

COMMUNICATIONS, ADVOCACY, AND THE JOSHUA TREE: A CHAT WITH BETH DARNALL

Beth Darnall, PhD, is an Associate Professor in the Department of Anesthesiology, Perioperative and Pain Medicine at Stanford University, USA. Her research examines different ways to best treat and prevent chronic pain, with a specific passion for utilising behavioural medicine strategies to facilitate pain control and opioid reduction. Darnall sat down with Lincoln Tracy, a research fellow from Monash University, Australia, at the 2019 Australian Pain Society Annual Scientific Meeting, which took place April 7-10, 2019, on the Gold Coast, Australia. Darnall discussed her path to pain psychology through journalism, her passion for advocacy, and her fondness of the 1987 album 'The Joshua Tree' from Irish rockers U2. Below is an edited transcript of their conversation.

What was your path to pain research?

That's an interesting question, because I didn't set out to be a pain researcher. In fact, I set out to be a journalist or to communicate about science. So, I pursued a bachelor's degree in mass communications. But it was during the pursuit of my degree that I realised that what I really wanted was to be leading the cool science that someone else would report—rather than reporting on other people's cool science. After finishing my degree, I wanted to further my education and subsequently pursued a PhD in clinical psychology—still without the knowledge that it would lead to pain research.

However, pain isn't integrated into psychological training systematically in the United States—it's virtually absent. It was only through treating patients that I realised that this was something I loved, and I connected with it very deeply because I had chronic pain as a child. I ended up pursuing a specific area of pain research and clinical work because I had a personal understanding of where the gaps lay.

How do you feel your earlier training in communications and clinical psychology helps you now, as you travel the world and share the research you do?

Well, the benefit of the clinical psychology training is relatively intuitive as my

research is built around investigating application of psychological principles and psychological treatments to improve pain care. Then I think the communications training taught me to concisely package a message in a digestible format. I have always been drawn to the mass communications of pain research findings, so I've had blogs on [Psychology Today](#) or have pursued lay public articles and writings. I think it's a critical aspect that we be able to communicate to the public what we're doing, why it's important, and why it's important to *them*.

That last part is particularly important for me as I'm investigating treatments that are consumed by the public, and there have been so many misconceptions about the role of psychology in the experience and treatment of pain. Part of my mission is to dismantle these misperceptions. By destigmatising psychological or behavioural interventions, there is increased receptivity and uptake of these treatments by the public as they increase their willingness to engage and participate—therefore improving their own outcomes.

Without that messaging piece, we lose our audience entirely. Increasing the public's willingness to engage in the treatments that we're investigating is a critical piece

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of improving access to pain care. I think it's been more important than I realised at the outset.

If you hadn't pursued this path into pain research, what do you think you would be doing?

If life were completely different, the only thing I can tell you is that I was on a trajectory to be a writer. Currently, I write for clinicians, scientists, and the public—but it's in a different way than I was initially pursuing. I can't imagine any alternate reality where I'm *not* writing—I feel it's just hardwired into who I am. But I have always joked that if I wasn't in my current career, I'd be a race car driver. I think that says a lot about my personality!

What are some of the biggest misconceptions people have about pain?

I feel there are a lot of misconceptions people have about pain. But one significant misconception is the amount of control people can have over their own pain and its impacts on their life. People can have much more control than they realise—such as using self-management techniques and soothing behaviours to enhance descending modulation and de-amplify pain processing. This is not well appreciated by the public—or even most general healthcare practitioners. While these strategies will not cure an underlying medical condition, they can greatly improve life in the context of chronic pain.

Altering this leads to patient empowerment and—ideally—engagement with low-risk, non-pharmacological strategies. I'm looking forward to the day when that's more broadly appreciated by the public and healthcare systems. That's why I see so much potential benefit in the accessible digital interventions I use in my research. It bypasses the need to see a clinician or to get a co-pay. I know that for many people it's not enough on its own, that individual

and group treatment can be so critical, and that some people might benefit from pharmacological therapy as well. But it's a great first step for people to begin understanding how some of these pieces fit together—and what they can do to help reduce their pain and suffering.

Looking forward to the next five to 10 years, what is there that you would like us to know about pain that we don't currently understand?

