

## Psychopathology & Chronic Pain

This paper explores the relationship between psychopathology and chronic pain within the literature as well as from a clinical perspective. Working in the pain management field for several years, questions have come up about this relationship and how exactly does psychotherapy help a person in obvious physical pain. In fact, what is pain anyway?

Included in this exploratory paper is the clinical (psychological) definition of pain from the DSM-IV-TR with a review of current national statistics. The next section further defines both pain and chronic pain from a physiological framework. The most recent thinking about pain management is presented in the next section. A discussion follows this addressing the relationship between chronic pain and the emotions. The MMPI-2 is often used as an evaluation tool in chronic pain management and so this is addressed briefly as well. A close look is then taken discussing chronic pain and Axis I disorders. A short case study applying this information in a clinical example is presented to tie this all together. The paper ends with a conclusion.

In the field of psychology, physical disorders with psychological components are referred to as Somatoform Disorders. The DSM-V-TR (2000) has a section, which addresses Somatoform Disorders. The psychopathology of pain is taken in account within this section. In general, these disorders include the:

Presence of physical symptoms that suggest a general medical condition (hence, the term somatoform) and are not fully explained by a generally medical condition, by the direct effects of a substance, or by another mental disorder. The symptoms must cause clinically significant distress or impairment in social, occupational, or other areas of functioning.... The physical symptoms are not intentional (i.e., under voluntary control)...there is no diagnosable general medical condition to fully account for the physical symptoms. (p. 485)

In the pain management clinic where I work, many patients receive an Axis I diagnosis of Pain Disorder (307.89) with Axis II diagnosis generally deferred. As I have been with these

clients, it is clear that this is their correct DSM-IV-TR diagnosis. However, the more I work with these clients, the more I realize how little I know about that actual connection between psychopathology and pain and how to effectively therapeutically treat them. More specifically, I realize that I need more information about chronic pain and exactly how does it affect one's psychology.

According to "LeMoult (2006) nearly 48 million people in the United States are subject to chronic pain and find little relief from current medications that, in turn, may have the potential for harmful side effects" (Haggard, 2008, p. 471). Furthermore:

A study by the Centers for Disease Control and Prevention's National Center for Health Statistics (2006), 1 in 4 U.S. adults reported a pain experience that lasted a full day during the previous month, and 1 in 10 reported an experience of pain lasting a year or more. (Haggard, 2008, p. 471)

These numbers are staggering considering issues of quality of life, quality of relationships, ability to work, and ability to simply live a comfortable life. The latest research on chronic pain speaks to these various factors as psychosocial variables that influence the perception of pain itself. In pain management and rehabilitation settings, chronic pain screening has recently expanded to take into account "psychosocial variables for clinical syndromes, personality disorders, and potential substance misuse" in order to get a complete profile of an individual's pain complaints (Dersh, Polatin, & Gatchel, 2002).

#### Chronic Pain Defined

"Pain is a ubiquitous experience. Ranging from mild to severe in nature, it is inevitable relatively frequent, and the most pervasive and prevalent form of human distress, contributing to significant reductions in quality of life" (Means-Christensen, Roy-Byrne, Sherbourne, Craske & Stein, 2008, p. 593). "Throughout this resurgence in pain research...there has remained a

stubborn insistence that pain, although multifaceted, is nonetheless a single kind of experience” (Grahek, 2008, p. 349). “Among the most common measures of pain intensity is the 0 to 10 numerical rating scale. A large body of evidence supports the reliability and validity of this measure for assessing pain intensity” (Tan, Jensen, Thornby & Rintala, 2008, p. 239).

The literature shows that pain itself is a result of a combination of sensory and emotional experiences that are linked to the threat of or actual damage on the physical body. Chronic pain then is pain that continues beyond the time it takes for the actual injury to heal. In order for the label of chronic pain to be applied there is a timeline depending on the situation. For example, pain six weeks after an event may be enough to label the pain chronic.

Kozłowska, et al. (2008) say the connection or interaction between pain and emotional processing are an evolutionary protective function that lets one respond to a threat as well as to protect against some danger. “The human capacity for a ‘subjective experience of pain’ functions as a high-level biological mechanism that signals threat to the integrity of the individual’s physical, homeostatic, psychological, or relationship context, in order to elicit a *variety* of protective responses” (p. 137)

Furthermore, Verma & Gallagher (2000) indicate that physical stimulus itself does not actually carry pain but instead becomes pain when psychological processes become involved.

