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Mind. Blown.

Millions of women are shattered by chronic pain. Many are put on a pharmaceutical diet of opioids that offer diminishing returns in relief—leaving some addicted. But could healing the body begin with treating the mind? *WH* health director Tracy Middleton investigates an alternative therapy that could help legions of sufferers piece their lives back together.

PHOTOGRAPHS BY JAMIE NELSON

Sometimes, it wakes me in the middle of the night: a punishing throb in my lower back. The pain has been my near-constant companion for half of my 41 years. I don't know its origins. As a health editor, and with no injury to point to, I suspect DNA may play a role—studies have shown a genetic link, and I come from a long line of bad backs. Regardless, over time it's become more tenacious. Insistent. For the past four years, it's been joined by a gnawing, steady thrum that radiates down my left leg from hip to knee, the by-product of a herniated disk pressing on a nerve in my spine. Some days, it whispers. Others, it roars.

My distress is just a drop in the bucket. Chronic pain—the kind that lasts longer than three months and torpedoed people's sleep, moods, relationships, and careers—affects roughly 100 million Americans. The majority are women, in part because we're more likely to be plagued by conditions like fibromyalgia, migraines, and low-back pain. Sixty percent of sufferers seek help from their family doctor; 40 percent will see a specialist (e.g., a gastroenterologist for Crohn's disease). Many of them—roughly 10 million annually—will, at some point, be given a prescription narcotic, an opioid to numb the pain.

I'm one of them. At times I can go days or weeks without the meds; but when even standing without pain becomes a struggle, I swallow them every six hours, per the label. I know the dangers: Up to 29 percent of patients given opioids for chronic pain misuse them; between 8 and 12 percent develop an opioid use disorder; and roughly 5 percent transition to heroin. I'm not represented in any of those statistics, but they linger in my mind, which is one reason I'd like to stop taking the drugs. The other? Research shows that, for many people, opioids become less effective the longer you take them.

Medication isn't the only way I've tried to appease my pain. I've gone to physical therapy, acupuncture, and chiropractic sessions and had regular massages and steroid injections. The last time I saw my pain-med doctor for the latter (I get shots every six months or so), he suggested the one thing he'd previously believed I could avoid: seeing a neurosurgeon to discuss removing the part of the disk that's pressing on the nerve. I was crushed. In essence, he was telling me—just as my chiropractor had before him—that he'd reached the limit of his ability to help.

I've watched my dad lose functionality with each of his four spinal surgeries (told you I came from a line of bad backs), and research shows up to 40 percent of people who have surgery for low-back pain don't get relief. Desperate to avoid that fate, I started researching other options and came across a surprising alternative, one that doesn't rely on addictive drugs or lackluster surgeries: pain rehabilitation programs that focus primarily on the mind to heal the body, decades old but gaining buzz again in the face of the nation's opioid epidemic.

Missed Connections

As women, we're often told our hurt is all in our heads. Even doctors are quick to dismiss it, according to some studies. The idea that pain is a figment of the imagination is pure BS, but there *are* deep connections—both emotional and biological—between chronic pain and the mind. That's why the goal of these rigorous outpatient programs isn't to eliminate pain (though in many cases it's significantly reduced); it's to change patients' relationship to pain so that it doesn't have such a stranglehold on their lives, says psychiatrist Xavier Jimenez, M.D., medical director of the Chronic Pain Rehabilitation Program (CPRP) at the Cleveland Clinic. At the heart of the treatment are counseling sessions and psychoeducational classes—the “psycho” side of the program's biopsychosocial approach. “Bio” is meds, such as antidepressants and nonaddictive pain pills, plus physical and occupational therapy; and “social” looks at external factors, like family or work, that can enable pain.

These interdisciplinary programs were the “gold standard in the '60s,” says Jeannie Sperry, Ph.D., a psychologist at the Mayo Clinic's Pain Rehabilitation Center in Rochester, Minnesota. But changes to the health-care system in the '90s saw patients sent to individual practitioners instead of pricey comprehensive programs. “We went from having around 2,000 of these programs to just a handful,” says Penney Cowan, founder and CEO of the American Chronic Pain Association.

Jimenez says the Cleveland Clinic's CPRP is usually a last-ditch effort for the roughly 300 people who attend annually. “Most have spent years going from doctor to doctor, collecting diagnoses,” he says. “Some have been in pain for 10 to 15 years.” Most swallow multiple medications and have had at least one surgery but are still so debilitated they're often unable to work or carry out everyday tasks like driving or housework.

