For people with pain “How do you spell relief?” can be a very difficult question. Many of them come to the ACPA after years of trying to find a way to relieve their pain. They’ve tried everything. They’ve seen just about every kind of health care provider you can imagine. And they have tried things that are on traditional medicine’s furthest borders, somewhere between alternative and desperate.

Calls come into our office daily from people with pain who are at their wits’ end, drained emotionally, physically, and financially from their efforts to seek relief. Many have given up on finding a means to end the pain and are just hoping for something—just what, they don’t quite know.

The list of things they have tried reads like a medical dictionary. In the beginning, they hope to find a simple solution to relieve their pain. But eventually, they move on to nerve blocks, biofeedback, acupuncture, radio frequency, massage, surgery, medications, physical therapy, electrical nerve stimulation, medications, vitamins, yoga, meditation, counseling, dieting, macrobiotic diets, swimming, walking, magnets, quitting their job, and moving to another part of the country. You name it, they’ve tried it. And when they hear of a new treatment—no matter how much they say they have given up—they will still jump at the chance for relief.

Many of these folks have the same problem I had. I tried each of these things, one at a time. If a therapy or treatment didn’t work, I would discontinue it and move on to the next thing. That was my pattern for six years. Then I found myself in a pain management program that offered many of the same solutions I had tried over the years.

But after almost six weeks of pain management I found that I had moved from being a disabled patient to living as a functioning person. It wasn’t magic. In fact it was a very difficult transition. There were a lot of factors involved, but the key was this:

CONTINUED ON PAGE 7...
Spelling Relief During the Holidays

by Sally Price

It's that time of year again. Many people are stressed out with lists of must-dos for this busy season of parties and gift giving.

For persons with chronic pain, such a list can be their Scrooge, stealing all their holiday spirit and more. Dave Duhrkoop, 59, of Troutdale, Oregon (near Portland), was determined that Scrooge would not send his spinal pain soaring. He keeps this spirit-stealer at bay with significant and frequent self-talk.

Temptations to overdo or over-expect abound around the holidays. “Superman and Superwoman are dead,” Dave reminds himself. “The holidays especially are a time of year when expectations are greater than at any other time of year,” said Dave. “Everyone is expected to be happy and exuberant and to have super endurance.”

To keep his pain in check during the holidays and any other time, Dave says he has worked hard at knowing himself. “I call it redefining yourself as ‘you with pain,’” he said. He did an assessment of his life before and after chronic pain, accepting the things he could no longer do but focusing on the things he could do and continues to do.

A Daily Self-Assessment Helps

First thing in the morning, when he looks at himself in a mirror, Dave counts his blessings, thankful to be alive, regardless of how he looks or feels. He then realizes another day is at hand, and asks the following questions:

1. What things in my life am I actually grateful for?
2. What can I do to make this day different, such as looking out for the small stuff?
3. What impact could I possibly have on another person today?
4. Am I going to let my pain and bad attitude distract me from having a good day? (Remember, it’s a choice.)
5. If I am in charge of my day—and my attitudes—then how can any outside influences mess it up?

People love to be around positive people because negative people are a dime a dozen.

“People love to be around positive people because negative people are a dime a dozen," said Dave. (He does recognize that negativity can reflect illness and that persons with chronic depression need to seek treatment.)

Define Yourself Realistically

Dave said that just the act of listing in his mind the things that are good in his life makes a difference. “This is especially important in today’s fast-paced world where the media are constantly trying to define us,” he said. “We need to have a good hold on who we are.”

With this mindset people won’t start thinking they need to be healthy and someone else may be likely to do something simply to please another person. “Don’t do things you don’t want to do. I have no problem in saying I can’t make it,” Dave said. “It’s how I take care of myself, plus it allows me to be stronger in areas when I need to be.”

Multiple Methods to Manage Pain

Dave began his odyssey with chronic pain in 1990. After multiple neck and low back surgeries, he was told he had arachnoiditis (inflamed layers around nerve bundles along the spine secondary to surgery), aggravated by a former back infection. He has disc problems and stenosis (narrowing) of the spine as well. As part of his treatments, he has two implanted pain devices—a spinal stimulator and a medication pump. When managing his back pain with medications, he tries to balance his mental alertness with the pain.

In addition to his physical aids, medication, and constant attitude adjustments, Dave uses exercise, healthy eating, and spirituality to manage the pain. Of the last, Dave said his personal religious beliefs have had a tremendous impact on his attitude. “Since I’ve become a Christian, my pain has become much more acceptable to deal with. It’s the same pain and problems, but knowing I have a higher power I can turn my pain over to is most important to me.”

Dave said normally his pain is 6 or 7 on a 10-point scale (10 being the most pain possible), but with the combination of life changes he has made, the pain is about a 3. He uses a little of everything to manage his pain, a little bit of medicine but not too much, and a little exercise.

Learning to Ask for Help

Working with the ACPA group that he facilitates, he has learned to stick up for himself. This has come in handy, he said, in emergency rooms, both for himself and when acting as an advocate for others in pain.

