Slide 1

WELCOME – where are we coming from?
Mental Health; Medical Health; Education

PLEASE QUIET CELL PHONES

Slide 2

NEW INFORMATION – FUNDING Chronic Pain

Hot Off The Presses

Slide 3

"SUPPORT for Patients and Communities Act" [H.R. 6] on Non-opioid treatment of pain pass the US Senate 10/15/18 98 to 1.

AREAS: PREVENTION; TREATMENT: WORKFORCE & SPECIAL POPULATIONS

Prevention

- Requires CMS to issue guidance to states on Medicaid coverage of non-opioid treatment and management of pain, including non-pharmacological therapies;
- Requires the Department of Health and Human Services (HHS) to issue a study within one year of best practices, coverage policies, and payments to providers related to the use of multi-disciplinary non-opioid treatments for acute and chronic pain management under Medicare, and to develop an action plan on recommended changes to Medicare and Medicaid policies and payments to prevent opioid addiction and improve access to medication-assisted treatment;
- Requires HHS to issue guidance to Medicare-participating hospitals on pain management strategies, including education of non-opioid pain management treatments and authorizes award grants to hospitals and emergency departments to test or develop alternatives to opioids for pain management.
- Requires HHS to convene technical expert panels to make future recommendations.

Slide 4

Treatment

- Requires states to cover medication-assisted treatment (MAT) under Medicaid, including methadone and all other FDA-approved drugs used in MAT, and counseling and behavioral treatment, beginning 10/1/2020.
- Gives states option for temporary Medicaid coverage of residential treatment for substance use disorder, up to 30 days per year
- Authorizes CMS to test the use of incentive payments to clinical psychologists and other behavioral health providers for the use of electronic health records (EHR) technology;
- Establishes Medicare coverage of services provided by opioid treatment programs, including individual and group therapy with a psychologist or other authorized mental health professional, under a bundled payment system, and authorizes a 4-year demonstration project
- Establishes coverage of telehealth services under Medicare and guidance re: Medicare for patients to receive treatment in their own homes for substance use and co-occurring mental disorders, for those patients with a substance use disorder.
- Strengthens federal agency reporting requirements on private sector health plan compliance with the Mental Health Parity and Addiction Equity Act (MHPAEA).

Slide 5

Workforce

- Supports expansion of the substance use treatment workforce through a new, targeted loan repayment program & by extending eligibility for National Health Service Corps loan repayment assistance to providers working in schools and other community-based settings.
- Requires the establishment of Regional Centers of Excellence in Substance Use Disorder Education for improving health professional training resources with respect to substance use disorder prevention, treatment, and recovery.
- Requires HHS to establish a competitive grant program funding at least 10 Comprehensive Opioid Recovery Centers to provide a full continuum of treatment and recovery services, including residential rehabilitation, community-based and peer recovery support services, job training and placement assistance, and to conduct training and outreach to educate the public and professionals on substance use disorders and respond to community needs;

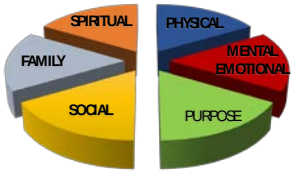
Slide 6

Special Populations

- Authorizes the CDC to support state efforts to collect data on **adverse childhood experiences**, and creates an interagency task force to promote best practices to identify, prevent and mitigate the effects of trauma on children and families;
- Establishes grant program to increase student access to evidence-based trauma support services, and requires HHS to disseminate resources to early childhood providers working with youth on ways to recognize and respond to early childhood trauma;
- Requires HHS to develop guidance to states on identifying funding for family-focused residential substance treatment programs, and authorizes grants to help states develop, enhance or evaluate family-focused treatment programs;
- Supports services for pregnant and postpartum women, creating a new funding stream to states for implementing "plan of safe care" provisions in the Child Abuse Prevention and Treatment Act (CAPTA), & requiring development of educational materials on pain management during pregnancy; & research on Neonatal Abstinence Syndrome
- Allows states to cover inpatient and outpatient services at residential pediatric recovery centers for infants with neonatal abstinence syndrome and requires HHS to issue recommendations on financing under Medicaid and CHIP for parents with substance use disorders and infants with neonatal abstinence syndrome.

Slide 7

Effective Intervention for Chronic Pain
Behavioral Treatment of Chronic Pain



James Keyes, Ph.D., ABPP
University of Washington Clinical Instructor

Slide 8

I have no Conflicts of Interest to report!

Slide 9

Disclaimer:

"Materials that are included in this course may include interventions and modalities that are beyond the authorized practice of mental health professionals. As a licensed professional, you are responsible for reviewing the scope of practice, including activities that are defined in law as beyond the boundaries of practice in accordance with and in compliance with your professions standards. "

Slide 10

WHERE ARE YOU AT TODAY? – Self Assessment

Oswestry Questionairre
Anxiety / Depression / Wellness
YOU NEED for this information in your practice

ARE YOU WILLING TO SHARE WITH OTHERS HERE?

