient's best interests at heart. And it can sometimes be the case that the patient is taking advantage of that broken system. But, usually this is not at the level of manipulation or malingering so much as it is a way of life that emerges little by little. Think about it. If I said to you, "Think about how much money you're making now and all the hassles that you have to put up with to make that money. Or, you could stay at home and get 60% of your income tax free as long as you continue to go to doctors' appointments to confirm that you're still sick." What would you do?

TCPR: That's a good question, and frankly, I'm not sure what I would do.

Dr. Clark: It comes down to what's motivating you every day. And as doctors, it's our job to help patients find a path toward being functional even in the presence of some pain, and even when some of the incentives are aligned against that outcome.

TCPR: I agree, and thanks very much for your time, Dr. Clark.

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This Month's Focus:
Pain Management

Next month in *The Carlat Psychiatry Report:* Side Effects

Managing Chronic Pain in Psychiatric Patients

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illustration connecting pain, distress, and disability.

2. Teach your patients to notice the way they think, the types of automatic thoughts, they tend to have, and how these thoughts can impact everything they do. Once patients are aware of their thoughts they can begin to take steps to change them. You can download a useful restructuring sheet at Painpsych.com/Pain-Resources.
3. Set concrete goals with your patients to increase their activity level even in the presence of their pain issues. Collaborating with a physical therapist can be an effective way to map progress within the context of a patient's limitations.

For more information, see:

http://www.painpsych.com/

Otis, JD. *Managing Chronic Pain: A Cognitive-Behavioral Therapy Approach*, Therapist Guide. Treatments that Work Series. New York, NY: Oxford University Press; 2007.

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