His assertiveness has also helped him to do one of the hardest things for people with chronic pain: ask for help. “I loathe asking for help but I will break my back for a friend,” he said, suddenly realizing the irony of his words. While this hard for him to ask others, he likes it when someone asks him for help.

And he keeps his sense of humor. Explaining that he’s six feet two and 200 pounds, he tells of the “funny looks” he gets when “I ask someone to take my groceries out to the car for me.” Does he feel he needs to explain? “No, I’ve learned to do that without feeling bad about it,” he said.

Dave is looking forward to the holiday season because he has learned a lot of lessons about pain control. “You deserve to be as happy during the holidays as you can be. Your pain isn’t going to go away, just because it’s Christmas. Your attitude about yourself and the world around you is what sets you apart as a special person.”

“You can live with chronic pain and still enjoy a great quality of life. Like you, I suffer from chronic pain and like you I have been on a quest the last 14 years that has brought me to a point of equilibrium in my life,” he said. “Learn to trust yourself. You can be your own best coach! Learn to live with your pain as an extension of your life.”

As Dave said, chronic pain is not the enemy, but rather an extension of you. And that “you” deserves to enjoy the holidays, too.
The Search for Pain Relief Spans History

by Alison Conte, Editor, Chronicle

I f you spell relief with prayer, meditation, or music, or yearn for a magic bullet to cure all ills, you have something in common with early civilizations. Since ancient times, human beings have used magic spells, dances, music rituals, prayer, sacrifice, and herbal remedies to try to relieve pain, fighting symptoms that they couldn’t see or understand.

The history of pain treatment goes back to Greece, Egypt, and China where early healers used techniques and medicines that evolved into pain treatments we commonly use today.

Indeed, it was the Greeks and Romans who first theorized that the brain and nervous system produced the perception of pain. Much later, LEONARDO DA VINCI suggested that the brain was the central organ responsible for sensation and that the spinal cord transmitted these sensations to the brain. In 1664, the French philosopher RENE DESCARTES described “bits of fire” bringing messages of pain from a foot to the brain, in what is still called a “pain pathway.”

Herbs and Medicines

In Homer’s Odyssey, Helen of Troy provides Ulysses and his companions with a drug to “lull pain and anger and bring forgetfulness to every sorrow,” probably a reference to opium. Some herbal remedies used in the Middle Ages in Europe contained useful opiates, but those that contained gold, ivory and “unicorn horn,” were less effective.

Opium’s power to relieve pain was widely recognized by the time of the Renaissance. PARACELSUS, (1493-1541) was a chemist, mystic, and physician who suggested a mineral-based approach to health problems, as opposed to the herbal medications in use at the time. He described the action of ether on children, reporting that this substance “quiets all suffering and relieves all pain.” Unfortunately, this discovery was not followed by any clinical application until the 1800s. Paracelsus also combined opium with alcohol to form laudanum, used for the relief of pain well into the 19th century.

In the U.S. in the late 1800s and early 1900s, dubious medical men recommended magnets and electricity for their healing properties and these treatments continue to impress some believers. A wide variety of concoctions labeled as balms or liniments were sold to people in pain and the ones that contained alcohol or cocaine probably provided some relief, along with the expected intoxication. Later, serious physicians and scientists would develop more reliable processes by which opium, morphine, codeine, and cocaine could be used to treat pain.

The heat from a hot, wet mustard plaster, popular in the 1930s, was a forerunner of treatment by “counter-irritant.” This is using one kind of pain or sensation to cancel out another, more severe pain, a practice that has been refined and is used today.

In 1817 Prussian pharmacist F.W.A. SERTURNER isolated morphine as the active ingredient in opium. The management of pain with morphine was somewhat limited until FRANCIS RYND in Ireland and CHARLES PRAVAX in France developed the hypodermic syringe and hollow needle in 1853.

Anesthesia for Surgical Pain

Discoveries related to minimizing surgical pain—such as chloroform, nitrous oxide, and ether around 1831—led to painless surgery to reduce chronic pain. Operations for trigeminal neuralgia, posterior rhizotomy, and retrograde syringe and hollow needle were developed.

In 1884 CARL KOLLER worked with SIGMUND FREUD on the use of cocaine as a treatment for morphine addiction. Soon, cocaine was providing effective anesthesia in many types of surgery, nerve blocks, and spinal, epidural, and caudal anesthesia. Its use spread to acute-pain and chronic-pain relief, until the toxic and addictive effects of cocaine became known and the practice was discontinued.

Other inventions were used to alleviate severe and persistent pain, including radiotherapy and X-rays (WILHELM ROENTGEN in 1895), light therapy, electrotherapy, hydrotherapy, thermotherapy, and mechanotherapy.

Anesthesia for Surgical Pain

Discoveries related to minimizing surgical pain—such as chloroform, nitrous oxide, and ether around 1831—led to painless surgery to reduce chronic pain. Operations for trigeminal neuralgia, posterior rhizotomy, and retrograde neuroectomy were developed.