Slide 11

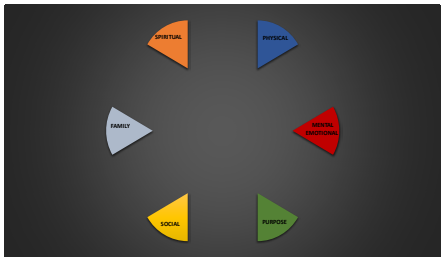
PHQ-9	OSWESTRY Disability Scale
Rate 0,1,2,3 (None, Some, Mod, Sev)	**Pain intensity**
1. Little Interest or pleasure doing things	**I have no pain at the moment**
2. Feeling down, depressed, hopeless	The pain is very mild at the moment
3. Trouble falling or staying asleep	The pain is moderate at the moment
4. Feeling tired; Little energy	The pain is fairly severe at the moment
5. Poor Appetite; or Too Much	The pain is very severe at the moment
6. Feeling bad about yourself; guilt	The pain is the worst imaginable at the moment
7. Trouble concentrating simple things	**Personal care**
8. Moving Slow or Speeded	I can look after myself normally without causing extra pain
9. Thoughts of death / self-harm	I can look after myself normally but it causes extra pain
	It is painful to look after myself and I am slow and careful
	I need some help but manage most of my personal care
	I need help every day in most aspects of self-care
	I do not get dressed, I wash with difficulty and stay in bed
➢ REMIND ME – Bernie Siegel, MD	**Sitting**
Love, Medicine & Miracles – How does he talk with patients about pain?	I can sit in any chair as long as I like
	I can only sit in my favorite chair as long as I like
	Pain prevents me sitting more than one hour
	Pain prevents me from sitting more than 30 minutes
	Pain prevents me from sitting more than 10 minutes
	Pain prevents me from sitting at all

Slide 12

How do you RATE YOUR PAIN (0-10)?
ALTERNATIVE version

Slide 13

THE WHOLE PERSON APPROACH TO CHRONIC PAIN



Slide 14

Chronic Pain – A nationwide problem

U.S. Incidence of Chronic Pain overall is 31% (apx. one in three).
Greater than all other (single) healthcare conditions.

Chronic Pain	100 Million Americans	Institute of Medicine
Diabetes	26 Million Americans	American Diabetes Association
Coronary Heart Disease	16 Million Americans	American Heart Association
Cancer	12 Million Americans	American Cancer Society

Healthcare costs annually range $560 billion - $635 billion

Lost productivity based on 3 estimates:

- Days of Work missed (from $11.6 to $12.7 billion)
- Hours of Work lost (from $95.2 to $96.5 billion)
- Lower Wages (from $190.6 billion to $226.3 billion).

Slide 15

Types / Areas of pain presentation:

Area of (Chronic) Pain	US Population
Low Back Pain	27%
Severe Headache / Migraine	15%
Neck Pain	15%
Pelvic Pain	14%
Carpal Tunnel Pain	8%
Facial / Dental Pain	4%
Abdominal Pain	3%

Slide 16

Small Group Discussion

WHAT exactly makes the difference between Acute Pain and Chronic Pain?

Slide 17

Acute vs. Chronic Pain - Definitions

Chronic Pain is currently defined as:

- Someone experiencing pain greater than 4-12 weeks, or
- Pain that is not healing as expected.

Slide 18

BUT…

Newer approaches to try and help patients improve more quickly and effectively talk about:

The IASP Definition of Chronic Pain has expanded to include ALL factors which might affect the experience of Chronic Pain:

An unpleasant sensory and ***emotional*** experience associated with actual or potential tissue damage, or described in terms of such damage.

IASP Taxonomy - International Association for the Study of Pain 12/14/17

Slide 19

Overview

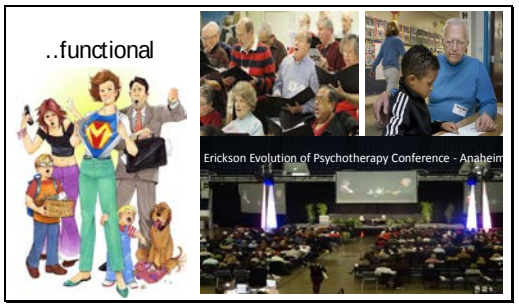
- Case Examples (Functional vs. Dysfunctional)
- Looking at a "Framework" for how to view Function
- Where to Start? – Where is the most likely Shift?
  - SHORT ANSWER: If you can get a patient with chronic pain doing ANYTHING different, you've changed the context; meaning or experience of their pain.
- Physical Arenas – you need to know!
- Mental / Emotional Arenas – most familiar
- Purpose
- Social
- Family & Spiritual

Slide 20

Functional Means Different things



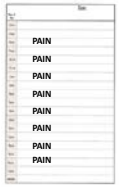
Slide 21



Slide 22

Slide 23

Functional vs. Dysfunctional –
Are there things outside of a pain focus at home?



Slide 24

Coincidental to Chronic Pain, the DSM Epistomology
Factors more likely associated with Mental Illness and Pain

- Female > Male (once out of childhood)
- Age of Onset (Majority start at or after adolescence)
- Precursor factors (Genetic; Social Learning; Abuse / PTSD)

- Women report more severe levels of pain; more frequent pain, and pain of longer duration than men. Henschke, N., Kamper, S.J., & Maher, C.G. (2015).
- Adolescent levels approach those of adults.
- Pain remains a serious problem in older age, with prevalence in adults over 65 at 25-76%, and in those in residential care ranging from 83-93%.
- **Incidence on those with PTSD diagnosis is 2.7x higher than typical.**

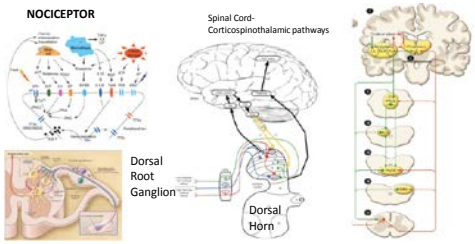
Slide 25

The *Pain Processing System*

Thalamo-subcortical-cortical-insular-networks

NOCICEPTOR

Spinal Cord-
Corticospinothalamic pathways



From: D'Mello 2008, Mendell 2003, Ossipov 2010

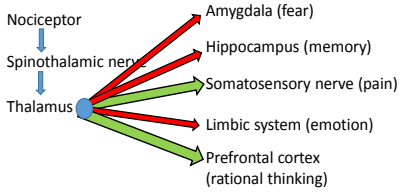
Slide 26

Steps of Pain Signals

- Initial Injury / Insult of some type: PAIN is meant to serve a purpose!
- Nerve or chemical signal is sent toward brain (Nerve type?)
- Local chemical agents released at the site (prostaglandins & Substance P) as well as hormonal / chemical changes in brain
- Note in pictures – not only is the sensory path stimulated, but transfer centers (thalamus) and **affective centers of the brain (Limbic System) are all stimulated.**
- Then, messages relay back to the area of injury, surrounding muscles/bones (MOVE) and sometimes other hormonal releases are present in the dorsal root area of the spine.