Neurological activity induced by a noxious stimulus in the nociceptor and or the neurological pathways is not pain; instead, pain is always a psychological state even though we may well appreciate that pain is usually initiated, and often perpetuated, by physical factors in peripheral tissues or the CNS [central nervous system]. (p. 103)

“The firing of C-fibers leads to or is related to the experience of pain” (Grahek, 2008, p. 350). This experience only happens when both “functional and phenomenal features...connect injury and pain. In other words, the neurophysiologic explanation of ‘sensory determinable’ still

relies on the functional properties of phenomenal states such as the experience of pain after injury” (Grahek, 2008, p. 350). Grehek (2008) further discusses a syndrome where there is sensory-limbic disconnection. This causes a separation of the “affective/cognitive motor aspects of pain from its representational/motivational features” (p. 350). There is the presence of pain but it does not register as a threat and therefore no action needs to be taken. “This, he claims, means...the representational capacity of pain (threat) is not necessarily to be found in its sensory—discriminative features. In other words, it may be that the sensation of pain per se does not carry a message [of threat]” (Grehek, 2008, p. 350).

Following this it means that pain is a subjective experience with an emotional basis. Verman & Gallagher (2000) further state, “pain is an experience we associate with potential tissue damage and actual loss of function; therefore it is [both] threatening and an emotional experience” (p. 104). This is supported by Kozłowska, et al. (2008) “pain can be evoked and modified by a variety of factors: emotional states, thoughts, beliefs, intentions, suggestion, injuries or social/attachment relationships, and memories of past injuries, as well as by the emotional state of close others” (p. 136). Additionally, “Skevington (1998) says, “affective pain best predicts the quality of life associated with pain and discomfort, suggesting that emotional properties of pain appear to have the closest conceptual association with quality of life” (Aigner, Forster-Streffleur, Prause, Freidl & Weiss, 2006, p. 84).

Consequently, how an individual registers and reports pain will depend on psychological factors such as emotional maturity (or not), cognitive schemas, and an ability to manage or soothe the overall internal threat of the injury or pain experience the individual perceives.

## Chronic Pain Management

In our culture, one way a person may try to soothe his or her pain is to go to a medical doctor (MD). The emotional distress and threat of the loss of function can be quite a burden on an individual and relief is sought out through this venue. Medications, usually opioids, prescribed by an MD are a common way people seek relief. Fortunately, it is becoming more common for MDs working in chronic pain to include psychologists on the healing team because an expanding body of research indicates that a multifaceted or biopsychosocial approach to managing chronic pain is more effective than medication alone. “Currently the most heuristic model for treating chronic pain is the biopsychosocial perspective. . . . From this perspective, pain is viewed as a unique, individualized experience, with pain symptoms modulated by a complex interaction among biological, psychological, and social factors” (Haggard, 2008, p. 471). Veasey (2008) says that “chronic pain—a persistent, life-altering, condition—is one of the most challenging clinical disorders for primary care physicians to treat” and therefore different perspectives from members of a cross-functional healing team is important (p. 806).

Veasey (2008) takes this to a higher level as he speaks of a more holistic approach to pain management that must be patient-centered that involves professionals and specialists in both behavioral health and physical rehabilitation. Veasey says the primary goal of chronic pain management is to restore functioning even with pain that may never go away, and so:

An affective treatment plan must address biopsychosocial factors as well as spiritual and cultural issues. Patients must be taught self-management skills focused on fitness, stress reduction, and maintaining a healthy lifestyle. Medications may be part of the treatment plan but should not be the sole focus. (p. 806)

In terms of assessing chronic pain more individually, clinicians must measure a broad range of contributing factors in a more systematized way. These factors include “physiological

dysfunction, tissue injury; the individual's and family members' emotional and cognitive states; reinforcing conditions; and a history of loss or trauma concerning the individual or a close other within the family or close social context" (Kozłowska et al., 2008, p. 137).

The next few sections take a closer look at the relationship between chronic pain, emotions, and psychopathology.