In 1884 CARL KOLLER worked with SIGMUND FREUD on the use of cocaine as a treatment for morphine addiction. Soon, cocaine was providing effective anesthesia in many types of surgery, nerve blocks, and spinal, epidural, and caudal anesthesia. Its use spread to acute-pain and chronic-pain relief, until the toxic and addictive effects of cocaine became known and the practice was discontinued.

Other inventions were used to alleviate severe and persistent pain, including radiotherapy and X-rays (WILHELM ROENTGEN in 1895), light therapy, electrotherapy, hydrotherapy, thermotherapy, and mechanotherapy.

Chronic Pain as Disease

Around 1945 the French surgeon RENE LERCHE identified chronic pain as a disease state, describing treatment of causalgia and reflex sympathetic dystrophy. Other physicians began to study the diagnosis and relief of pain and sympathetic-block anesthesia became a popular treatment of pain involving known nerve tracts and pain of obscure origin.

During World War II JOHN BONICA, an anesthesiologist, was one of the first physicians to appreciate the difficult problems presented by people with chronic pain. He realized that complex pain problems could best be managed by a team approach. In 1960, Dr. Bonica developed one of the first multidisciplinary pain centers in the U.S. at the University of Washington in association with DR. LOWELL E. WHITE JR., and nurse DOROTHY CROWLEY.

In recent years, the use of high technology has helped doctors understand the mechanisms of pain much better and provide new treatment modalities, according to STAN CHAPMAN, PH.D. “In select cases, patients are helped by PET scanning to understand how pain is processed in the brain and by the availability of advanced methods of spinal cord stimulation, radiofrequency lesioning, and innovative delivery systems for medications,” he said.

Today there are many improvements in interventional treatments for chronic pain and more options, medications, and other methods of pain relief. “Research keeps expanding and the field of chronic pain management has matured from a fledgling organization of a few professionals to a field in its own right, with its own organizations, journals, and board exam for physicians,” Chapman added.

However, Dr. Chapman reminded us that there are still too few practitioners to treat people long term and more comprehensive rehabilitation programs aimed toward emotional coping and functional restoration are needed.

CONTINUED ON PAGE 6...
“For those in need of comprehensive interdisciplinary management, treatment options are poorer and more limited than it was the case 15 years ago,” he said.

**Learning from the Past**

**DR. STEVEN FEINBERG,** physiatrist and pain medicine specialist with more than 20 years in pain management, feels that the most important development in recent history is the recognition that chronic pain is best managed by a treatment team of doctors and therapists as educators who shift health and well-being responsibility to the individual.

“The functional restoration model includes timely and accurate diagnosis and evidence-based treatment; treating the individual with respect and dignity, assessment of the person’s psychosocial strengths and weaknesses and support system; efforts at education along with expectation management; functional goal setting; ongoing assessment of patient participation and compliance, complicating problems, and progress toward achievement of goals,” said Dr. Feinberg.

HILDE BERDINE, PharmD, BCPP, agreed. She is assistant professor of pharmacy practice at Mylan School of Pharmacy, Duquesne University, Pittsburgh. “In my practice I try to approach the patient holistically, especially those people with chronic pain. As clinicians, we must focus on the psychological aspects of pain and use other than drug therapies in treating pain. I believe alternative therapies can be explored, such as biofeedback, meditation, and group support,” she said.

A significant advancement is the identification, assessment, and treatment of pain as a priority in medical care. “We need to assess pain as the fifth vital sign, from pediatric patients to the elderly. We must believe the patient’s report of pain and treat pain and the patient with dignity and respect, regardless of ethnic background, cultural beliefs, or past history of substance abuse,” she said.

To build on the progress of the past, the future must include multidisciplinary conservative chronic pain care, said Dr. Feinberg. Along with limited medication and education for relapse prevention, he advocates for “proper activity and work pacing, ergonomic accommodation, and when appropriate, transitional return to gainful employment.”

Though the history of pain shows us that we have made great progress in treating chronic pain, all the medications and invasive interventions are “just tools in the tool chest of the physician,” as Dr. Feinberg said. “Ultimately, the successful individual with chronic pain takes control of life and minimizes interactions with the medical community. It is all about having a useful, happy, and productive life despite having a chronic pain problem.”

**Sources:**

- A more extensive list of organizations concerned with specific and general chronic pain can be found on the ACPA Web site at Partners for Understanding Pain, [http://www.theacpa.org/pa_main.asp](http://www.theacpa.org/pa_main.asp).
- The International Association for the Study of Pain (IASP) was incorporated in 1974 and now publishes the scientific journal *Pain*.
- The American Society of Regional Anesthesia (ASRA) initially was founded in 1923.
- The American Pain Society (APS) started in 1978.
- The American Chronic Pain Association was founded in 1980.
- The American Academy of Pain Medicine was organized in 1983 and publishes *Clinical Journal of Pain*.
- The World Institute of Pain was organized in 1994 and publishes *Current Review of Pain*.

