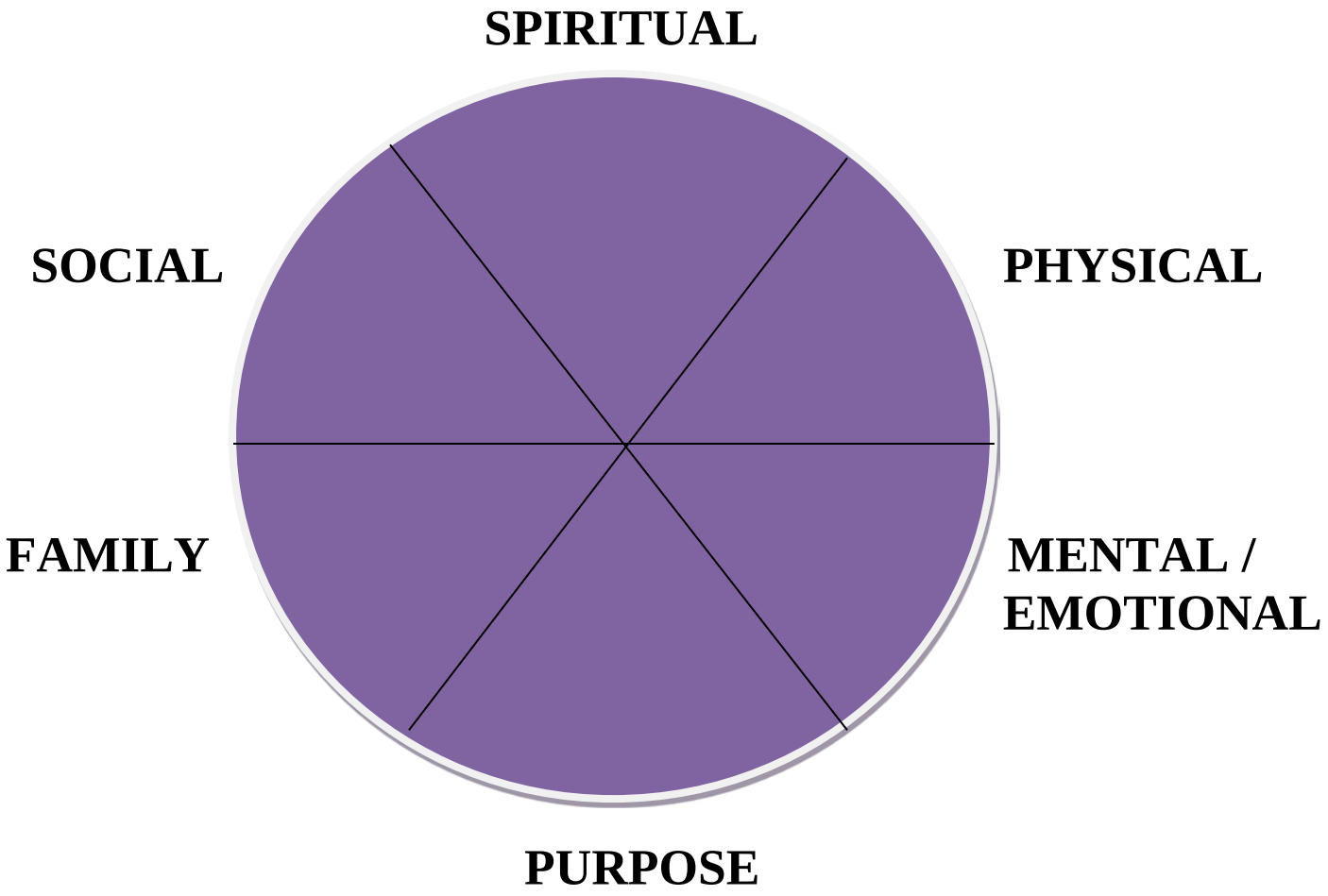
The WHOLE PERSON Wellness Approach to treating Chronic Pain



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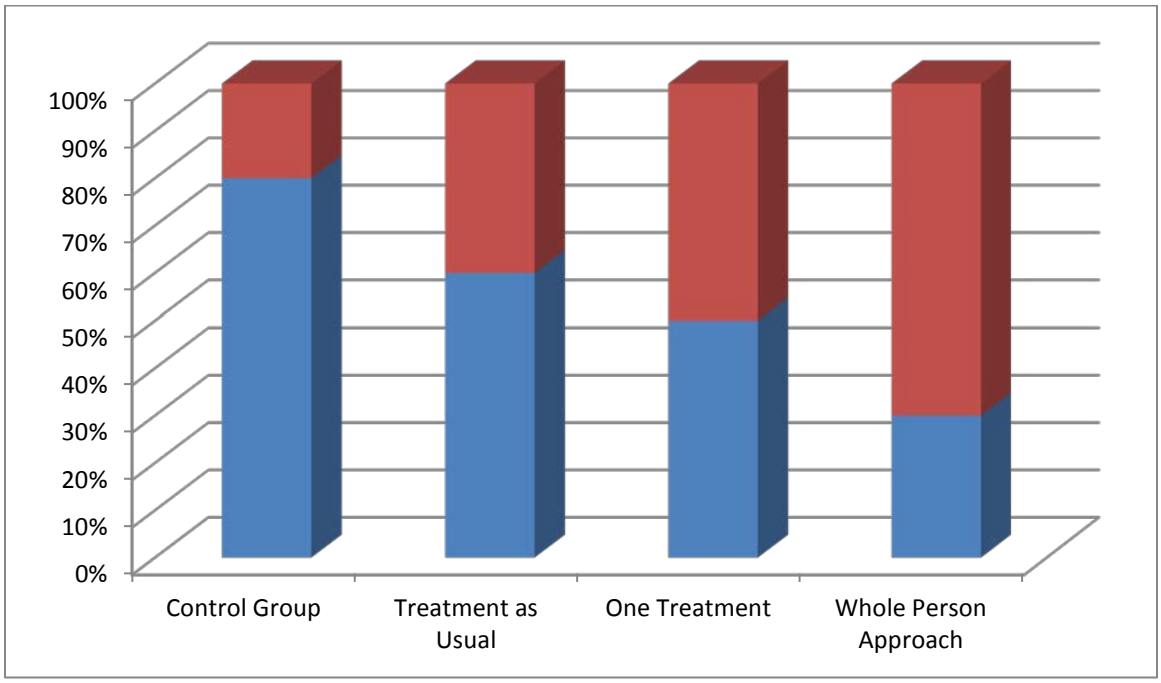
Section I

ASSESSMENT

HOW DO YOU KNOW IT'S HELPING?