### Chronic Pain and the Emotions

The literature shows a very clear connection between chronic pain and emotions. Von Korff and Simon (1996) suggest, "that psychological distress may be a maladaptive response to pain or that psychological distress may be induced or exacerbated by the physical and psychological stress of pain" (Means-Christensen, Roy-Byrne, Sherbourne, Craske & Stein, 2008, p. 598). For example in a panic attack, "the 'catastrophic' interpretation of bodily sensations elicits anxiety, and this...leads to...increased...physiological activity. The result is an amplification of the bodily sensations. The positive feedback loop between internal perceptions and physiological activity can accumulate in a panic attack" (White et al., 2008, p. 428).

Another emotion related to chronic pain is anger. "Anger is related to heightened acute and chronic pain sensitivity. Whereas patients with chronic pain disorders report high levels of trait anger and hostility...findings implicate anger regulation—the suppression...of anger—as a particularly robust determinant of chronic pain severity" (Burns et al., 2008, p. 645). More specifically, there is "a causal connection between the tendency to suppress anger and the worsening of clinical pain" (Burns et al., 2008, p. 651).

Burns, et al., (2008) propose that anger suppression has disastrous effects on health predicated on the theory that repression of an emotion actually takes effort. This effort is "pitted against ongoing cognitive or behavioral activity" causing physiological arousal (p. 645-646).

“Gross (2002), for instance, showed that when people suppress behavioral responses to stressful stimuli, they exhibited greater physiological arousal than people allowed to respond without interference; thus, revealing the “effort” needed to inhibit or suppress” (Burns et al., 2008, p. 645-646). To exacerbate the issue it was also found “among patients, anger inhibition seems to be related to poor adjustment, and poor response to pain treatment” (Burns et al., 2008, p. 645).

Burns et al. (2008) also says that this effort to suppress anger will “contaminate” future painful stimuli making it more salient (p. 650). They discuss the reason for this in the following way:

Recent neuro-imaging studies have suggested that anger is an approach motivation emotion. . . . Suppression of an approach-motivation emotion may engender more pronounced ironic effects than suppressing a withdrawal-motivation emotion, such as sadness, and so have more powerful delayed effects on responses to later noxious stimuli. Thus, anger may exert effects on pain that are unique from other negative emotions, and regulating this strong, approach-motivation emotion may generate more pernicious delayed effects than regulating anger otherwise and regulating other (withdrawal-motivation) emotion and suppression. (Burns et al., 2008, p. 646)

Even in healthy normal people, Quartana and Burns (2007) found that, “attempt[s] to suppress thoughts/feelings or behaviors during provocation reported greater pain intensity during subsequent pain induction. . . . than those who did not suppress” (Burns et al., 2008, p. 650).

The research shows there is a clear link between emotions and chronic pain with the suppression of anger perhaps being the most pain intensifying and damaging. Now attention will be given to several psychopathological issues as they relate to pain and pain regulation.

#### Chronic Pain and MMPI-2 Disability Profile

In terms of psychopathology and chronic pain, I have been curious about why and how the MMPI-2 is utilized in assessing psychological issues in individuals with chronic pain. This section includes an exploration of the usefulness of this instrument.

The patients that come into the clinic where I work are required to take the MMPI-2. This is an integral part of the assessment process. As I read the assessment reports including the results of the MMPI-2 for my clients, I became concerned that nearly everyone had both an Axis I and Axis II diagnosable problem. Initially, I was apprehensive as I read the reports, which included the MMPI-2 computer print out for many of these clients, indicating that they would be highly resistant to psychological therapeutic intervention. I think that in the first six months of being at this clinic I read a grand total two “normal” profiles. It was fascinating to experience the difference between these individuals and everyone else. In general, the “normal” profile people were grounded, active, concerned about their lost functionality but were generally emotionally mature with good coping skills. It has not been the case for most of my other clients. (My supervisor has indicated this is a very difficult population to help but that if I can learn to work with clients with chronic pain, then I can work with anyone.)

As early as 1974, Sternbach identified that both these response patterns on the MMPI-2 were significant within pain populations.