**Relief**

*Continued from Page 1…*

For those in need of comprehensive interdisciplinary management, treatment options are poorer and more limited than it was the case 15 years ago,” he said.

**History of Pain Relief**

“Though the history of pain shows us that we have made great progress in treating chronic pain, all the medications and invasive interventions are ‘just tools in the tool chest of the physician,’” as Dr. Feinberg said. “Ultimately, the successful individual with chronic pain takes control of life and minimizes interactions with the medical community. It is all about having a useful, happy, and productive life despite having a chronic pain problem.”

Sources:

- A more extensive list of organizations concerned with specific and general chronic pain can be found on the ACPA Web site at Partners for Understanding Pain, [http://www.theacpa.org/pa_main.asp](http://www.theacpa.org/pa_main.asp).

**Growth in Organizations for Pain**

Today we understand that pain is more than a temporary inconvenience. When it impairs daily life and productivity, it becomes a serious economic and major health problem.

A number of organizations now help people with pain and work to educate pain management professionals.

- The International Association for the Study of Pain (IASP) was incorporated in 1974 and now publishes the scientific journal *Pain*.
- The American Society of Regional Anesthesia (ASRA) initially was founded in 1923.
- The American Pain Society (APS) started in 1978.
- The American Chronic Pain Association was founded in 1980.
- The American Academy of Pain Medicine was organized in 1983 and publishes *Clinical Journal of Pain*.
- The World Institute of Pain was organized in 1994 and publishes *Current Review of Pain*.
- The World Institute of Pain was organized in 1994 and publishes *Current Review of Pain*.

A more extensive list of organizations concerned with specific and general chronic pain can be found on the ACPA Web site at Partners for Understanding Pain, [http://www.theacpa.org/pa_main.asp](http://www.theacpa.org/pa_main.asp).

The functional restoration model includes timely and accurate diagnosis and evidence-based treatment; treating the individual with respect and dignity, assessment of the person’s psychosocial strengths and weaknesses and support system; efforts at education along with expectation management; functional goal setting; ongoing assessment of patient participation and compliance, complicating problems, and progress toward achievement of goals,” said Dr. Feinberg.

Dr. STEVEN FEINBERG, physiatrist and pain medicine specialist with more than 20 years in pain management, feels that the most important development in recent history is the recognition that chronic pain is best managed by a treatment team of doctors and therapists as educators who shift health and well-being responsibility to the individual.

“The functional restoration model includes timely and accurate diagnosis and evidence-based treatment; treating the individual with respect and dignity, assessment of the person’s psychosocial strengths and weaknesses and support system; efforts at education along with expectation management; functional goal setting; ongoing assessment of patient participation and compliance, complicating problems, and progress toward achievement of goals,” said Dr. Feinberg.

HILDE BERDINE, PharmD, BCPP, agreed. She is assistant professor of pharmacy practice at Mylan School of Pharmacy, Duquesne University, Pittsburgh. “In my practice I try to approach the patient holistically, especially those people with chronic pain. As clinicians, we must focus on the psychological aspects of pain and use other than drug therapies in treating pain. I believe alternative therapies can be explored, such as biofeedback, meditation, and group support,” she said.

A significant advancement is the identification, assessment, and treatment of pain as a priority in medical care. “We need to assess pain as the fifth vital sign, from pediatric patients to the elderly. We must believe the patient’s report of pain and treat pain and the patient with dignity and respect, regardless of ethnic background, cultural beliefs, or past history of substance abuse,” she said.

To build on the progress of the past, the future must include multidisciplinary conservative chronic pain care, said Dr. Feinberg. Along with limited medication and education for relapse prevention, he advocates for “proper activity and work pacing, ergonomic accommodation, and when appropriate, transitional return to gainful employment.”

Though the history of pain shows us that we have made great progress in treating chronic pain, all the medications and invasive interventions are “just tools in the tool chest of the physician,” as Dr. Feinberg said. “Ultimately, the successful individual with chronic pain takes control of life and minimizes interactions with the medical community. It is all about having a useful, happy, and productive life despite having a chronic pain problem.”

Sources:

- A more extensive list of organizations concerned with specific and general chronic pain can be found on the ACPA Web site at Partners for Understanding Pain, [http://www.theacpa.org/pa_main.asp](http://www.theacpa.org/pa_main.asp).

ABC News, May 9, 2005, “A Brief History of Pain, Did Ancient Cultures Understand Pain Treatment Better Than We Do?”


S

ince the early days of his career, Dennis C. Turk, Ph.D., has been
driven to understand pain and how it can be alleviated. His 30 years of
experience have given him an understand-
ing of the magnitude of the pain
problem as well as ideas about how
to improve treatment in the future—ideas
that don’t involve any “magic pill” or
single breakthrough treatment method.