I'm not there yet. But I can't play with my kids or go to a barre class without feeling a twinge, and that's frustrating and disheartening. So I traveled to Cleveland to see if I could glean something from the CPRP's methods that could help me—and any of our readers who are in a similar situation.

“It's Hell Week”

That's how Eugene Elbert, a friendly nurse at the Cleveland Clinic's CPRP, describes the program's initial days to a gathering of new patients. He's only half-joking. The treatment is intense (three to four weeks of eight-hour days, Monday through Friday), and patients have to adhere to some strict rules—the first being that they can't talk about the very pain that brought them here. (The exceptions: emergencies and discussions in therapy of pain's emotional impact.) If they do, with any of the staff, “we're gonna walk away,” Elbert gently, but firmly, reminds the group.

Even though the patients were told this beforehand, it sounds harsh. After all, they're at a pain treatment center, with suffering

so profound it makes even the simplest everyday activities agonizing. What else *would* they discuss? But there's good reason for the tough love. Research shows the way we talk about pain can actually contribute to it.

People who catastrophize pain (“my life is ruined”) or feel helpless about it (“things will never get better”) feel it more severely, says Sperry. One theory why: When the body is in a constant state of high alert, your muscles tense, your heart rate goes up, and your breathing becomes more rapid—all of which can increase pain. Women seem most prone to this mind trap, possibly because we may have more nerve receptors that can cause us to physiologically feel pain more intensely, but also because, from a young age, girls tend to receive more attention than boys when they talk about pain, says Darcy Mandell, Ph.D., an attending psychologist at the Cleveland Clinic's CPRP. The message that others will be there to support us when we are hurt may condition women to think about pain in a more reactive way, she says. One study found that among chronic pain sufferers who catastrophize, females reported greater pain intensity and were more likely to take opioids than men with the same condition.

Talking about pain isn't the only thing participants give up. Those who take opioids (about 40 percent of people entering the program) know in advance that they have to taper off the meds. That's because while the drugs are effective at curbing short-term hurt, over time they can hijack signals in the central nervous system, actually making the body more sensitive to pain, says Jimenez. This nervous system meltdown, called hyperalgesia, is why some patients find their pain worsens despite their taking increasing amounts of opioids.

Head Hurt

“Pain is felt in the body, but it's an experience of the mind,” says Mandell. Say you twist your ankle. Receptors in the joint shoot signals to your brain that say: *Hey, there's a threat down here; do something about it.* The brain decides what that something is, based on the situation. If you're just walking in the woods when you stumble, the brain might immediately produce a sensation so sharp you'd have to limp home. But! If you tripped because there was a poisonous snake in your path, your brain would determine the reptile is the greater danger. You'd hightail it out of there, not giving your ankle a second thought until you were safely home. Same injury, different brain response.

Next Best Thing

Not everyone can put their life on hold for weeks to attend a pain rehab clinic. But you may be able to locate a physician who can shape an individual treatment plan using a similar integrative approach. Here's how: Find a local pain-medicine doctor—the American Academy of Pain Medicine (painmed.org) and the American Board of Pain Medicine (abpm.org) both have online directories—and ask which combination of treatments (e.g., cognitive behavioral therapy, yoga, medication) may be right for you. Penney Cowan, founder of the American Chronic Pain Association, suggests peer support groups to further improve well-being (search for one at theacpa.org).

Snake or no snake, you've damaged the ankle joint, so you feel acute pain—the type that's a direct result of harm to tissues, joints, or bones. You'd probably take it easy for a few days or pop OTC painkillers until the injury heals (typically three to six months, depending on severity) and the ache goes away.

But in chronic pain sufferers, for reasons that aren't entirely understood, the *danger!* signals keep getting sent, even after an injury has healed. These ongoing messages eventually rewire the nerves, making them extra sensitive. In this heightened state, ordinary sensations become blown out of proportion by the time they reach the brain. This neurological glitch is called central sensitization, and it can be triggered by anything that activates the central nervous system—"injury, muscle strain, accident, medication, or emotional stressor," says Jimenez.

Once this happens, people aren't more sensitive to just things that should hurt, but also to things that shouldn't. Smells, tastes, sounds, and light can become amplified. A gentle touch can feel excruciating. That's how Caitlyn Campbell,* a 29-year-old from Lexington Park, Maryland, who was recently treated at the Johns Hopkins Pain Treatment Center in Baltimore (a similar center to the Cleveland Clinic's), described her agony. "I couldn't even tell where my pain was; it was like having the flu every single day," says Caitlyn, who suffers from several chronic pain disorders, including celiac disease and Addison's disease (a disorder of the adrenal glands). The multiple conditions wound up her nervous system to the point where "just rolling over in bed hurt," she says.