- Neurotic Triad (NT): elevations on Scales 1 (Hypochondriasis), 2 (Depression), and 3 (Hysteria);
- Conversion V (CV): elevations on Scales 1 (Hypochondriasis) and 3 (Hysteria), with Scale 2 (Depression) more diminished by comparison

These individuals tended to be pensive about somatic concerns. Findings suggest “individuals with NT profiles tended to respond well to the treatment of musculoskeletal pain. [However], individuals who produced CV profiles were generally shown to have poorer treatment outcomes, particularly when they produced a sub threshold Scale 2 elevation” (Haggard, 2008, p. 472). A number of studies have replicated these results (Bradley, Prokop, Margolis, & Gentry, 1978; McGill, Lawlis, Selby, Mooney, & McCoy, 1983; Turk & Fernandez,



1995)” and, as a result, pre-treatment screening with the MMPI-2 has become a standard in the field of chronic pain” (Haggard, 2008, p. 472).

A more contemporary study by Gatchel and colleagues (2006) identified the following MMPI-2 profiles (from MMPI-2 data) as suggestive of a possible role for psychopathology in chronic pain populations NT, CV, and:

- Floating Profile (renamed the Disability Profile (DP)): presents with a minimum of four elevations on the Clinical Scales.

This profile indicates significant psychological distress and chaos. According to the American Psychiatric Association (2000) this profile equates to the Axis II, Borderline Personality disorder. This profile was renamed by Gatchel and colleagues (2006) in order to “identify within the musculoskeletal spine pain and behavioral medicine literature subjects who may present with distinct complications” (Haggard, 2008, p. 472). They found:

Individuals who display such a response pattern often lack any one specific defense mechanism with which to manage life stressors and thereby experience much more severe emotional distress. Because of this complexity, these individuals are often resistant to traditional psychiatric approaches (Gatchel et al., 2006). (Haggard, 2008, p. 472)

In this study by Gatchel, et al. (2006) 53.2% of participants who took the MMPI-2 identified as having the Disability Profile. This psychological information is critical to the individual and the treatment team in understanding how to best support this individual. In addition, the healing process will most likely be long and difficult if at all. In my brief experience, I experience the validity of this information. I can also say that I have already had a number of clients who have benefited from the humanistically oriented cognitive/behavior approach to therapy. Attending to each one individually, listening, reframing, and simple mindfulness exercises have been helpful, even with bleak MMPI-2 predictions.

### Chronic Pain and Axis I Disorders

Bair et al. (2003) reviewed research looking for the connection between pain and depression. They “found that 27% of pain patients in primary care clinics are suffering from major depression” (Means-Christensen, Roy-Byrne, Sherbourne, Craske & Stein, 2008, p. 594). Another study by McWilliams et al. (2003), with data from a large US cross-national survey, found that about “35%...reporting arthritis pain suffered from an anxiety disorder...22% had a mood disorder...controlling for other medical conditions, arthritis approximately doubled the risk for panic disorder, posttraumatic stress disorder (PTSD), and depression.... Additionally 70% of depressed patients report only somatic symptoms” (Means-Christensen, Roy-Byrne, Sherbourne, Craske & Stein, 2008, p. 594, 597).

This literature review went on to say that:

The report of a pain symptom was associated with a 2.5- to almost 10-fold increase in positive screens for panic disorder, GAD, or depression. A report that pain interfered with the patient’s work was also associated with an increase in the odds of screening positively for panic disorder...or depression.... At the diagnostic level, odds of having major depressive disorder increased with the endorsement of each of the three types of pain as well as interference from pain. Muscle pain and stomach pain increased the odds for GAD and panic disorder. (Means-Christensen, Roy-Byrne, Sherbourne, Craske & Stein, 2008, p. 597)

In another review of the literature, several hypotheses were presented as to the relationship of pain and the development of psychopathology. Evidence strongly supported the idea that depression actually followed chronic pain (consequence hypothesis). Less evidence supported the idea that the depression happened first and then the chronic pain started (antecedent hypothesis). The scar hypothesis, also supported, is the idea that a history of depression can cause a vulnerability to pain disorder. This was most common in individuals with a Major Depression diagnosis (versus any other DSM diagnosis). Yet, another literature review

indicated that “pain was associated with a spectrum of psychological illnesses, and... anxiety disorders were as common as depression... that pain and negative emotions were in part related by a trait of vulnerability to dysphoric, somatic, and psychological symptoms; and... co-vary with psychological distress” (Verma & Gallagher, 2000, p. 107). More specifically, “depression may be related to a heightened interpretation of pain symptoms, whereas GAD may be related to prolonged tension of muscles as a consequence of anxious feelings” (Means-Christensen, Roy-Byrne, Sherbourne, Craske & Stein, 2008, p. 597).