Slide 27

Pain Pathways (in Central Sensitization)



Slide 28

Central Sensitization thought related to:

Slide 29

Central Sensitization - Summary

In Summary

It causes real pain due to scrambled signals in the brain

Therapy is the only thing that helps

Slide 30

ACES – Adverse Childhood Experiences scale KPSD

Significant Events Studied:

- Recurrent physical abuse
- Recurrent emotional abuse
- Contact sexual abuse
- Alcohol/ drug abuser in home
- Incarcerated household member
- Someone with Mental Illness
- Mother is treated violently
- One or No parents
- Emotional or Physical neglect

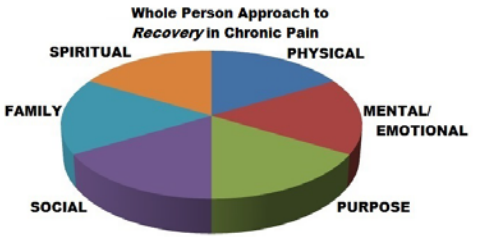
64% with 1; 12% > 4

Robust Correlation:

- Depression, Suicide Attempts
- Multiple Sex partners & STD's
- Smoking / Alcoholism
- Cognitive / Emotional Impairment
- Adoption of risky health behaviors
- Disease, Disability & Social Problems
- Early Death
- Chronic Pain Disorders

Issue becomes RESILIENCE

Slide 31



Slide 32

Case Examples

1. 55 year old partnered LPN sent to see me with Chronic LBP, Arthritis, daily narcotic use; and recent loss of job due to number of days absent from work. Not engaged in exercise, not going to social encounters, mildly depressed (long-term issues of abuse/ neglect in family), caring for partner who is disabled / often bed-ridden.

2. 60 year old married Teacher sent to see me following lack of progress in recovery for fractured metatarsal. Loss of function included – not at work, not engaged in regular hiking (favorite hobby), requesting 2nd (3rd?) opinion on next steps for foot. Still doing some exercise; Still socializing; Not on pain medications but took recommendation and started on anti-depressants. *However,* between referral/1st visit and 2nd visit 2 months later - she returned to work part-time, took a vacation trip with husband, and review with podiatry gave final "bad news" no more to do with foot.

Slide 33

Where to start?

Case 2 ("Functional") – Already doing 2 types of exercise*, already socializing, already returned to purposeful activity, improved mood following antidepressant and return to some work. With this type of patient, the goal can be "enriching what's there".

Case 1 ("Dysfunctional") - Have to get a sense of her history: What worked for her in the past?, Where does she take pride?, How does she see your role in assisting? Can you use "Motivational Interviewing" to get her to choose some place to start that is different than her ususal?

Slide 34

VIDEO

Slide 35

SMART GOALS

- **S**pecific and significant
- **M**easurable and meaningful
- **A**chievable and action-orientated
- **R**ealistic and reasonable
- **T**imely / time-limited

- Define the GOAL (Who, What, Why)
- Can you track PROGRESS?
- Is it a reasonable goal, Action based
- Is the goal relevant, worthwhile / consistent with the person's needs?
- What's the time limit for trying?

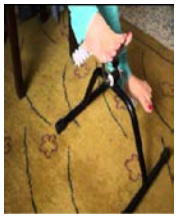
Slide 36

Physical – YOU have to know

- Type of injury (simply – Bone, Muscle/Tendon (soft tissue) or Nerve?
- How long since date of injury? (Centralization of Pain)
- What medications? (Research on TCA's, Development of "Tolerance")
- How is sleep? Have to be sleeping (Address mental & physical parts)
- *3 areas of exercise (in order): Aerobic; Stretches; Strengthening
- Areas of Overlap - *Behavioral Activation* for depression; *Desensitization* to fear of activity; Demonstrating *Reframed Cognitions* about their condition (disabled?); Restarting *Self-Efficacy; Physical changes to release of neurotransmitters.*

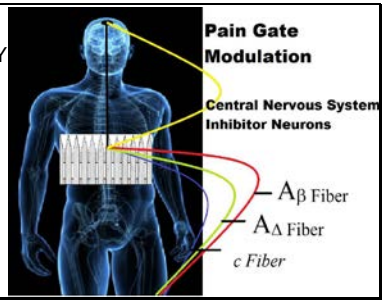
Slide 37

Physical Activities

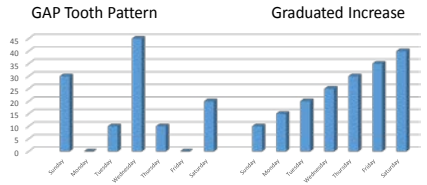

Slide 38

Use the GATE THEORY of Pain to help.



Slide 39

PACING -Need to Discuss & Practice Pacing with patients who have chronic pain over and over, like they never had learned this self care.