Example of Assessment

ASSESSMENT

Getting to know about your patient, their injury / problem and their *relationship* with chronic pain helps you gain a better understanding of which factors can be addressed or helped by treatment. Assessment can also help patients better understand their own pain.

Encourage the *telling* of the story – once. During this telling, you as an experienced therapist may pick up areas of problem in moving through / beyond an injury and how the person became "stuck." What are the "reinforcers" going on for this patient? Interpersonal; financial; pain relief; fear… It may be useful to use a "structured clinical interview" that helps highlight areas of concern (or creating your own) so you can compare the different areas of function & concern. [See one example by at Google Books, Table 4.1: in Cognitive Therapy with Chronic Pain Patients By Carrie Winterowd, PhD, Aaron T. Beck, MD & Dan Gruener.]

Learning how and where the person has developed "disability" in their life may assist you in starting points. You may want to utilize tests of disability including **Roland Morris or Oswestry** to get a "baseline score".

Do ask the patient about "what your day is like?" This information will help you determine at what level and areas of first intervention. You may need to use motivational interviewing to discuss and perhaps encourage readiness to do something different than they have been. On rare occasions, I realized that a patient had some physical issues that I believed needed further work-up, but for the vast majority of patients patients were done with physician based interventions when I began to see them and when referred back to their doctor by counselors, social workers, etc. they felt both abandoned and the doctors felt - they didn't help.

Look at some examples of "lead- in questions" by area:

PHYSICAL	• If the patient tells you that because of their pain they are *not leaving* the house, except for medical visits, what might be your first areas of intervention? • If the patient tells you that because of back pain, they are unable to do *anything* physical What next • If the patient tells you the doctor cut down their opioid *medications*, and their goal is for you to help them get it back, where do you start?
MENTAL / EMOTIONAL	• If the patient tells you they have trouble getting to *sleep* because of pain; they're up until 2AM usually watching television, where to start? • If the patient tells you that they can't get comfortable because of pain; where to start? • If the patient reflects that the pain has made their *depression* much worse, they're drinking, and they just don't see how it can get better until someone can fix their pain, where to start?
SOCIAL	• If the patient tells you "I don't want to be around my friends when I'm hurting. It's not fair to them. So, I *haven't been in touch* with them lately." Where does that lead? • If the patient tells you: "I've *never* been someone with a lot of friendships. I used to see people at work, but now I'm at home most of the time
PURPOSE	• Patient is not working, says they don't have time to do anything with all their doctor's appointments and taking care of the house. They don't really see people like they used to. They used to always be involved in things. What could you help start?
FAMILY	• Patient states - my family used to be helpful, but more recently has just left me alone. I feel like they don't really understand what I'm going through
SPIRITUAL	• If the patient tells you that they have no way of *calming* themselves, or of being comfortable because their pain is so severe. They're not religious, never have been a joiner of groups, where to start?

Possible ICD-10 (DSM-V) Pain Diagnoses for presentations of Chronic Pain include:

1. F45.1 Somatic Symptom Disorder (300.82)

1. One or more somatic symptoms that are distressing or result in significant disruption of daily life.
2. Excessive thoughts, feelings, or behaviors related to the somatic symptoms or associated health concerns as manifested by at least one of the following:
    a. Disproportionate and persistent thoughts about the seriousness of one's symptoms.
    b. Persistently high level of anxiety about health or symptoms.
    c. Excessive time and energy devoted to these symptoms or health concerns.
3. Any one symptom may not be continuously present, but the state of being symptomatic is persistent typically > 6 mos.

2. F54 Psychological Factors Affecting other Medical Condition (316)

1. A medical symptom or condition (other than a mental disorder) is present.
2. Psychological or behavioral factors adversely affect the medical condition in one of the following ways:
    a. The factors have influenced the course of the medical condition as shown by a close temporal association between the psychological factors and the development or exacerbation of, or delayed recovery from, the medical condition.
    b. The factors interfere with the treatment of the medical condition (e.g., poor adherence).
    c. The factors constitute additional well-established health risks for the individual.
    d. The factors influence the underlying pathophysiology, precipitating or exacerbating symptoms or necessitating medical attention.
3. The psychological and behavioral factors in Criterion B are not better explained by another mental disorder (e.g., panic disorder, major depressive disorder, posttraumatic stress disorder).

3. F45.21 Illness Anxiety Disorder (300.7)

1. Preoccupation with having or acquiring a serious illness.
2. Somatic symptoms are not present or, if present, are only mild in intensity. If another medical condition is present or there is a high risk for developing a medical condition (e.g., strong family history is present), the preoccupation is clearly excessive or disproportionate.
3. There is a high level of anxiety about health, and the individual is easily alarmed about personal health status.
4. The individual performs excessive health-related behaviors (e.g., repeatedly checks his or her body for signs of illness) or exhibits maladaptive avoidance (e.g., avoids doctor appointments and hospitals).
5. Illness preoccupation has been present for at least 6 months, but the specific illness that is feared may change over that period of time.
6. The illness-related preoccupation is not better explained by another mental disorder, such as somatic symptom disorder, panic disorder, generalized anxiety disorder, body dysmorphic disorder, obsessive-compulsive disorder, or delusional disorder, somatic type.

4. F44.4 Conversion Disorder (300.11)

1. One or more symptoms of altered voluntary motor or sensory function.
2. Clinical findings provide evidence of incompatibility between the symptom and recognized neurological or medical conditions.
3. The symptom or deficit is not better explained by another medical or mental disorder.
4. The symptom or deficit causes clinically significant distress or impairment in social, occupational, or other important areas of functioning or warrants medical evaluation.

Other issues of Malingering or true Factitious Disorder are quite rare.
Don't forget to diagnose associated Depression; Anxiety; PTSD; Substance Abuse; etc.

You may be exposed to physicians referring a patient who have been diagnosed with "Chronic Pain Syndrome:" Chronic pain syndrome (CPS) is a common problem that presents a major challenge to health-care providers because of its complex natural history, unclear etiology, and poor response to therapy. CPS is a poorly defined condition. Most authors consider ongoing pain lasting longer than 6 months as diagnostic, and others have used 3 months as the minimum criterion. In chronic pain, the duration parameter is used arbitrarily. Some authors suggest that any pain that persists longer than the reasonably expected healing time for the involved tissues should be considered chronic pain.

CPS is a constellation of syndromes that usually do not respond to the medical model of care. This condition is managed best with a multidisciplinary approach, requiring good integration and knowledge of multiple organ systems. Approximately 35% of Americans are estimated to have some element of chronic pain, and approximately 50 million Americans are disabled partially or totally due to chronic pain.