A study by Stirgo (2009) used brain scans to compare participants with depression to a control group. All individuals were put in a situation where they anticipated pain. The brain scans showed “participants with depression [had] increased brain activity, especially in the amygdala... anticipating pain... [but] as the painful stimulus was applied [they had] greater brain activity in the amygdala and lower activity in... parts of the brain responsible for adjusting sensitivity to pain” (p. 1). Therefore, depressed patients are less able to regulate pain perception at the same time they are more emotionally reactive to the pain once it starts.

This is important for treatment considerations in terms of these clients learning to soothe their amygdala and thus calm the threat the pain presents. Hamilton et al. (2008) has shown that “positive affect appears to moderate pain and stress in women with FM [Fibromyalgia]” (p. 496). It makes sense that learning to have more positive affect will counter symptoms of both psychopathology and pain.

One more area to briefly address is chronic pain and substance use or abuse. Rosenblum, Marsch, Joseph & Portenoy (2008) report “historically, concerns about addiction have apparently contributed to the under treatment of disorders widely considered to be appropriate for opioid therapy [however] the use of opioids for chronic nonmalignant pain remains controversial”

(p. 405). The addition of psychologists to pain management teams has helped to identify and regulate those individuals who have a substance abuse history. With a team approach, the MD has more information to inform his or her decision regarding pain management with medications for each individual. Chronic pain and substance abuse together are a slippery slope where the medications, over time, become less effective. Anecdotally, about 50% of my clients have self-regulated their dosage beyond where the MD has set it in order to regulate their pain. Over time, “each of these problems is related to marked deterioration in psychiatric and psychosocial functioning” and so must be monitored carefully (Brooner, 2008, p. 485).

#### Sally and her Shingles

In putting this all together, I would like to review Sally’s case. She was referred to the pain clinic because of a two-year bout with Shingles. She was experiencing high stress wondering when and if her Shingles would ever go away. She reported family stress, marital stress, physical stress, and job stress. Just about every category of her life, she reported a great deal of stress and anxiety. Her MMPI-2 results came back with a possible diagnosis of Dystymia with a passive dependent personality with little insight. Treatment recommendations were that she might respond well to a directive, action-oriented treatment approach and possibly to assertiveness training. The first session she gave her background and cried a lot saying she did not understand why her pain was so great.

Through a number of sessions, she uncovered that she is still trying to manage adult children, her husband lost his job and is passive, she has not been able to work due to her shingles, and more. Throughout a number of sessions we have worked together where she has been able to plan and then carry out a plan of attending to both her need to control along with her self-imposed expectation that she be passive in the face of another’s anger directed towards her.

She has suppressed her own anger for years. Throughout the last few months, her pain has been better at times and worse at times. Eventually she began to experience that when she was able to remain calm her pain lessened.

She had a breakthrough a couple of weeks ago when she was able, with insight, to track back a full week to the stressor that was the origin of her most recent pain episode. Once she talked it through, she remarked, “Wow, the pain is gone.” She has some distance to travel yet before integrating the new coping skills and new behaviors she is learning. However, she is an individual that has done remarkably well with a directive therapeutic approach, as well as mindfulness exercises, helping her to uncover her emotional history, and how it interrelates with her pain.

The MMPI-2 information was great for recommending a therapeutic approach. But these results also indicated that this person was not likely capable of developing insight. I found this to be untrue and that she has gained insight through her work in therapy. This supports the idea that all the information about a client must be taken into account but also with a “grain of salt.” It is necessary to focus on the client and his or her experiences to inform the therapeutic process.

My limited experience of working with clients with pain is that they have a great need to be heard and seen in their experience. Many people come into the office without any concept of the mind/body connection, nor do they want one. Many others are true seekers of healing and are willing to explore the mind/body connection. Those individuals end up having the capacity to change their lives through this work regardless of the odds.

### Conclusion

This paper explored the relationship between psychopathology and chronic pain. A number of topics were discussed including the clinical definition of psychologically oriented

pain from the DSM-IV-TR. Next chronic pain was defined and discussed in terms of pain management. Chronic pain and emotions were addressed next. The MMPI-2 is often used as an evaluation tool in chronic pain management and so relevant MMPI-2 profiles added to the discussion. The next section talked about chronic pain and Axis I disorders. A short case study applying the information in a clinical example was presented to tie this all together.