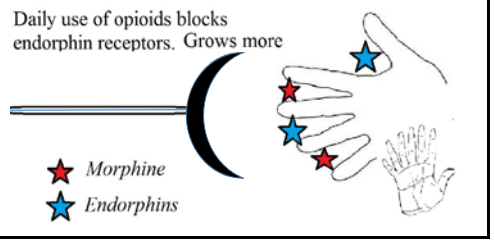
Slide 40

MEDICATIONS for PAIN (Pain Killers)

- Opioid Receptor Blockers (Buprenorphine; Methadone)
- Opioid Medications (Morphine; Hydromorphone; Fentanyl)
- Atypical's (TCA's; Anticonvulsants; Other)
- Muscle Relaxants (Flexeril; Methocarbanol; Soma; Tizanidine*; Baclofen*)
- Topical Agents (Analgesics: Icy Hot; Biofreeze; Capsacian)
- OTC Analgesics (Aspirin; Acetaminophin; Naproxen; Ibuprofen)

Slide 41

PROBLEM with daily use of Opioid Medicines



Slide 42

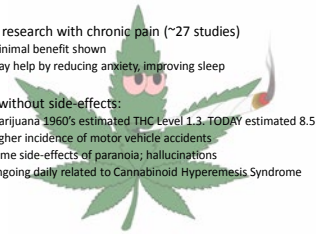
??March 2018 - Opioids no more effective than OTC medications for chronic osteoarthritis pain??

Krebs, E.E., Gravely, A., Nugent, S, et. al (2018). Effect of Opioid vs Non-opioid Medications on Pain-Related Function in Patients With Chronic Back Pain or Hip or Knee Osteoarthritis Pain. *JAMA (319,* 9): 872-882. doi:10.1001/jama.2018.0899

RANDOMIZED CONTROL STUDY; N=240 (somewhat small); 3.4 point decrease in pain on 0-10 Pain Scale vs. 3.3 point decrease after 12 month's trial. MEANINGS?

Slide 43

Marijuana



- Little research with chronic pain (~27 studies)
  - Minimal benefit shown
  - May help by reducing anxiety, improving sleep
- NOT without side-effects:
  - Marijuana 1960's estimated THC Level 1.3. TODAY estimated 8.5
  - Higher incidence of motor vehicle accidents
  - Some side-effects of paranoia; hallucinations
  - Ongoing daily related to Cannabinoid Hyperemesis Syndrome

Slide 44

OTHER MEDICATIONS/ SUBSTANCES

What about other medications or substances?

Have you heard about CBD's? Not pot; won't get you high but it can…

What about Ketamine Withdrawal Programs from Opioids; just 1 week..

New Non-Opioid Medication will help with your pain…

In my work with patients, I advocate "Self-Management" not external management approaches. What about these "newer / better" tools? Does they fit a self-management approach?

Slide 45

Mental / Emotional
– where *we* have most experience

- Motivational Interviewing – ADD in MI to whatever approach you use.
- Evidence base of CBT – both Activation AND Changing Beliefs
- Research on decreasing paired anxiety associated with activity (Do it with them!)
- PACING, PACING, PACING
- Research on magnification of pain signals related to depression and anxiety – sometimes we cannot change the pain, but *can* change the things *worsening* the pain.
- Relaxation Examples and In-Vivo Practice
- Role of hypnosis for functional and dysfunctional individuals here.
- Humor

Slide 46

Two EBT models for Chronic Pain

John Otis - Treatments that Work	**VA - CBT for Chronic Pain**
1. Pain education	1. Assessment
2. Breathing	2. Treatment orientation
3. PMR and imagery	3. Goal setting
4. Aut. neg. thoughts	4. Exercise and pacing
5. Cognitive restruct.	5. Relaxation
6. Stress	6. Pleasant activities 1
7. Pacing	7. Pleasant activities 2
8. Pleasant activities	8. Cognitive coping 1
9. Anger	9. Cognitive coping 2
10. Sleep	10. Sleep
11. Relapse	11. Discharge planning

Slide 47

PAIN IS NOT OBJECTIVE

Study of 2000 "NORMAL" individuals over 35 MRI Revealed "abnormal" results in 2/3 of their backs. ASKED how many have back pain, only 15% indicated that as a symptom. OFTEN, the place they indicated pain was different than the "objective" problem was noted.

Slide 48

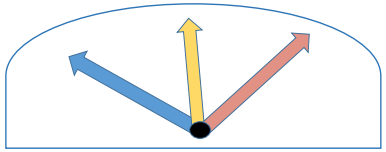
CONTEXT of Pain

- Football Player in HS Championships with broken leg
- Violinist with a cut on his Left Hand vs. Dancer with cut on Left Hand
- Meaning of WORDS: Age related change vs. Degenerative Disc Disease
- No Name for it = Worse Distress; NAME it = Better sense of control
  (Neuromuscular Sensitivity Disorder)
  WHEN patients continue to "search" for another answer,
  that is often a "warning sign" that emotions are in charge of pain.

Slide 49

Continuum of Relaxation, Meditation, Hypnosis

RELAXATION MEDITATION HYPNOSIS



Slide 50

Hypnosis

See about becoming "certified" American Society of Clinical Hypnosis

Hypnosis is "evidence based" for chronic pain

- Analgesia [Numb; Cooling; Warming]
- Warming Hands/ Feet [Migraine / Autogenic Training]
- Dissociation [Positive use of ignoring a wiring problem]
- Time Distortion [Time before/ after the problem better]
- Changing Cognitive / Affect about pain
  - (Increased Exercise; Control; Less Distress when noticed)

What is "self-hypnosis?" How do patients practice?