See Scales for assessment below:

We are interested in the types of thoughts and feelings that you have when you are in pain. Listed below are 13 statements describing different thoughts and feelings that may be associated with pain. Using the following scale, please indicate the degree to which you have these thoughts and feelings when you are experiencing pain.

0 - Not at all **1 -** to a slight degree **2 -** to a moderate degree **3 -** to a great degree **4 -** All the time

When I'm in pain…. **PCS (Pain Catastrophizing Scale)**

Rating		
	1.	**I worry all the time about whether the pain will end.**
	2.	**I feel I can't go on.**
	3.	**It's terrible and I think it's never going to get any better.**
	4.	**It's awful and I feel that it overwhelms me.**
	5.	**I feel I can't stand it anymore.**
	6.	**I become afraid that the pain will get worse.**
	7.	**I keep thinking of other painful events.**
	8.	**I anxiously want the pain to go away.**
	9.	**I can't seem to keep it out of my mind.**
	10.	**I keep thinking about how much it hurts.**
	11.	**I keep thinking about how badly I want the pain to stop.**
	12.	**There's nothing I can do to reduce the intensity of the pain.**
	13.	**I wonder whether something serious may happen.**
	TOTAL:	Rumination (Questions 8,9,10,11). Mean 8. Abnormal 11 Magnification (Questions 6,7,13). Mean 3. Abnormal 5 Helplessness (Questions 1,2,3,4,5,12). Mean 8. Abnormal 13 Total Score (All Questions) Mean 20. Abnormal 30

DELETE THESE CUTOFFS BEFORE HANDING OUT

PDI (Pain Disability Index)

These rating scales are designed to measure the degree that aspects of your life are disrupted by persistent pain. In other words, we would like to know how much your pain is preventing you from doing what you would normally do, or from doing it as well as you normally would. Respond to each category by indicting the overall impact of pain in your life, not just when the pain is at its worst. For each of the 7 categories of life activity below, circle the number on the scale that describes the level of disability you typically experience. A score of 0 means no disability at all, and a score of 10 means that all the activities in which you would normally be involved have been totally disrupted or prevented by your pain.

(1)Family / Home Responsibilities

This category refers to activities related to the home or family. It includes chores or duties performed around the house (e.g., yard work) and errands or favors for other family members (e.g., driving the children to school).

0	1	2	3	4	5	6	7	8	9	10

No Disability Total Disability

(2)Recreation -This category includes hobbies; sports; and other leisure time activities

0	1	2	3	4	5	6	7	8	9	10

No Disability Total Disability

(3)Social Activity

This category refers to activities which involve participation with friends and acquaintances other than family members. It includes parties, theatre, concerts, dining out, and other social functions.

0	1	2	3	4	5	6	7	8	9	10

No Disability Total Disability

(4)Purpose / Occupation

This category refers to activities that are part of or directly related to one's job. This includes non-paying jobs such as volunteer work.

0	1	2	3	4	5	6	7	8	9	10

No Disability Total Disability

(5)Sexual Behavior
This category refers to the frequency and quality of one's sex life.

0	1	2	3	4	5	6	7	8	9	10

No Disability Total Disability

(6)Self-Care
This category includes activities that involve personal maintenance and independent daily living (e.g., talking a shower, getting dressed, etc.).

0	1	2	3	4	5	6	7	8	9	10

No Disability Total Disability

(7)Life-support Activity
This category refers to basic life-supporting behaviors as eating, sleeping, and breathing.

0	1	2	3	4	5	6	7	8	9	10

No Disability Total Disability

ROUTINES:

Since last visit, I have kept regular routines as follows:

Social Contacts	

Medications	

Exercise	

Purpose	

Mood	

Current Medications for Pain: _____
_____

Refills are ordered by: _____

My next refill is due: _____

I have missed _____ Days From Work or volunteering in the last month, solely due to pain.

Migraine Disability Assessment Scale (MIDAS)

1. In the last three months, how many days did you miss work or school because of your headaches?
_____

2. On how many days in the last three months was your productivity at work or school reduced by half or more because of your headaches? (Do not include days counted in question 1 where you **missed** work or school).

3. On how many days in the last three months did you not do household work because of your headaches?

4. How many days in the last 3 months was your productivity in household work reduced by half or more because of headaches? (Do not include days counted in question 3 where you did not do household work).

5. How many days in the last 3 months did you miss family, social or leisure activities because of headaches?

6. How many total days in the last 3 months did you have a headache? (Continuous Headache - count each day)

7. On a scale of 0 to 10, how painful were your headaches on average?
(Where 0 is not pain at all and 10 is pain as bad as can be).

==========

You may want to have patients complete a **Headache Diary**. Best is 4 periods per day, rating level of severity of headache and any additional medications taken for headache (or other interventions attempted).

Rate your headache 4 times per day, at mealtimes and bedtime using the above scale.
Headache Rating Scale:

Headache Levels	0 = No Headache 1 = Very Mild Headache, aware of it only when attending to it. 2 = Mild Headache, could be ignored at times. 3 = Moderate Headache, pain is noticeably present. 4 = Severe Headache, difficult to concentrate, can do undemanding tasks. 5 = Extremely Intense Headache, incapacitated.

1. ***HEADACHE INDEX****:* The average headache score for the week, found by summing all 28 ratings from the week (4 ratings per day for 7 days) and dividing by 7. This is a most sensitive measure, but may not be readily interpreted by the patient.

2. ***HEADACHE-FREE DAYS***: The number of days in a week that the patient has no headache activity. This is a very meaningful measure to the patient. It is adopted it in lieu of a pure frequency with migraines or mixed headaches. It is helpful for cases when it is difficult to know when one headache ends and another begins

3. ***PEAK HEADACHE RATING***: The single highest headache rating from among the 28 ratings for the week. An intensity measure, this seems to be sensitive to treatments which ameliorate but do not eliminate headaches.

MIDAS Scoring Rules

Grade	Definition	MIDAS Score
I	Little or no disability	0-5
II	Mild disability	6-10
III	Moderate disability	11-20
IV	Severe disability	20 +

Graded Chronic Pain Scale (MY FORM)

NAME: _____ Patient Number: _____ DATE: _____ Referred By: _____	APPOINTMENT LABEL

Please answer the following questions about your most bothersome site of pain.

1. In the past 3 months, did you have PAIN, in your:

Back	☐	Headache	☐	Joint	☐	Facial	☐
Neck	☐	Abdominal	☐	Chest	☐	Don't know	☐

2. If you have more than one pain, which area bothered you the most in the past 3 months?

Back	☐	Headache	☐	Joint	☐	Facial	☐
Neck	☐	Abdominal	☐	Chest	☐	Don't know	☐

3. How many days in the last three months (90 days) have you had this type of pain? _____

4. How would you rate your pain on a 0 to 10 scale at the **present time**, that is right now, where 0 is "no pain" and 10 is "pain as bad as could be"?