There is—and has been—a very large focus on opioid medications and reducing risks for patients. I would love there to be more pharmacological options that offer improved pain care without the risk of addiction. While I am a behaviourist and focus on these aspects in my research, we still need pain medicine—pharmacology has such a critical role for so many of our patients. I feel there is less appreciation for the importance of pharmacology, so I always want to advocate for that. I would love there to be major discovery in non-addictive medications.

Unfortunately, we have gone much too far on limiting opioids in the United States. This has been to the detriment of many people with pain where we are inflicting additional pain and suffering on patients *who actually benefit* from opioids. Because of this I feel the imperative is to treat the individual, not the dose. Some people benefit from opioids—and it is humanitarian care to preserve their access to that form of treatment. While I'm a strong advocate for behavioural interventions, I also spend a lot of my free time advocating for patients to have access to pharmacology as well.

Part of the solution is transcending the mentality that the way we treat pain is binary—that it's behavioural or pharmacological. The reality is that it's both. We need the whole toolbox to deliver

precision care to the individual—*without judgment of what we utilise* from the toolbox.

How do you deal with negative comments and feedback online?

That's interesting, because it happens on both sides. If patients misinterpret my advocacy for better access to behavioural treatments, then there is the perception that "well, she just wants to take our opioids away". But at the same time, when I advocate for patients to have the *right* access to medications other people think "well, she's promoting a risky and potentially addictive medication". I get negative comments from all sides. The truth is, I see both sides and advocate for a balanced approach that is focused on access to pain care that is right for the individual patient.

When I communicate things online I try to provide access to evidence-based pain care—regardless of how one individual may feel about that. There is so much emotion wrapped up in these topics, and from the patient perspective I understand the judgement they receive from medical professionals. Patients may feel stigmatised by being referred to a psychologist—they feel like they have been told that their pain is all in their head.

Therefore, if I represent psychology in that tweet or in that conversation, I understand why there are negative perceptions about what that represents to them, feeling judged or blamed, or that I'm attempting to take something away—when nothing is further from the truth. While I do support psychological treatments, I equally advocate for access to opioids on my feed. It's partly my responsibility to provide balanced information with the hope that people will see that as they form their opinions.

If you are on Twitter long enough and you have anything to say that's going to be controversial, you will engender negative feedback. I guess the adage is that you don't take it personally or engage with it. I view my Twitter feed as a profession news feed—here's what I think, here's what I'm doing, here's what I support. But it's not meant to really engage at the individual level or try and convince people of anything. I don't see that as my role at all, so I offer a perspective and then don't worry about people's opinion of me. That's quite freeing. You also must have a thick skin—and know how to utilise the mute button!

What are some of the most important things you try to teach the PhD students and trainees that you work with?

One thing I have learned from my own journey has been questioning perceived obstacles and finding a way to do what I was passionate about doing in the absence of funding or support. We spend so much time trying to secure funding and resources—but you need to think about how you can be creative with your approach and use the time to do your research without formal permission from a funding agency. In the United States we are constantly focusing on getting funding—yet there are often pieces of work that can be done in the absence of *any* funding. I think it is critical that you keep making progress with your research—particularly early on in your career.

On a different note, I don't really talk much about maintaining a work-life balance because I freely admit that I *don't* have any work-life balance. I love what I do and am really passionate about it—so it ceases to be work. It just becomes part of my mission and what gives me life. If I'm not doing research or writing I'm advocating to ensure that the policies that are put forward in the United States

are patient-centred, compassionate, and grounded in evidence. There are people who do this on a full-time basis, but it has been something that has brought even more meaning to the work that I do—and the connection that I feel to people.

Do you have a favourite song or piece of music?

I love music that has either a piano or a violin. I'm not as fussed about the type of music—techno or rock, for example—I just love these instruments and really resonate with the songs they feature in. With respect to an impactful album, though, there was one from a few decades ago when I was younger—you probably weren't even born! I think The Joshua Tree, from U2, is just

stunning. I was listening to it just the other day and after all this time I think almost every song off that album is just beautiful.

Thanks for giving up your time, Beth. I really appreciate it.

Thank you so much, Lincoln, it's been such a pleasure.

Lincoln Tracy is a postdoctoral research fellow in the School of Public Health and Preventive Medicine at Monash University and freelance writer from Melbourne, Australia. He is a member of the Australian Pain Society and enthusiastic conference attendee. You can follow him on Twitter ([@lincolntracy](#)) or check out some of his other writing on his [website](#)



LINCOLN TRACY AND ASSOCIATE PROFESSOR BETH DARNALL