Slide 51

Purpose

- Used to be called work – until I started dealing with 75 year olds.
- The feeling you are contributing to something bigger than you helps!
- Other feedback loops –
  - Routines of Activity , Social Learning Theory (Bandura); Social Engagement; Accomplishment; Feeling their body.
  - Re-learning NOT to overdo (Fibromyalgia)
- Helping set reasonable expectations (e.g., volunteer 2 hrs. 2x weekly)
- Setting expectations / ability to be at work, creating success

Slide 52

Social

- Tendency to withdraw, or have pre-morbid difficulties in social life makes this area one that is absolutely necessary to review.
- Schedules (Pacing) of interaction (not none, not overdoing)
- Re-learn appropriate ways of interacting (not all about disability)
- HOW do you respond when someone asks: "How are you doing?" (Humor)

Slide 53

Teach Assertiveness

Slide 54

Spiritual & Family

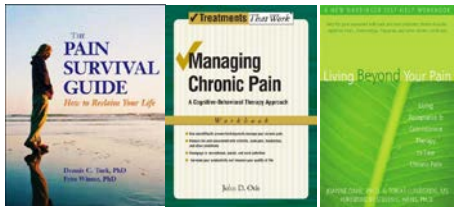
My EHR does not have a stock phrase ('smartphrase') for these two individualized areas

- **SPIRITUAL**– like purpose, ways of connecting to something *larger*
- We *KNOW* that mindfulness, relaxation, and similar are helpful
- Catholic Nuns – Same effect from Rosary as Progressive Relaxation on their body and mental state.

- **FAMILY** – Too MUCH or too little?
- Boundaries, Assertiveness, Healthy Communication
- Healing from Childhood neglect or trauma

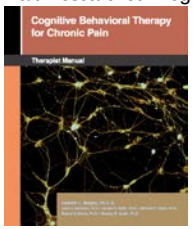
Slide 55

Resources - Books



Slide 56

Veteran's Administration
Paid Researched Program



SAMHSA
Presentation Pain

Slide 57

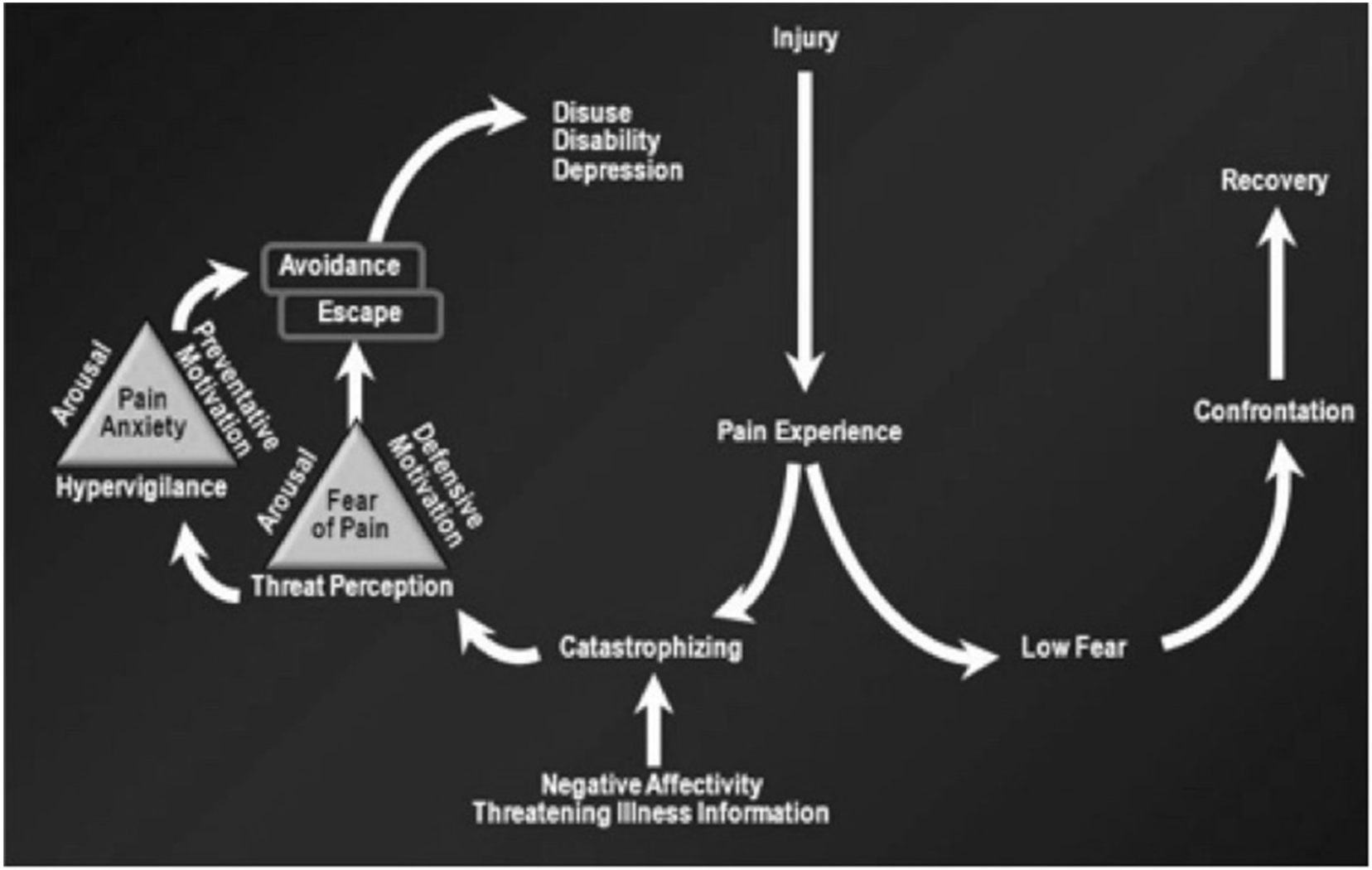
Specific Treatment Factors?