NO PAIN — PAIN AS BAD AS COULD BE

0 1 2 3 4 5 6 7 8 9 10

5. In the past three months, how intense was your **worst pain,** rated on a 0 to 10 scale, where 0 is "no pain" and 10 is "pain as bad as could be"?

NO PAIN — PAIN AS BAD AS COULD BE

0 1 2 3 4 5 6 7 8 9 10

6. In the past three months, how would you rate your **least pain,** rated on a 0 to 10 scale, where 0 is "no pain" and 10 is "pain as bad as could be"?

NO PAIN — PAIN AS BAD AS COULD BE

0 1 2 3 4 5 6 7 8 9 10

7. In the past three months, how would you rate your **usual** level of pain?

NO PAIN — PAIN AS BAD AS COULD BE

0 1 2 3 4 5 6 7 8 9 10

8. What are your biggest fears or worries about your pain?

_____

_____

9. What do you want most from today's visit?

_____

_____

10. About how many days in the last three months (90 Days) have you been kept from your usual activities (work, school or housework) because of your pain? _____

11. In the past three months, how much has your pain **interfered** with these activities?

	0 = Not at all										**10 = A Lot**
Work / Volunteering	0	1	2	3	4	5	6	7	8	9	10
Household Chores	0	1	2	3	4	5	6	7	8	9	10
Family Activities	0	1	2	3	4	5	6	7	8	9	10
Recreation or Exercise	0	1	2	3	4	5	6	7	8	9	10
Social Activities	0	1	2	3	4	5	6	7	8	9	10
Sex	0	1	2	3	4	5	6	7	8	9	10
Sleep	0	1	2	3	4	5	6	7	8	9	10
Eating	0	1	2	3	4	5	6	7	8	9	10

12. Check if you have had any of the following:

Recent Injury	☐ Date	Fever	☐	Chills	☐
Loss of Appetite	☐	Weight Loss	☐ lbs.	Weakness	☐
Bladder Trouble	☐	Bowel Trouble	☐	Cortisone	☐
Diabetes	☐	Cancer	☐	Chemotherapy	☐

13. Are you Working? Last Date of work? _____

☐ Yes ☐ No My job is Length at Job _____

14. Is your injury job related?

☐ Yes ☐ No

15. If you are not working, have you tried to return to your job? ☐ Yes ☐ No

16. What happened when you tried to return work? _____

_____

17. Do you want to return to your job? ☐ Yes ☐ No

18. Do you like your job? ☐ Yes ☐ No

19. Is there any legal action planned or pending about your injury? ☐ Yes ☐ No

20. Is your injury from an Accident(s)? Give date(s) _____

21. Have you had any blood relatives with alcohol or drug problems? ☐ Yes ☐ No

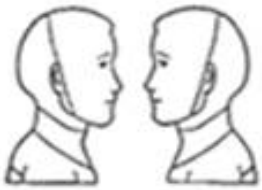
PAIN DIAGRAM

Using the symbols given below, mark the areas on your body where you feel the described sensations. Include **all** affected areas.

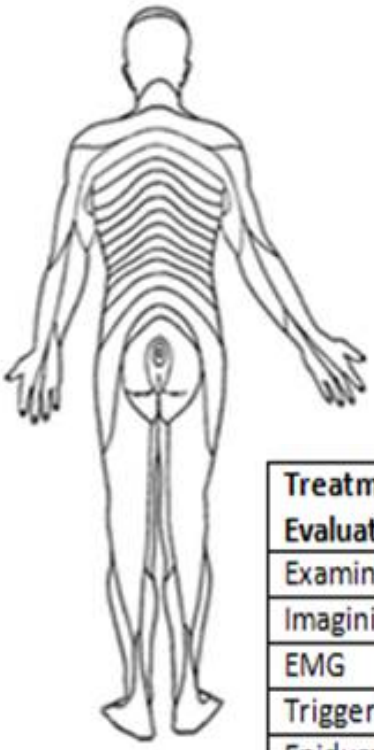
Pins & Needles = 00000 Stabbing = ///////

Burning = xxxxxx Deep Ache = zzzzzz

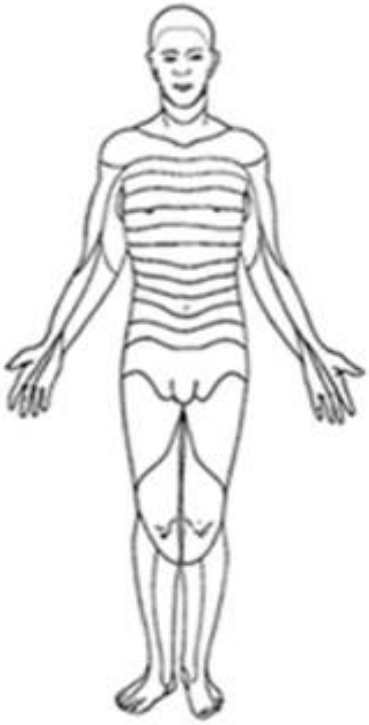
Side



Back



Front



Treatment or Evaluation Tool	Date	Helpful?	
Examination		Yes	No
Imagining		Yes	No
EMG		Yes	No
Trigger Pt Injections		Yes	No
Epidural Steroids		Yes	No
Nerve Root Blocks		Yes	No
Cortisone Injections		Yes	No
Facet Injections		Yes	No
Chiropractic		Yes	No
Acupuncture		Yes	No
Massage		Yes	No
Naturopathy		Yes	No
Physical Therapy		Yes	No
TENS Unit		Yes	No
Biofeedback/Counseling		Yes	No
Hypnosis		Yes	No
Ice/Heat		Yes	No
Bed Rest		Yes	No
Other		Yes	No

PHQ-9

Over the *last 2 weeks,* how often have you been bothered by any of the following problems? *(use "✓" to indicate your answer)*	**Not at All**	**Several Days**	**Half the Days**	**Nearly Every Day**
1. Little interest or pleasure in doing things				
2. Feeling down, depressed, or hopeless				
3. Trouble falling OR staying asleep, or sleeping too much				
4. Feeling tired or having little energy				
5. Poor appetite OR overeating				
6. Feeling bad about yourself— that you are a failure or have let yourself or your family down				
7. Trouble concentrating on things, such as reading the newspaper or watching television				
8. Moving or speaking so slowly that other people could have noticed. OR the opposite—being so fidgety or restless that you have been moving around a lot more than usual				
9. Thoughts that you would be better off dead, or of hurting yourself in some way				
	Not at all	**Somewhat Difficult**	**Very Difficult**	**Extremely Difficult**
10. If you checked off *any* problems, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?				