“Pain is a national epidemic, but we’ve
done a miserable job of getting the
word out,” Turk says. Because pain can
be caused by many different diseases,
injuries, and syndromes, the magnitude
of the pain problem gets lost. “There
are foundations and charities for
diseases that cause pain, but there’s
no poster child for pain,” Turk points
out. And pain has a high cost to individu-
als, their families, and to society,
whether it’s caused by a short-term
problem or by something that will
never be fixed. In a recent president’s
message for the American Pain Society,
Dr. Turk cited statistics that say
42 percent of American adults experience
pain every day, and that pain’s effect on
families may be even more signifi-
cant than its effect on individuals with
pain (see the sidebar for more details).

A psychologist by training, Dr. Turk
began his research on pain in the mid-1970s. He has carried that interest
through his career, both in his own
research and in his clinical and teach-
ing activities. At Yale University, he
taught courses on pain assessment and
on coping skills, both subjects of his
early research. In the early 1980s he
moved to the University of Pittsburgh,
where he directed the Pain Evaluation
and Treatment Institute at Presbyterian
University Hospital (now University of
Pittsburgh Medical Center). Currently,

Dr. Turk is the

John and

Emma Benicia

Professor of

Anesthesiology

and Pain

Research

and

directs the

Fibromyalgia

Research

Program at the

University of Washington School of

Medicine in Seattle. He is a former
ACPA board member, the current chair
of the ACPA’s Professional Advisory
Board and has just completed a two-
year term as president of the American
Pain Society, a multidisciplinary orga-
nization for health care professionals.

Despite the significance of the pain
problem, Dr. Turk points out that
our arsenal for combating pain has
changed surprisingly little since ancient
times. Opioids, nonsteroidal anti-inflam-
matories like aspirin, surgery, and electrical
stimulation have been used as pain
management strategies for thousands of years.”

The standard recorded treatment for pain
was opium for headaches. Prehistoric
skulls have been found with precisely
cut holes believed to be created to
relieve pain, and willow bark, from
which aspirin is derived, was recom-

mended by Hippocrates,” Turk says.

“The early Greeks used torpedos fish,
which give off an electric current, to
relieve pain. Today we have opioids,
nonsteroidal anti-inflammatory drugs
(aspirin), surgery, and transcuta-

neous electrical neurostimulation,”

Turk says.

Treatment techniques have improved
greatly, of course, and modern pain-
relieving drugs and surgery techniques
are much more sophisticated than
primitive ones, but Dr. Turk says that
no truly new treatment options have
come to light; rather we have variations
on the ancient approaches. This differ-
ence is striking when you think about
how many breakthroughs have come in
other areas of medical science over the
past few decades—new cancer
treatments, for example, or advances
in diabetes care.

Although he expects no new treatment
options, Dr. Turk sees great hope in the
area of treatment customization. “I
think we’re going to move away from
treating everyone with the same disease
the same way,” he says. Scientists are
beginning to understand why the same
treatment doesn’t work for every person
with the same problem. “Now, we have the
idea of a ‘standard treatment,’” he
says, “but just because someone has
migraine, for example, that doesn’t mean
they’re just like everyone else who
has migraine.”

Genetic research has shown that people of
different ethnic backgrounds respond differently
to some medications. And differences are
also being uncovered in the way
men and women experience pain,
adapt to symptoms, and respond to
pain treatments.

The individual characteristics of people
at risk for chronic pain also might be
used to change how they are treated.
Dr. Turk is currently doing research on
whiplash injuries sustained in motor
vehicle collisions to determine what
factors predict who will develop lasting
neck pain following a whiplash injury
and who will recover quickly. These
factors might have to do with prior
history, the type of injury, or be traits
of the injured person. The study also is
testing a rehabilitation program to
see if it can prevent the development
of chronic pain and disability.

“We need to find out what characteris-
tics predict how an individual is going
to respond to treatment, and use that
to customize the treatment to the indi-
vidual,” Turk says. He points out that
this is a frequently overlooked concept
in medical research. “Treatment studies
talk about ‘average differences’, which
means that some patients did well and
some did not,” he says. “We need to do
responder analysis to determine what
the characteristics are of the people
who did well on that treatment com-
pared to those who did not.”

Dr. Turk’s president’s message for the American Pain Society (APS) for winter 2006 presented statistics from a survey of pain and discussed pain’s impact on society.

Here are some of the points he made:

42 percent of all adults in the United States experience daily pain of some sort; 89 percent experience pain at least once a month. (Gallup/Anthins Foundation 2000)
Every year nearly half of all Americans see a physician because of pain. (Mayer Clinic, 2000)
Chronic pain is responsible for more than $350 billion in healthcare and disability costs annually. (U.S. Census Bureau, 1996)
Productivity loss among workers with common pain conditions accounts for 632 billion per year (Skawt et al., 2000)
Assuming two close family members for each of the 50 million Americans with chronic pain, pain directly affects roughly half of the U.S. population.
A 1987 study found that the spouses of people in a pain rehabilitation program had 2.5 times more depression than the patients themselves. (Flor et al., 1987)
Less than one percent of the budget-supported grants given by the National Institutes of Health in 2003 were awarded to projects with a primary focus on pain. (Brindley et al., 2005)

Dr. Turk’s president’s message for the American Pain Society (APS) for winter 2006 presented statistics from a survey of pain and discussed pain’s impact on society.