Pain Class was 2x/ week for 6 weeks. The CARF Pain Program Daily 4 weeks.
Most "Effective" shift after the "Evaluation Session" for pain program - ??
Most Effective Tool? Schedule; Exercise; Relaxation (SELF-Managed)
Self vs. Other directed care seems quite important.
Likelihood of Functional Improvement – Lower than other areas (30%?)
Set provider expectations accordingly
Can you create a "*virtual team*" to work on these issues?

Slide 58

Questions?

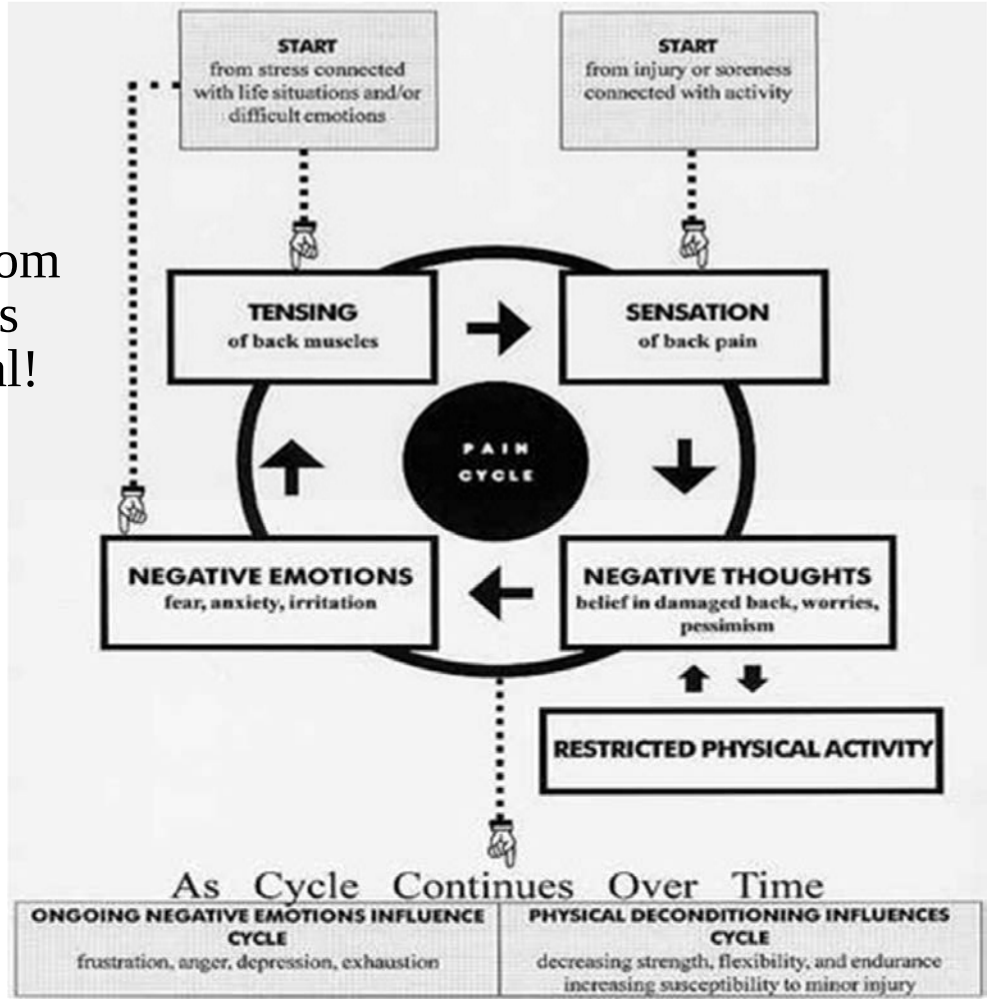
- What / How will you put this information into practice next week?
- Motivational Interviewing - Modeling