GAD -7

Over the last 2 weeks, how often have you been bothered by the following problems?	Not At All	Several Days	More than Half the days	Nearly Every Day
1. Feeling nervous, anxious or on edge.	0	1	2	3
2. Not being able to stop or control worrying.	0	1	2	3
3. Worrying too much about different things.	0	1	2	3
4. Trouble relaxation.	0	1	2	3
5. Being so restless that it is hard to sit still.	0	1	2	3
6. Becoming easily annoyed or irritable.	0	1	2	3
7. Feeling afraid as if something awful might happen.	0	1	2	3

TOTAL SCORE _____ = _____ + _____ + _____

Add Columns

If you checked of any problems above, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not Difficult at All	Somewhat Difficult	Very Difficult	Extremely Difficult
☐	☐	☐	☐

The AUDIT Alcohol Questionnaire

Drinking alcohol can affect your health. This is especially important if you take certain medications. We want to help you stay healthy and lower your risk for problems that can be caused by drinking. The following questions are about your drinking habits.

Circle your answers. Then, find your score in the top row above your answers. At the end, total your scores, and look at the back of the sheet to rate your drinking habits.

Questions	0	1	2	3	4	Your Score
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times a month	2-3 times a week	4 or more times a week	
2. How many drinks alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more	
3. How often do you have six or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
5. How often during the year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
7. How often during the last year have you had a feeling of guilt or remorse after drinking? daily	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
8. How often during the last have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
9. Have you or someone else been injured because your drinking?	No		Yes, but not in the last year		Yes, during the last year	
10. Has a relative, friend, doctor, other health care worker been concerned about your drinking or suggested you cut down?	**No**		Yes, but not in the last year		Yes, during the last year	
					TOTAL	

DAST-10 Questionnaire

These questions concern your potential involvement with drugs, excluding alcohol and tobacco, during the past **12 months**. When the words “drug abuse” are used, they mean the use of prescribed or over-the-counter medications/ drugs in excess of the directions and any non-medical use of drugs. The various classes of drugs may include: cannabis (e.g., marijuana, hash), solvents, tranquilizers (e.g., Valium), barbiturates, cocaine, stimulants (e.g., speed), hallucinogens (e.g., LSD) or narcotics (e.g., heroin). Remember that the questions do not include alcohol or tobacco. Choose the response that is mostly right for you. You may choose to answer or not answer any of the questions in this section.

These questions refer to the last 12 Months	**NO**	**YES**
1. Have you used drugs other than those required for medical reasons?	0	1
1. Do you abuse more than one drug at a time?	0	1
2. Are you always able to stop using drugs when you want to? (If you never use drugs, answer “Yes.”)	**1**	**0**
4. Have you had "blackouts" or "flashbacks" as a result of drug use?	0	1
5. Do you ever feel bad or guilty about your drug use? (If you never use drugs, choose “No.”)	0	1
6. Does your spouse (parents) ever complain about your use of drugs?	0	1
7. Have you neglected your family because of your use of drugs?	0	1
8. Have you engaged in illegal activities in order to obtain drugs?	0	1
9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	0	1
10. Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding, etc.)?	0	1

Total Score:_____

SCORING

Scoring rules and classification criteria for the Graded Chronic Pain Scale

Characteristic Pain Intensity is a 0 to 100 score derived from Questions 4, 5, & 7:

Mean = [Pain Right Now + Worst Pain +Average Pain] X 10 /3 = _____

Disability Score is a 0 to 100 score derived from Question 11:

Mean = [Work Activities + Family Activities + Recreation or Social Activities] X 10/3 = ___

Disability Days*(1 mo. or 3 mo.)* is from question 10 = _____ X 2 = _____

[If using the 3 month version, multiply Disability Days by 2 before calculating Disability Points.]

DISABILITY POINTS

Add the indicated points for Disability Days (Question 10) and for Disability Score.

DISABILITY SCORE (Sum from question 11)		DISABILITY DAYS (Question 10) (If using 3 month version, multiply Disability Days by 2)	
0-29	0 Point	0-6 Days	0 Point
30-49	1 Point	7-14 Days	1 Point
50-69	2 Points	15-30 Days	2 Points
70 +	3 Points	31 + Days	3 Points

GRADED CHRONIC PAIN CLASSIFICATION	
PAIN FREE	
GRADE 0	No pain problem (prior six months or three months)
LOW INTERFERENCE	
GRADE I	Characteristic Pain Intensity less than 50 and
Low Intensity	less than 3 Disability Points.
GRADE II	Characteristic Pain Intensity of 50 or greater and
High Intensity	less than 3 Disability Points.
HIGH INTERFERENCE	
GRADE III	3-4 Disability Points, regardless of
Moderately Limiting	Characteristic Pain Intensity.
GRADE IV	5-6 Disability Points regardless of
Severely Limiting	Characteristic Pain Intensity.

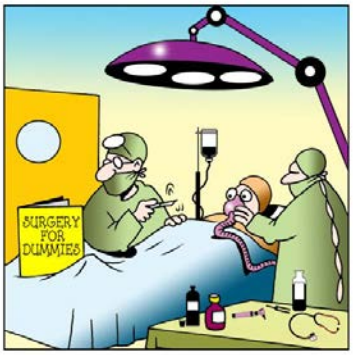
CHRONICITY CLASSIFICATION	
NON-PERSISTENT PAIN	1-89 PAIN DAYS (Question 1)
PERSISTENT PAIN	90-180 Pain Days (Question 1)

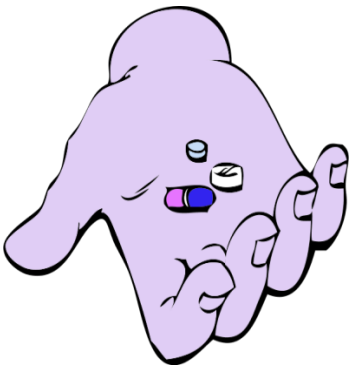
PHQ-9	GAD-7	AUDIT	DAST
0-4 None or Minimal Depression	0-4 None	0-6 Not Significant	0 No Problem noted
5-9 Mild Depression	5-9 Mild Anxiety	>7 Concerning	1-2 Mild Monitor
10-14 Moderate Depression	10-14 Moderate Anxiety	>20 likely Alcohol Dependence	3-5 Mod. Investigate
15-19 Moderately Severe Depression	>15 Severe Anxiety		6-8 Substantial – Tx
>20 Severe Depression			9-10 Severe - Intense

Section II

INTERVENTION

For our purpose of mental health treatment of chronic pain, we're having to assume the "MEDICAL" interventions have been tried:





What are the ways - WE can be of benefit to our patients?