Dr. Turk also witnessed the growth of the support group movement first hand as an ACPA board member from 1996 to 1999. “While at Yale I had sent a letter to ACPA founder Penney Cowan saying that I was interested in what she was doing,” Turk says. “Coincidentally, I ended up in Pittsburgh soon after that. She snapped me up immediately.”

Although he left Pittsburgh in 1996, Dr. Turk stays involved with ACPA as a member of its professional advisory board.

In the future, Dr. Turk hopes support groups will continue to improve in 

quality through organizations like ACPA that present a positive message and provide organizational resources. He also believes the support movement will need to become more inclusive. “Support groups tend to be a middle class phenomenon, but pain doesn’t discrim-
inate,” he says. People of lower socio-
conomic status who are just getting
by might not have time to attend a
traditional support group meeting, but
they could benefit from the resources of
groups like ACPA.

“When you think beyond the individ-
ual with pain to include his or her impact on significant others (for exam-
ple, family, co-workers) and communi-
ty, you see that pain has costs not just in dollars spent on health care,” says
Dr. Turk. Ironically, the key to solving
that problem might be to look more
specifically at individuals than we have
in the past. It is a mission that
Dr. Turk continues to champion.
ACPA Update

Radio Program on Breakthrough Pain

Millions of people across the U.S. learned the facts about breakthrough pain on October 3, when the ACPA conducted a radio media tour, funded by an unrestricted educational grant from Cephalon, Inc. The broadcasts included basic introductory information and a question/answer session.

ACPA founder and executive director Penney Cowan, ACPA board member Dr. Ross H. Todd, director of the Pain and Emergency Medicine Institute at Beth Israel Medical Center, led the discussion.

Breakthrough pain (BTP) is an intense increase in pain that occurs suddenly even when pain-control medication is being used, according to Dr. Todd. It can happen spontaneously or in relation to a specific activity, sometimes three to four times a day, and last an average of 30 to 60 minutes. Sadly, four percent of people treated for chronic pain associated with cancer and 74 percent of people treated for other chronic pain conditions will experience BTP.

Penney reviewed how untreated BTP affects people physically and emotionally, with the fear of increased pain preventing them from enjoying normal activities. Paying attention to when BTP occurs can help, as you work with your doctor to develop a treatment plan. This might involve medication, relaxation techniques, pacing your activities, and learning different pain management skills to reduce the triggers that cause these flares.

To receive a free pamphlet, Managing Breakthrough Pain, contact the ACPA national office at 1-800-533-3231 or email ACPA@pacbell.net.

U.S. News Article Reviews Online Information

As we all know, the Internet can be a powerful source of information—and misinformation—about pain treatment. But it can also offer a community of support for people in pain, according to an article on the U.S. News and World Report Web site.

“The Web can offer the therapy of community—the knowledge that you are not alone, and tips from people suffering in similar ways,” it states. It also quotes Kristianne Sunde, resource coordinator for the ACPA, who says, “Talking to others who experience intractable pain is itself a tonic.” You can find a link to the article at www.theacpa.org.

New ACPA Groups

Welcome to our new groups:

Dallas Needham
Hemet, CA

Neal Nicolason
Long Beach, CA

Robin West
Placerville, CA

Judith Mitchell
Placerville, CA

Rani Fleury
Placerville, CA

Pat Merzitt
Stanhope, NJ

ACPA Facilitators Have a New Coach

Kristianne Sunde really loves her job. As the new Facilitator Resource Coordinator for the ACPA, she gets to talk with support group facilitators and regional directors from Russia, Ireland, Australia, Brazil, and Canada, as well as across the United States. “The Boston accents are the trickiest,” she said laughing. “But I love building relationships with them as well as their families. It is just such a joy and encouragement to me.”

Kristianne, 20, works part time at the ACPA office, helping to connect with our 236 support group leaders and establish a better system of communications among them. “I’m their coach and their cheerleader, encouraging them to be better at what they’re already great at,” she said.

Kristi is available to any member, but especially to facilitators who need help in running their support groups. “We have posters, supplies, materials—anything they need we will do our best to provide,” she said. She is also collecting ideas from facilitators—from New England to Canada to California—in hopes that she might share these ideas with others. “We can share strategies on how to start a group, build attendance, resolve conflicts, and increase participation, as we learn from each other’s experiences and work as a team,” she said.

I am so impressed with our facilitators’ strength and dedication

Kristi worked as Penney Cowan’s administrative assistant at the ACPA in 2005, but moved out of the area to continue her education at Fresno Pacific University in Fresno, California. When the Facilitator Coordinator position was created in the summer of 2006, she seemed a perfect fit, as she was making plans to move back to her hometown in Rocklin, within a five-minute drive of the national office of the ACPA.

When she’s not at the ACPA, Kristianne is at William Jessup University (Rocklin, California) working toward her two bachelor’s degrees in Youth Ministry and Bible/Theology. She lives with her parents, two younger sisters, Brittany and Megan, and their beloved Golden Retriever, Sadie. She also enjoys playing and watching sports, reading, scrap-booking, quilting, traveling, volunteering at the local elementary school, and teaching the flute.