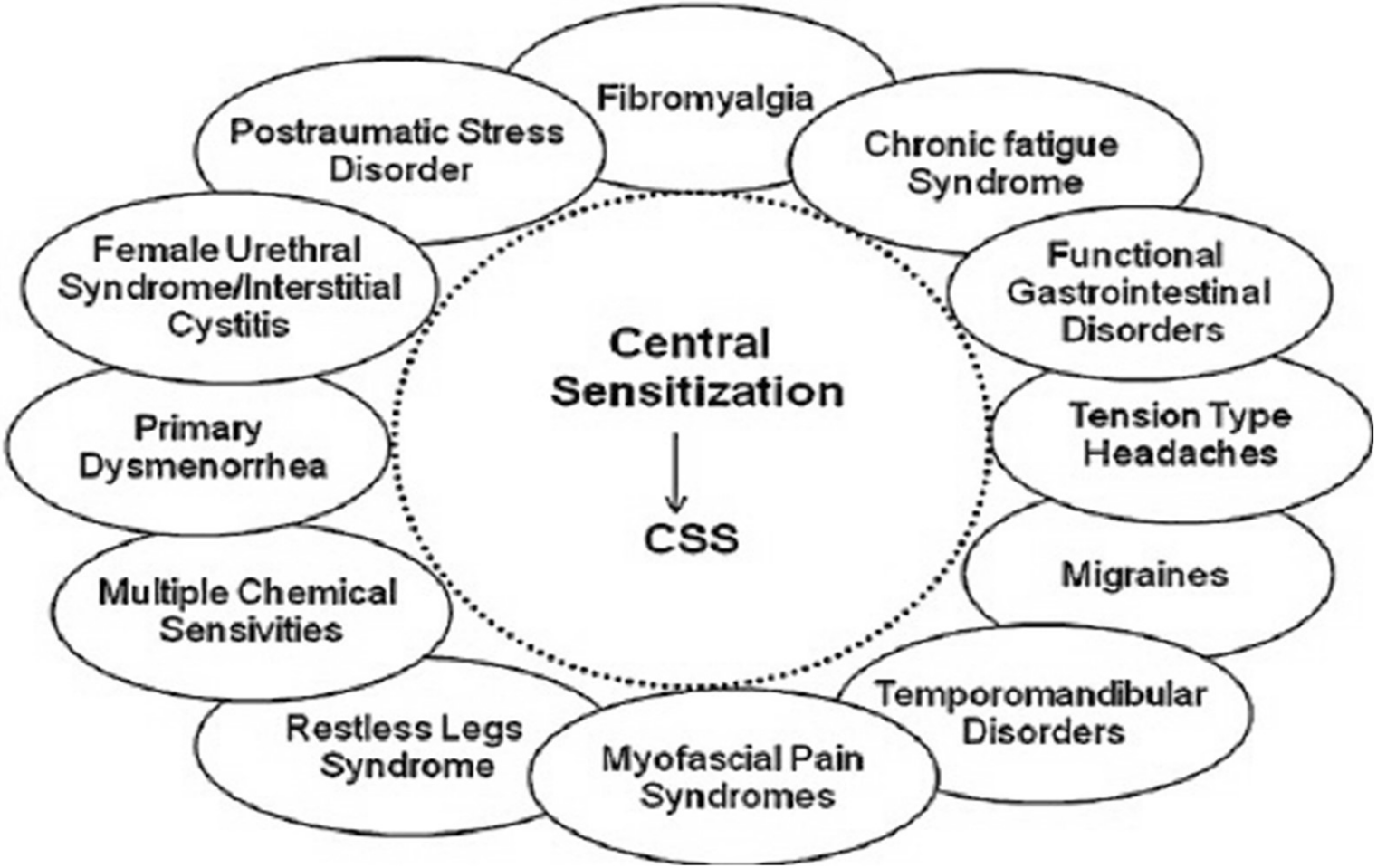
Vlaeyen, JW, & Linton, SJ. (2000). Fear avoidance and its consequences in chronic musculoskeletal pain: A state of the art. ***Pain***, 85(3), 317-332.

Fear-Avoidance Model of Chronic Pain

Pain can initiate from the Emotion side as well as the Physical!



Central Sensitization thought related to:



MY SUPPORT TEAM

MD:
PHONE#

RN/MA:
PHONE#

PT:
PHONE#

Counselor:
PHONE#

NOTES

WHAT YOU CAN DO ABOUT CHRONIC PAIN

A GUIDEBOOK FOR PRACTITIONERS AND PATIENTS

Developed by

Dr. Jamie Keyes

Clinical Instructor, University of Washington

What is Chronic Pain, and does this apply to me?

Chronic Pain is a painful condition that has not begun to get better within 3 months of starting, or is not resolving as quickly as expected. The condition can be one that has a clear diagnosis, or one for which no diagnosis has been reached.

How would a Guidebook help ME?

There are certain strategies of managing chronic pain that apply to everyone. If there has been a thorough medical work-up, and there are no currently planned interventions such as surgery, epidural injection, etc.
(and sometimes even when these are planned) these strategies will likely be helpful in better managing the pain problems for you and your health are team.

How to practice?

There will be several log or diary sheets at the end of this booklet. Use of these to record your efforts and the effects on you pain will be most helpful for both you and your healthcare team.

ABC METHOD		
ACTIVATING Event /Thought (Upset Feelings)	BELIEFS (Any Distortions?)	CONSEQUENCES (Upset Feeling or Behavioral Issue)

DISPUTES (More Realistic Thoughts)	EFFECTS (Improved Feelings / Different Outcome)

This refers specifically to jumping to a negative conclusion that is not justified by the facts of the situation. Two types of jumping to conclusions are Mind Reading and Fortune Telling.

A. Mind Reading. You assume you know why someone else does what he/ she does, and you don't bother to check it out. For example, you pass a coworker in the hallway and say "Hi!" He doesn't respond. You think "He must be upset with me. What did I do wrong?" When you check it out, you find that the coworker was preoccupied about a sick child he had just left at home.

B. Fortune telling. You "know" that things will turn out badly. Given your bad luck, you predict it as an already established fact. For example, you wake up with a headache. You say, "Now my whole day is ruined.

7. Emotional Reasoning

This refers to taking your emotions as evidence for the truth. If you feel that something is right, then it must be true. For example, you find yourself thinking, "I feel useless. [Therefore] I am useless."

8. Labeling

This refers specifically to identifying a mistake or negative quality and then describing an entire situation or individual in terms of that quality. For example, instead of seeing yourself as an individual who has a pain problem, you find yourself saying, "I'm defective, imperfect, and good for nothing."

9. Personalization

This refers to taking responsibility for a negative event even when the circumstances are beyond your control. For example, you and your spouse go out to eat at a fancy restaurant, but the service and food are poor. You find yourself feeling responsible for making a bad choice and "ruining" your evening together.

10. Shoulds

These are attempts to motivate (or browbeat) yourself by saying things like, "I should know better," "I should go there," or "I must do that." Such statements set you up for feeling resentful and pressured. The also imply that you are complying with an external authority.

THE FIGHT OR FLIGHT RESPONSE

In our bodies, we have a powerful tool to deal with danger called the Fight or Flight Response.
This reaction to stress enabled humans to survive when the world was a more dangerous place. The specific events that happen in our body are:

- brain releases the chemical adrenaline
- heart beats more quickly
- you either hold your breath or shallow breathe more quickly
- muscles mildly tense up
- blood pools around vital organs by restricting blood flow to the hands and feet
- causes cooling / tingling of the extremities
- pupils of the eyes dilate
- sweat more for body cooling
- can have hair raising – like a cat!