The number of people with central sensitization is likely "in the millions, if not more, because it's linked to so many conditions, including fibromyalgia, multiple sclerosis, and irritable bowel syndrome," says Jimenez. With chronic back pain, there can be an underlying physical problem—like my compressed nerve—with or without central sensitization, says Jimenez. Doctors don't know

Relax Your Brain

Remember: The more stressed you are, the more pain you feel. Mindfulness techniques can help dial down that tension and prevent hurt. You can mix and match the techniques below; just aim for two or three five-minute sessions a day. (Need more direction? Download Curable, an app that teaches chronic pain sufferers about the brain-body connection and guides them through relaxation exercises.)

Conduct a body scan. Lying down, bring attention to your toes. Acknowledge all sensations, painful or pleasant, without judgment, then breathe into them. Continue to work up to the top of your head.

Breathe deeply. sitting or lying down, place one hand on your abdomen and the other on your chest. Inhale slowly through your nose and into your belly. Pause a few seconds, then exhale slowly through your mouth. Repeat until you feel calmer.

Meditate. Sit comfortably and bring your awareness to the present moment. Notice what's happening, physically and emotionally right *now*—not the future or the past. Mind strays? Gently bring it back.

why some people develop the glitch and others don't, though they suspect genetics, mood disorders, and past mental traumas (for example, physical, sexual, or emotional abuse as a child; surviving a natural disaster; being in combat) are involved. These events may seem unrelated to physical pain, but experts believe past ordeals may prime the nervous system so that it's already in a state of überreactivity by the time an illness or injury strikes.

Power in Knowledge

A little over a year ago, a therapist I was seeing for a bout of depression kept bringing up my back pain, convinced it was contributing to my low mood. At the time, I thought she was barking up the wrong tree. Yes, my pain was annoying, but it wasn't debilitating. But she may have been on to something. Turns out, depression and pain often exist in a vicious cycle. When everything aches, depressed sufferers may cut back on activity to avoid reinjury, which makes them more susceptible to getting hurt and lowers their mood; or they may lose sleep and become hopeless about their situation, which can lead to depression...which can then provoke more pain. Research suggests that 30 to 50 percent of people with chronic pain also struggle with depression or anxiety.

This mind-body connection is why a full 70 percent of the Cleveland Clinic's CPRP is psychological. Patients attend individual and group cognitive behavioral therapy and go to classes that tackle topics like anger management, self-esteem, mindfulness, resilience, and acceptance. Once a week, a family member is required to join the patient in therapy and classes—a nonnegotiable that Mandell says is critical. "Well-meaning loved ones may do certain things out of love or lack of understanding that can contribute to an individual's disability," she says. "For example, one woman with fibromyalgia who came to the program felt judged by, and distant from, her husband, who periodically made indirect, snide comments because he was frustrated by her disease. This made her feel ashamed and depressed, so she ended up doing less, exacerbating the cycle." At the CPRP, the couple learned to communicate more effectively. "The wife was able to tell her spouse she prefers to hear his frustration directly, and he found she could listen without getting angry," says Mandell.

Patients also learn biofeedback, a therapy I experienced firsthand. Mandell wired me up to a monitor with sensors that measured my heart rate, temperature, sweat production, and muscle tension. Then she grilled me with math equations (not my forte). My body temp and heart rate immediately soared. I became sweaty and tense. After a few minutes, she told me to try to relax. I tapped into the deep breathing I learned in yoga; within 30 seconds, my vitals dropped. That's the goal, says Mandell: Teach people to recognize the involuntary physiological reactions to stress that inflame pain, then give them tactics to tune them down the next time they feel frazzled.

Giving In, Not Giving Up

The mind-body approach works. Studies show the programs improve patients' quality of life. And although they're not cheap (including a hotel for three weeks, the Cleveland Clinic's program costs around \$17,000 but is covered by most insurance plans), research shows they save money in health-care costs in the long term. Best of all: They reduce pain. After three to four weeks of treatment at the Cleveland Clinic, more than 60 percent of patients said this was the case for them.

*Name has been changed.