“The response has been wonderful,” Penney said. “It means so much to hear from someone who can validate the experiences and feelings of the person with pain and offer real tools for dealing more productively with a pain condition.”

Kristianne said that the New York State Legislature had unanimously passed the Palliative Care Education and Training Act. “It means so much to hear from someone who can validate the experiences and feelings of the person with pain and offer real tools for dealing more productively with a pain condition.”

In the post-program evaluation questionnaire, one attendee wrote, “I just heard about this event yesterday and have been in pain for some time. I thought this would be helpful, but it could only stay for part of the program. Ten minutes into it I felt I had to tell my job to tell them I wouldn’t be in to work. This was too important to leave.”

The program was underwritten by a grant from Pfizer. Learn more about managing nerve pain on our web site.

The Voices of People with Pain.

For the March issue of the Chronicle, we are asking ACPA members to share their stories. Give us your answer to: “What has living with pain taught me?” or “How has learning to manage pain changed my life?”

Please limit your story to around 600 words (one and a half pages typed, double spaced) and send it by January 15, 2007 to Alison Conte, Editor, ACPA Chronicle, c/o acpagroups@pacbell.net, or Resource Coordinator, ACPA, P.O. Box 850, Rocklin, CA 95677.
As a support group facilitator, I appreciate information from other facilitators on how they conduct their meetings. I know from visiting my groups over the years that all vary in interesting ways. It is easy to get stuck in one format for meetings, but we could “freshen up” any group by sharing ideas and change. Change is good!

In our Scottsdale, Arizona group, for instance, we pass around a seashell to give everyone a chance to talk. When you have the shell you can talk about hard to make eye contact with others when you are new to a group. It also gives you “the floor” with no interruptions.

Our Prescott, Arizona group wanted to use a pine cone, but I believe they changed to something a little less rough. If the person with the shell doesn’t feel like talking, he states his name, and passes it along. When the shell is passed, the group knows that a person is done speaking.

Shift Focus from Symptoms

For a couple of meetings in a row, I found people spent too much time describing all their symptoms and dwelling on pain, and other conditions that our group members had. I took the list outside the room and left it on a chair in the hallway (no names on it of course). Then I said, “All of our pain conditions are being left outside of the meeting.” It was a great way to demonstrate that we needed to concentrate on pain management skills, rather than our pain condition. It worked!

End with Relaxation

I usually end with a short relaxation session using guided imagery to help members relax each body part with emphasis on breathing. Or we use a relaxation tape. This, I find, is a great way to send people home, relaxed and calm. I have my meetings in the evenings twice a month. Usually, by the end of the day, most of us have higher pain levels, so by then, the relaxation really is appreciated.

Sometimes, members hesitate to get up to leave, as they are so relaxed. I am usually the one leading this exercise, talking in a calming slow, soothing voice. This relaxes me too.

Here are some other meeting ideas that have worked for us:

- Ask if a member would like to present a topic at a meeting, or conduct the small relaxation session.
- Ask for suggestions on types of guest speakers: psychologists, hypnotherapists, pharmacists, acupuncturists, etc.
- Have “family night” to encourage family or friends to attend (though they are always welcome). This year a couple of members brought young children, who participated and benefited from the meeting, learning that it wasn’t unusual to have a parent with pain problems.
- Gadget Night. Everyone brings in any apparatus they use to help their pain condition or side effects from it.
- Sharing hobbies or passions. One member brought a poem and another a cartoon. One did some stained glass crafts, and another showed a painting. This went over well, as people were so proud of their talents and it gave others ideas of what they might like to try.
- Some groups do mild exercises. I tried this, but it was not something my group was very receptive to. Sometimes, I do “office yoga” with them: mild stretches from a sitting position.

The ACPA Chronicle would love to hear what other group leaders do that works well for their members. Send your suggestions to acpgroup@pacbell.net, or Kristianne Sunde, Facilitator Resource Coordinator, ACPA, P.O. Box 850, Rocklin, CA 95677.

Facilitator’s Forum: What Works for Your Group?

by Penny Rickhoff, Arizona Regional Director

Penny Rickhoff, Arizona Regional Director, finds gardening is a hobby that helps her relax and manage her chronic pain. Having support group members share their hobbies and talents can add variety to the usual meeting agenda.

No matter what the theme is for the meeting, I always find at least a few minutes to talk about something in pain management that they can practice at home whether physical or psychological.

The ACPA Chronicle would like to hear what other group leaders do that works well for their members. Send your suggestions to acpgroup@pacbell.net, or Kristianne Sunde, Facilitator Resource Coordinator, ACPA, P.O. Box 850, Rocklin, CA 95677.