Chronic pain is prevalent. There is a clear relationship between emotional distress (psychopathology) and chronic pain. The best approach is a person-centered professional team approach to provide as many possible avenues of support for an individual with chronic pain in order to offer avenues beneficial to the restoration of life balance.

## References

- Aigner, M., Forster-Streffleur, S., Prause, W., Freidl, M., & Weiss, M. B., M. (2006). What does the WHOQOL-Brief measure? Measurement overlap between quality of life and depressive symptomatology in chronic somatoform pain disorder. *Soc Psychiatry Psychiatr Epidemiol*, *41*, 81-86.
- American Psychiatric Association. (2000). Diagnostic and statistical manual of mental disorders, Fourth Edition, Text Revision. Washington, DC, American Psychiatric Association.
- Brooner, R. K. (2008, August). Advances in treating chronic nonmalignant pain and substance use disorders. *The Canadian Journal of Psychiatry*, *53*(8), 485-486.
- Burns, J., Quartana, P., Gilliam, W., Gray, E., Matsuura, J., Nappi, C. et al. (2008). Effects of anger suppression on pain severity and pain behaviors among chronic pain patients: Evaluation of an ironic process model. *Health Psychology*, *27*(5), 645-652.
- Grahek, H. (2001). *Feeling pain and being in pain, second edition*. MA: MIT Press.
- Grahek, N. (2007). (2008, November 2008). Review of feeling pain and being in pain, 2nd edition (H. Stam, Ed.). *Canadian Psychology/Psychologie Canadienne (US)*, *49*(4). *Feeling Pain and Being in Pain*.
- Haggard, R. A., Stowell. (2008). Relationship between the MMPI-2 and psychosocial measures in a heterogeneous pain population. *Rehabilitation Psychology*, *53*(4), 471-478.
- Hamilton, N., Affleck, G., Tennen, H., Karlson, C., Luxton, D., Preacher, K. et al. (2008). Fibromyalgia: The role of sleep in affect and in negative event reactivity and recovery. *Health Psychology*, *27*(4), 490-497.
- Kozłowska, K., Rose, D., Khan, R., Kram, S., Lane, L., & Collins, J. (2008, March-April). A conceptual model and practice framework for managing chronic pain in children and adolescents. *Harvard Review: Psychiatry*, *16*(2), 136-150.
- Means-Christensen, A., Roy-Byrne, P., Sherbourne, C., Craske, M., & Stein, M. (2008). Relationships among pain, anxiety, and depression in primary care. *Depression and Anxiety*, *25*, 593-600.
- Meeks, T., Dunn, L., Kim, D., Golshan, S., Sewell, D., Atkinson, J. et al. (2008, November 27). Chronic pain and depression among geriatric psychiatry inpatients. *International Journal of Geriatric Psychiatry*, *23*, 637-642.
- Rosenblum, A., Marsch, L., Joseph, H., & Portenoy, R. (2008). Opioids and the treatment of chronic pain: Controversies, current status, and future directions. *Experimental and Clinical Psychopharmacology*, *16*(5), 405-416.

- Strigo, I. A., et al. (2008). (2009, November). Association of Major Depressive Disorder with altered functional brain response during anticipation and processing of heat pain. Brain scans indicate that depression can increase pain perception (Harvard Mental Health Letter, Ed.). *Archives of General Psychiatry*, 65(11), 1275-84.
- Tan, G., Jensen, M., Thornby, J., & Rintala, D. (2008). Categorizing pain in patients seen in a veteran's health administration hospital: Pain as the fifth vital sign. *Psychological Services*, 5(3), 239-250.
- Veasey, G. (2008, December). Managing chronic pain: What's the best approach? *The Journal of Family Practice*, 57(12), 806-811.
- Verma, S., & Gallagher, R. (2000). Evaluating and treating co-morbid pain and depression. *International Review of Psychiatry*, 12, 103-114.
- White, K., Raffa, S., Jakle, K., Stoddard, J., Barlow, D., Brown, T. et al. (2008). Morbidity of DSM-IV Axis I disorders in patients with noncardiac chest pain: Psychiatric morbidity linked with increased pain and health care utilization. *Journal of Consulting and Clinical Psychology*, 76(3), 422-430.