Intervention – Following the 6 Part; Self-Care Circle:

PHYSICAL:

1. POSTURE - does the person maintain plumbline posture?
Top of Head; Ear Flap; Shoulder; Hip Pointer; Knees; Ankle pointer. Even when they say they've become more comfortable in an *altered* posture, that should not be encouraged to remain (typically).

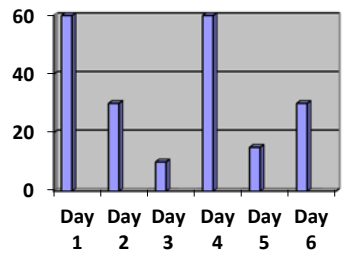
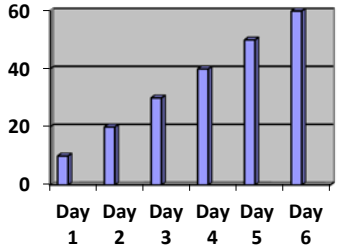
2. EXERCISE – How to start someone on a very basic program of moving their body. Ideally ALL should do stretches if possible. After that - Intuitively determined aerobic exercise - should it be Walking?; Stationary Bike?; Swimming?; Yoga? IF really progressing well, then a 3rd step would be re-strengthening. No ONE way is the right thing, but creating any increased activity level has demonstrated benefit to pain.

Issues to consider:
What is the medical diagnosis?
- Knee problems – may need to do biking
- Spinal Stenosis – walking can be more difficult

Despite "Specific Diagnosis" overall body **stretching** program important! Doesn't matter - all can do these stretches - if modified (below).

Consistency is the BIGGEST goal:
- Swimming - best for body, but preparation & hard to maintain
- Walking - don't need any equipment, just go
- Yoga - going to have to talk with instructor (communication issues)

Overdoing (not **pacing**) is often the biggest problem in starting exercise. Patients estimate the amount they feel they can do, then cut it 25%. Start there with goal of achieve consistency and build back up to that level they first "could do" with almost daily activity. GAP TOOTH activity logs are negative predictors of physical recovery, when patient charts show variability in Highs & Lows of activity. We need small, progressive increase to get positive result.

WRONG	CORRECT
	

If I had to personally pick an order to start (e.g., could only do 1 physical thing), it would be daily stretches, because it can be done anywhere, demonstrates progress, and people feel better. Second would be the aerobic / cardiovascular walking or other physical exercise. Finally I would add in weights or some strengthening. [If never to PT, get a personal regimen setup].

January

EXERCISE LOG

Sun	*Mon*	*Tue*	***Stretching*** *DONE ✓* *Wed*	*Thu*	*Fri*	*Sat*
1 ☐	**2** ☐	**3** ☐	**4** ☐	**5** ☐	**6** ☐	**7** ☐
8 ☐	**9** ☐	**10** ☐	**11** ☐	**12** ☐	**13** ☐	**14** ☐
15 ☐	**16** ☐	**17** ☐	**18** ☐	**19** ☐	**20** ☐	**21** ☐
22 ☐	**23** ☐	**24** ☐	**25** ☐	**26** ☐	**27** ☐	**28** ☐
29 ☐	**30** ☐	**31** ☐				
Write # minutes of Exercise & Check the box if stretching done.	**Put Time to Sleep and wake in the date as well.**	**Put Time watching TV in each date as well How's the balance?**			2015	

Exercise Log (2)

	Time Done AM/PM	Type(s) of Exercise	Duration of Exercise	Stretch Before?	Stretch After?
Sunday					
Monday					
Tuesday					
Wednesday					
Thursday					
Friday					
Saturday					

	Time Done AM/PM	Type(s) of Exercise	Duration of Exercise	Stretch Before?	Stretch After?
Sunday					
Monday					
Tuesday					
Wednesday					
Thursday					
Friday					
Saturday					

	Time Done AM/PM	Type(s) of Exercise	Duration of Exercise	Stretch Before?	Stretch After?
Sunday					
Monday					
Tuesday					
Wednesday					
Thursday					
Friday					
Saturday					

DAILY STRETCHING EXERCISES

WHOLE BODY STRETCHES - DAY 1, 3, 5 OF THE WEEK

Exercise Name	Position	Description	Count
Forward Neck Rolls	Standing*	Roll neck slowly forward from right shoulder to left shoulder, then back. (Do not look up or bend neck backwards).	1, Back
Shoulder Shrugs	Standing*	Shrug shoulders up, relax, push shoulders down, relax.	Count 4
Shoulder Circles	Standing*	With arms at sides, circle shoulders backwards	Count
Calf & Achilles Stretch	Standing	Step forward with left leg; keep right leg straight with flat heel. Count 20. Switch. Step forward with right leg; Bend left leg, flat heel.	20 Secs
Push-Pull Row	Standing*	With arms straight out, shoulder width apart, push out (round shoulders) then pull elbows back as if rowing. Knees slightly bent.	1, back
Linebacker Squat	Standing	Standing with feet just beyond shoulder width, arms at side, bend knees & squat (as if to sit) while lifting arms up in front of you.	1, Up
Bridging	Back	Do a pelvic tilt (Breathe), lift buttock up, bring down, relax	4 count
Sit-up/Crunches	Back	Keep pelvic tilt, lift shoulders up few inches & down	1 Down
Hamstring	Back	With towel around foot, **gently** lift leg and move toward straight. Switch	20 Secs
Hip & Glut Swings	Standing	Swing Right leg Forward, Center, Side, Center then Backward, Center (bent knee and toes pointed straight ahead). Count up to desired reps. Then, Switch legs.	6 Count
Marching	Standing	Raise right leg then left, with knees high in front.	4 count
Laterals	Standing	Step w/ left foot to left, followed by right foot (a small hop). Then, reverse starting with right foot. (keep knees bent).	1 & 2, and 3 & 4.
Heel Rises	Standing	Slowly, rise up on toes, raising heels, then come slowly down.	1, Down

* Can also be done sitting or in another position

If counting, Count 1-2-3-4 or 1 and 2. IF 20 seconds, hold pose for 20 seconds. Typically start with 4 reps, and no more than 20 reps - ever.