Special thanks to our hardworking regional directors:

- Pat Gebhardt, Oregon Regional Director
- Penny Rickhoff, Arizona Regional Director
- Diane Slomkowski, Ohio Regional Director
- Clare Trautmann, Mid Atlantic States Regional Director (West Virginia, Virginia, North Carolina, South Carolina, Georgia)
- Helen Caminiti, Central Pennsylvania Regional Director
- Marriann Farrell, Western Pennsylvania Regional Director
- Cindy Steinberg, New England Regional Director (Maine, Vermont, New Hampshire, Massachusetts, Rhode Island, and Connecticut)
- Stephen Kelly, Ireland Regional Director
- Margaret Knight, Australia Regional Director
- Marina L., Russia Regional Director

Facilitator’s Forum: What Works for Your Group?
**In Memory of**

**Geneva Cottrill**

Sadly, we lost another ACPA member this year—Geneva Cottrill. Penney Cowan remembers Geneva as being very active with the support group in Chillicothe, Ohio. “Every holiday her group would set up a table at a local department store and do gift wrapping to raise money for the ACPA. They were the only group to ever do that,” recalled Penney.

**In Memory of**

**Larry Bennett**

Larry, 87, was a familiar face to ACPA facilitators at retreats, lifting spirits with Sunday morning devotional messages over many years. Larry was a quiet, unassuming man who gave a strong message. Pat Gebhardt, ACPA Oregon regional director, remembers Larry as “an inspiring individual who had a great deal to share with younger, less experienced leaders.” At a retreat in 1995, he helped lead a workshop called “Good Grief: Dealing with Loss.”

“Larry had a wealth of information to share on all sides of the issue,” Pat said. She recalled that he was a chaplain during WWII, and later, a hospital chaplain. He lived with chronic pain for 25 years, most of that time as facilitator of an ACPA group in Harrisburg, Pennsylvania.

Everyone who was around Larry for any time was struck by the devotion he showed his wife, Betty.

She had chronic pain for the last six years of his life and he joked that they were the only husband-wife team in their ACPA group. She accompanied him to one retreat, at which they celebrated their 50th wedding anniversary. “The deep love and commitment between them was apparent to us all,” said Pat.

Larry loved the ACPA and credited its literature and support group as being of great help to him. “Although Larry was less active in recent years, his passing is truly a loss to ACPA,” said Pat.

“I can always picture Larry’s smile. It was special and made everyone feel good,” added Diane Slomkowski. “He was kind, understanding, and always willing to listen and hear what you had to say. He will be missed so much.”

**In Memory of**

**Geneva Cottrill**

Sadly, we lost another ACPA member this year—Geneva Cottrill. Penney Cowan remembers Geneva as being very active with the support group in Chillicothe, Ohio. “Every holiday her group would set up a table at a local department store and do gift wrapping to raise money for the ACPA. They were the only group to ever do that,” recalled Penney.

**In Memory of**

**Larry Bennett**

Larry, 87, was a familiar face to ACPA facilitators at retreats, lifting spirits with Sunday morning devotional messages over many years. Larry was a quiet, unassuming man who gave a strong message. Pat Gebhardt, ACPA Oregon regional director, remembers Larry as “an inspiring individual who had a great deal to share with younger, less experienced leaders.” At a retreat in 1995, he helped lead a workshop called “Good Grief: Dealing with Loss.”

“Larry had a wealth of information to share on all sides of the issue,” Pat said. She recalled that he was a chaplain during WWII, and later, a hospital chaplain. He lived with chronic pain for 25 years, most of that time as facilitator of an ACPA group in Harrisburg, Pennsylvania.

Everyone who was around Larry for any time was struck by the devotion he showed his wife, Betty.

She had chronic pain for the last six years of his life and he joked that they were the only husband-wife team in their ACPA group. She accompanied him to one retreat, at which they celebrated their 50th wedding anniversary. “The deep love and commitment between them was apparent to us all,” said Pat.

Larry loved the ACPA and credited its literature and support group as being of great help to him. “Although Larry was less active in recent years, his passing is truly a loss to ACPA,” said Pat.

“I can always picture Larry’s smile. It was special and made everyone feel good,” added Diane Slomkowski. “He was kind, understanding, and always willing to listen and hear what you had to say. He will be missed so much.”

**ACPA Changes Membership Process**

The ACPA is a peer support organization: we help each other learn to live fully in spite of chronic pain.

When you donate to ACPA, you help us provide resources, materials, and that personal connection that can make such a difference to people in pain.

Starting January 1, 2007, anyone who makes a donation of $25 or more becomes a member of ACPA for one year. (Existing members will be grandfathered for one year, ending in Dec. 31, 2007.)

New members will be able to extend their membership each January with another donation in response to the annual appeal.

Thank you to Endo Pharmaceuticals and Abbott Laboratories for their support of ACPA’s programs and materials.

The ACPA is happy to acknowledge the birthdays, anniversaries, and special occasions of members or their loved ones. We also provide space in The Chronicle for tributes, memorials and thank you notices. To recognize a loved one on our tribute page, call 1-800-533-3231 or write to ACPA at P.O. Box 850, Rocklin, CA 95677. We welcome gifts in any amount.