Take Monica Walters.* The now-33-year-old Cleveland medical assistant entered the program in 2013 after spending years chasing ways to stop the hurt from fibromyalgia and an autoimmune disorder that left her feeling “like a giant bruise,” unable even to shower without pain. In the process, she became addicted to prescription painkillers and anti-anxiety meds. Rehab helped her get off the pills but didn’t take away her physical anguish. “I knew something was wrong, but no one could fix me,” says Monica.

At the CPRP, she had to accept that was true. “I was a complete shit show when I started the program,” she says. The three weeks she spent in treatment helped her to change her perception of her pain while also making it less intense and less frequent. In the past, exercise was so torturous that she stopped altogether; now she goes to the gym but respects her body’s limits. “When I’m doing squats, I know

I may have to slow down,” she says. “But I don’t stop.”

Having to accept she’ll live with some degree of pain forever may seem depressing. But both Monica and Caitlyn say their treatment “saved my life.” For years, their days and nights were defined by their chronic agony. That’s no longer the case. Cowan calls this a transformation “from patient to person.” Caitlyn puts it more simply: “I actually have a life now.” She’s exercising for the first time in years and helping her husband renovate their house. Likewise with Monica, who is working, going out with friends, and leading addiction-recovery support groups. “My pain doesn’t stop me from what I want to do,” she says.

As for me, I’m struggling to accept that I’ll probably always have some hurt. Like everyone else, I want a quick fix—a pill or treatment that will instantly mend my jacked-up back (Jimenez tells me that surgery can sometimes relieve the type of nerve-related pain that travels down my leg, but it won’t do



The invisibility of chronic pain can lead to loneliness and isolation.

anything for the decades-old, diffuse low-back ache). Still, I recognize my current strategy of nonacceptance is only making my pain worse. Prime example: I don't want to face my body's limitations, so I overdo it, going on long runs, even though the impact is notoriously hard on the back (my doctor would prefer I swim). My pain ratchets up for days. In the pain-management world, this kind of behavior is, for obvious reasons, called "push-crash-burn."

It's time to try something else. Jimenez says you have to tackle all three branches of the program—that bio, psycho, and social mix—to see improvement. For me, that's discussing alternatives to my opioid prescription with my doctor, making more time for meditation, and maybe going back to that therapist. Redefining my relationship with pain is a work in progress. But with each step toward acceptance, I feel less of a need to try to control my pain—and it has less control over me. ■

Tell Us What Hurts

Dozens of conditions can cause chronic pain. For the most common ones, here's how head-first therapies can help.

Fibromyalgia

Lady Gaga revealed her struggle with this disorder in her *Five Foot Two* documentary. Like Gaga, 4 million people (the majority of them women) experience all-over aches and pain, extreme fatigue, and cognitive difficulties. (The cause is unknown, but genetics, inflammation, and nervous system snags are suspected.) One new study found patients who reflected on their emotional experiences with fibro had less pain and depression and more overall functioning than those who had traditional cognitive behavioral therapy. Psychodynamic therapy, which examines how unconscious thoughts and feelings influence the patient, can help with this; find a trained therapist at apsa.org.

Chronic Pelvic Pain

The umbrella term for any non-menstrual-cycle-related hurt in the pelvic area (such as endometriosis or pain during sex) that lasts six months or longer, CPP affects anywhere from 6 to 27 percent of women. One study showed that 20 minutes of daily mindful meditation significantly reduced patients' pain.

Irritable Bowel Syndrome

Twice as likely to occur in woman as in men, the condition impacts up to 15 percent of people. Mindfulness training (deep breathing, meditation) has been found to help patients avoid catastrophizing about the condition.

Low-Back Pain

Roughly 80 percent of people experience acute low-back pain at some point (from, say, shoveling too much or overexercising); for 20 percent, the pain becomes chronic. The American College of Physicians recently issued new guidelines that advise practices such as yoga and guided relaxation instead of potentially addictive opioids. If drugs are needed, the recommendation is to use nonsteroidal anti-inflammatory drugs (NSAIDs) to reduce inflammation, and muscle relaxants; opioids should be used only in rare circumstances.

Headaches

Women are more likely than men to suffer more intense and longer-lasting skull crushers and migraines. In one new study, headache patients had less pain and depression after three weeks of being treated at an interdisciplinary pain rehabilitation program.

Autoimmune Diseases

Conditions such as celiac disease, multiple sclerosis, lupus, and rheumatoid arthritis can cause widespread pain; they occur when the body's immune system attacks healthy cells by mistake. One study discovered MS patients who had mindfulness training were less depressed and anxious; a group that received biofeedback as well also reported less fatigue and stress.