WHOLE BODY STRETCHES - DAY 2, 4, 6 OF THE WEEK

Exercise Name	Position	Description	Count
Chin Glides	Sitting*	Gently, pull your chin straight back & release, as if jaw were on rollers. Do not tilt your head.	1, Back
Upper Trap	Sitting*	Bring R ear towards R shoulder. Hold for 20 seconds. Do not lift L shoulder. (Hint drape L arm behind your back). Then, do Left side	20 Secs
Shoulder Rotation	Sit in Chair	Cross arms at shoulder level, rotate upper torso R, center, L, center. (think: I Dream of Jeanie).	4 count
Forward Leans	Sitting - edge of chair	Tighten abdomen; Feet wide on floor. Lean forward as if to stand; return to sitting.	1, Back
Lunges	Standing	Tighten abdomen, then step forward with the R leg, and bend knee (keep knee centered over toe & **start small**). Return to standing and repeat with L leg.	4 count
Leg Lift	Hands & Knees	Tighten abdomen. Lift R leg, kicking foot out; Return to start. Now, Alternate to L leg. [Keep shoulders & back straight like a table]	1, Down
Arm Lift	Hands & Knees	Tighten abdomen. Lift R arm to shoulder level or **less**, sticking hand out; Return to start. Now, Alternate with L arm. [Keep shoulders & back straight]	1, Down
Cat/Camel	Hands & Knees	Tuck your head down, and tighten your stomach (pelvic tilt) arching your back and rounding your shoulders.	20 secs
Side Leg Lift	Lying on Side	Bottom leg slightly bent for support. Keeping top leg straight, lift it a few inches then down. Do all reps, and then repeat on other side.	1, Down
½ Press-Up	Abdomen	Push up, leaving waist on the floor (Use forearms if wrist problems).	1, Down
Shoulder "T's"	Abdomen*	Arms straight out from sides (like the letter T), squeeze shoulder blades together and lift arms up 3-6 inches while turning thumbs upward	1, Down
Box Step	Standing	R Foot - Step to the right, bring left foot together; step back with right foot, Move left foot diagonally to the left, and bring right foot together; then step forward with right foot, and bring left foot together. Repeat to the left.	1"and"2 (across) 3"and"4 R,R,L,R L,L,R,L
Toe Rises	Standing	Rise up on toes, then down.	1, Down

* Can also be done sitting or in another position

If counting, Count 1-2-3-4 or 1 & 2. IF 20 seconds, hold pose for 20 seconds.
Typically start with 4 reps, and no more than 20 reps - ever.

MEDICATIONS:

Controversial issues about medications and Chronic Pain.
Many people think "Pain = Pain Killer medications"

However, that's a) not always true and b) what type of pain killer?
A. *Opiate or Narcotic* medications are typically now not found to be very useful on a long-term basis for most conditions. The body is set up to develop "tolerance" (not addiction - which is a different issue) so that the lower dose will no longer work, and the person will require higher and higher doses to "feel" the same. When these medications are missed or stopped, patients often report - my pain was much higher so that proves it *is* helping. In fact, after just 2-3 weeks of continuous use there may be withdrawal / rebound effects of stopping narcotic medication. As well, no evidence of increasing function as a result of taking opioid medications.

B. *Tricyclic Antidepressants* may be your friend! We know from research that older antidepressants that are used at 1/5-1/10th their previously used dose are effective interventions of both a) turning down nerve based pain and b) assisting in sleep. There are contra-indications in elderly due to lowering blood pressure and/ or creating dizziness (no falls). But, these are one of the front-line helpful medications for pain.

C. Antidepressants have not demonstrated very significant benefit for chronic pain. While there are some that have been "FDA Approved" for pain (e.g., duloxetine and pregabalin - an anticonvulsant), there is little evidence that they are any better than tricyclic antidepressants, or whether they can be of long-term benefit for pain - they have been too recently on the market. In standard antidepressants, many physicians prescribe venlafaxine (Effexor) due to its apparent effect on 2 different neurotransmitters. Initially, many of these medications are thought to be "wonder drugs" but over time the benefit rate demonstrates lower levels of effectiveness than first thought.

D. Other medications such as "adjuvants" can be a helper to other medications or used themselves for pain. Such medications as *anticonvulsants* (originally tried for seizures) may help nerve based pain. *Muscle relaxants* may be used intermittently (though again not typically as useful used daily - due to rebound) to help with muscle tightness / spasm problems. *Anti-inflammatories* are controversial. Some naturopathic types may be mildly helpful (e.g., bromelain), while stronger versions (e.g., ibuprofen) may cause bleeding of the stomach lining if overused. While still a "first line approach," these are becoming less supported recently. *Topical Anesthetics* or *Analgesics* are medication options that may provide some numbing or reduction in pain, with lower overall side-effect profiles (not taken internally). Examples of these medications include: Lidocaine cream; Salicylate creams; Menthol; etc. Capsaicin works in a unique counter-irritant way - turning down pain signals with mild chemical burning that desensitizes the nerve receptors to the pain signals.

E. What about *Naturopathic* medication approaches? The primary issue is lack of evidence. While many of the ideas presented have sound logic or theory behind them, the development of research to document that this works on most of the people most of the time without serious side-effects / costs is really important to establish. There is ALWAYS a cost / benefit to any plan of medication intervention - and you have to determine the perceived benefits are likely to outweigh the costs.

MENTAL / EMOTIONAL

Depression, Anxiety & Anger. We are now aware from research that individuals with significant problems of emotion are likely to actually have higher pain reports, due to magnification of symptoms and increased sensitivity to pain signals. While it likely is bi-directional (those with pain may have worse emotional function), we believe that there are clear interventions for Depression; Anxiety & Anger problems. What to do? Typical mental health approaches to improving these problems are one area that a patient does have *control*.

As you create "control" the person with chronic pain will become more functional and able to better manage even unremitting chronic pain.

Treatment for Depression, Anxiety & Anger:

- **Cognitive Behavioral Therapy** (awareness of & changing negative appraisal (especially catastrophizing) of issues surrounding chronic pain. Behavioral experiments may also be a part of this approach, helping patients create success at lower level activities, allowing resumption of functioning. Primarily focused on in anxiety, exposure and desensitization approaches have proven quite helpful in a number of treatment foci (depression, pain and anger) as well. Specific tools called defusion, acceptance, values, and exposure are part of a subset of CBT called ACT and can be used for treatment of chronic pain (Dahl, Wilson, Luciano & Hayes).
- **Behavioral Activation** (walking (noted above); scheduling activities; setting hours of sleep and awake time; scheduling social activities) [See work by Martell & Dimidjian].
- **Problem-Solving Steps**: Individuals with pain problems may need assistance and practice in learning to solve psycho-social problems. Evidence supports this as helping chronic pain. Teach the 6 steps of problem-solving and practice [see work by D'Zurilla & Goldfried; Spivac & Shure].
- **Creativity, Humor & Imagination**: Very important in "scheduling" to make time to initiate creative and imaginative type activities. This is a doorway to other "possibilities" that might come as the person is getting better. Humor and ability to "lighten" the situation can be very helpful.
-

SLEEP:

Sleep is a MAJOR issue affecting function and coping with chronic pain. While it is a physical activity - it really belongs in the "Mental / Emotional" category because the biggest culprit of sleep problems - even in individuals with chronic pain - is mental & emotional factors. The more you can use CBTi or even basic sleep hygiene approaches to get people having more regulated and deep sleep the better they can cope with other areas of problems and function.

RELAXATION / MEDITATION [HYPNOSIS]:

There is significant research on the ability of a person with chronic pain to learn techniques to help themselves "feel differently" about their situation to their having recovery. Tailoring these areas of intervention, you can teach very structured to more diffuse relaxation approaches. Exercises such as "Square Breathing" may help you learn how the person tolerates being quiet; self-regulation; openness. Their response may help you learn whether to continue to focus in more physically oriented ways [e.g., Progressive Muscle Relaxation Training; Body Scan] or if you can also do more purely mental exercises [e.g., Quieting Response; Autogenic Training]. There is now a double blind study of both CBT for Chronic Pain and Mindfulness Based Stress Reduction (Mindfulness) that has shown both have equal benefit to the patient - if it fits their style & expectations.

There are protocols available to the trained hypnotherapist to assist a patient with chronic pain as well. Some of the specific techniques that some of these other tools could create, would also be created in the use of hypnosis. Specific goals such as: Analgesia; Amnesia; Dissociation; Time Distortion or Age Regression; Symptom prescription or substitution; and Metaphor or Changing the Meaning all could be of help - depending on the current issue / state of this person's difficulties / stuck spot.

PURPOSE:

There is less overall research on this area than those above. But individuals with chronic pain often withdraw from activities that would actually be of benefit to them. For this reason, part of the treatment being discussions of how they will engage in some type of "purposeful activity" (outside of their family / household) has been found to be very beneficial. One area of specialized practice in chronic pain is "worker's compensation". There have been numerous studies here that the longer a patient is away from their work site, the worse the likelihood of full recovery. Even if someone is present but not able to do typical responsibilities - being on a schedule; showing up for something where you feel 'valued'; having social interaction and ideally positive social engagement; the more likely they are to remain in that "functional" category - even with conditions of chronic pain.

FAMILY:

Issues with family in problems of chronic pain tend to appear in 2 primary extremes - overly helpful or not helpful / devaluing. Of course there are ranges of familial response styles, and any person's perceptions of thir family may have strong effects. There is again significant research that "solicitous" spouses - who assist the person with injuries or pain in doing everything, provide extra attention and nurturance - to the point the person is now feeling more special than typical - may actually inhibit recovery. On the other hand (and this is often more typical), after a short while of being supportive, many times family members become demoralized; hopeless; distant and disengaged; sometimes even shaming a family member who cannot participate the way they once did. This type of discarding or shaming can create a scar that even medicine cannot heal. In either extreme, psychotherapy has a role in assisting. In the former case, teaching the difference between passive, aggressive and assertive, and requesting the person with chronic pain be assertive with family about what they can do (in line with Behavioral Activation - scheduling; Purpose - taking on things they can manage; Social - engagement in "family time" activities if they have maintained *pacing*) all help the person resume better "function". In the latter case, issues are more difficult. While the general US Divorce rate is 50%, the rate among individuals with chronic pain approaches 80%. There may need to be some individual counseling for spouses or children, as well as family based intervention. If there are ways to create the "family time" type of interactions, while ensuring there is not dismissive or shaming / belittling type of interaction, then the person may begin to again be engaged in the family and again more "functional."

SOCIAL:

Social is a difficult area. What is proposed may be quite different than the person did "premorbidly". There are some individuals who are by nature more "introverted" and not likely to enjoy the recommendation of "joining a group." There are "extroverted" people who may not be able to have the same *type* of interactions socially they used to engage in based on their pain. This is again an "art" of finding something that people with chronic pain can begin to do (again outside their household) on a somewhat regular basis, with a goal for "balanced time - together and alone". You may recognize this concept from an evidence based intervention for bipolar disorder called "Social Rhythm Therapy". The suggestion is that many individuals with issues of pain may never have found ways of being comfortable socially - and need help to be successful in a group setting. This includes teaching about *Boundaries*, about communication skills of *Active Listening and I-statements*, of how to recognize when someone is mistreating you and setting *Assertive* (not aggressive not passive) limits. However, despite the challenges and drawbacks, there is evidence that if patients can get engaged in some regular group based activity, this is likely to build their functionality. The issues are: it needs to be scheduled (e.g., weekly choral group; monthly book club; etc.). If people say - "I get together with my friends" you may find upon closer examination they just as often cancel that because a) they're not feeling well and b) their friends understand - groups don't. Second, it should be in some area that the person has had some interest or in which they can now get some secondary gain - appreciation; social success; feeling of making a difference; feeling of growing themselves. Ideas can come from weekly newspapers (classes; groups; outings), but ideally should not be solely based on problems (e.g., pain support groups).

One other *Major* area in the "Social" realm becomes the interaction of the patient with his or her care team. If like most people, we are conditioned - When I'm sick, I go to the doctor and they "fix it" or make me better. However, with issues of "chronic pain" - they can't "fix it", which sets up dissonance - either this doctor doesn't know what they're doing; or there's something wrong in me (maybe it's all in my head). If there are not discussions about the role of physicians; massage therapists; physical therapists; psychotherapists; etc. helping "***manage pain" and "improve function"*** vs. fix the problem - there can be great difficulties in communication and social engagement with the healthcare team.

SPIRITUAL:

There is now solid research on the overall health benefit and more specifically in management of chronic pain for having some type of spiritual connection. Often people think of "church" when spiritual is mentioned. However, in this context, it refers to a connection with something larger than ourselves - which could be nature; humanity; a higher power; God; or some other concept of something larger. Discussion with your patient about the ways they connect to the Spiritual side of themselves and how that is put into practice is also often quite beneficial - as it gets rediscovered as the person grows toward health and recovery.

NEURO PLASTICITY:

While the area of understanding neural plasticity is just evolving, there is strong research that doing some of the activities that are noted in each of these sections - changes the brain. Given the theory or concept that people are often "stuck" when it comes to coping with chronic pain, the ability to shift brain processes and doing something different really does make sense that we are rewiring the brain.

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