While at one time this was a useful tool, now it often becomes activated at low levels (e.g., someone saying something that upsets you). Unlike in prehistoric times, we don't have 4 hours to unwind the effects of "Fight or Flight." Therefore, unless you do something actively, the effects can begin to build up in your system. Physical effects such as high blood pressure, heart disease, digestive problems, and some autoimmune disorders, and emotional effects of depression, anxiety, and some relationship problems are all thought to be related to chronic low-level stress. It becomes essential that you practice relaxation of some form, in addition to the regular routine of exercise in order to "undo" the effects of the Fight or Flight response.

POWERFUL INTERVENTION

If we were going to describe the MOST POWERFUL intervention, the thing that helps the most people, most of the time, it's MOST likely that would be the place you'd start. Right?
Power in this case comes from something quite subtle; something that may seem insignificant: Routine.
We have found that individuals with ongoing, chronic pain have most often let the pain dictate their lives to the point they've lost a "normal" routine. Therefore, to help get the pain back under control, we have to re-establish "Routine." What is involved in routine? All the other areas we will mention below: exercise, relaxation/meditation, socializing, medication use, changing negative thoughts, etc.

What is routine? It is the creation of a scheduled way of doing things, which is not affected by how you feel, by other things that happen, etc. For example, you may have an aerobic exercise routine of 20 minutes stationary bicycling. When you have a pain flare-up, it is essential that you not **NOT** exercise.

1.
2.
3.
4.
5.
6.
7.
8.

NEGATIVE THINKING

Many individuals with chronic pain have negative thinking styles which can increase pain. Look through these 10 styles to see which you do. You may want to figure out a system to create more neutral or positive thoughts. 10 Types of Cognitive Distortions:

All or Nothing Thinking This refers to a tendency to evaluate personal qualities or situations in extreme, black or white categories. For example, before chronic pain, you used to play baseball on the weekends. Now you find yourself thinking, "If I can't play baseball, I can't enjoy the sport anymore." There is an apparent advantage to thinking in black-and-white, all-or-nothing terms. It is more predictable and creates the feeling that there is order in the world around you. This, in turn, should give you an edge to controlling your world. Unfortunately, it doesn't work. Uncertainty is all that we have. Living comfortably with uncertainty is possible, but it takes time.

Overgeneralization This refers to the tendency to see a single negative event as a never-ending pattern of defeat. Given the preceding example, you might respond, "I'll never be able to enjoy anything anymore." Misery does love company, but globalizing misfortune in this way creates an exaggerated sense of rejection and loneliness.

Mental Filtering This refers to the tendency to dwell exclusively on a single negative event, perceiving the whole situation as negative. For example, you're preparing brunch for friends and discover that you do not have an essential ingredient to make a dish you were planning to include. All you can think of is how the whole brunch will be ruined. It gives you indigestion.

Discounting the Positive This refers to the tendency to take neutral or positive experiences and turn the focus onto the negative. For example, a friend comes over and tells you that you look great. Your immediate thought is this: "I don't feel great; She doesn't understand me." Maybe not, but try a simple "thank you" first. Maybe you don't look as bad as you feel!

Magnification and Minimization In magnification, you exaggerate the importance of a negative event or mistake. If, for example, you experience a flare-up in your pain, you find yourself saying, "I can't stand this! I can't take this anymore." As a matter of fact, however, you can. You may not want to, and that's okay, but you can take it. In minimization, conversely, you take positive personal qualities or events and deny them their importance. For example, a when a family member comments on how nice it is to see you at a family outing, and you reply, "A lot of good it does if I can't participate in the activities."

PURPOSE

Purpose is the act of doing something with positive, meaningful outcome. While some of us would not say our work provides this, for most individuals, work is a purposeful routine. Other areas of purpose to think of are school and volunteering. If you are a t a state in which you can no longer work or are retired, it is essential that you have some purposeful activity to help distract you from pain, and to provide something more important and meaningful to focus upon. We usually recommend volunteering just 2 hours, 2x per week. At that level, you can pace yourselves to get other needs (exercise, relaxation and chores) all done without exhausting yourself. If you are returning to work, you may need to pace yourself as well. Discuss with your health care provider how you can successfully get a work routine established again.

Instead, keeping the routine, you've established, you cut back the amount of time, and stationary bicycle for 5 or even just 2 minutes, so you've maintained the routine. Then, when you're feeling better tomorrow, it's not as difficult to get back into the routine.

As mentioned above, there are specific routines that people who have ongoing, chronic pain have to keep that other people don't. For example, some people can exercise 3 times a week, and stay in shape. People with chronic pain usually must exercise 5-7 days per week, but at lower intensity to develop conditioning and the extra energy/endurance to do what's necessary. While many people can multitask, people with chronic pain need to plan and pace their activities better, and take time out for relaxing muscles and clearing their minds throughout the day. While negative thinking strikes everyone sometimes, the irritability and negative thinking that accompanies ongoing pain takes extra practice to work.

EXERCISE

The 1st routine we're going to discuss is exercise. Many people with ongoing pain tell us, "How can I exercise when I'm hurting all the time?"

First, we need to make sure you are safe. This requires that your practitioner tell you it is SAFE to do mild exercise. That is, even though you may hurt, you are not doing any "damage" with exercise **[Hurt ≠ Harm]**. If you wait until you "feel better" to exercise, it will never happen. Therefore, we should create a simple enough exercise plan that you can begin **NOW**, that will lead to future SUCCESS.

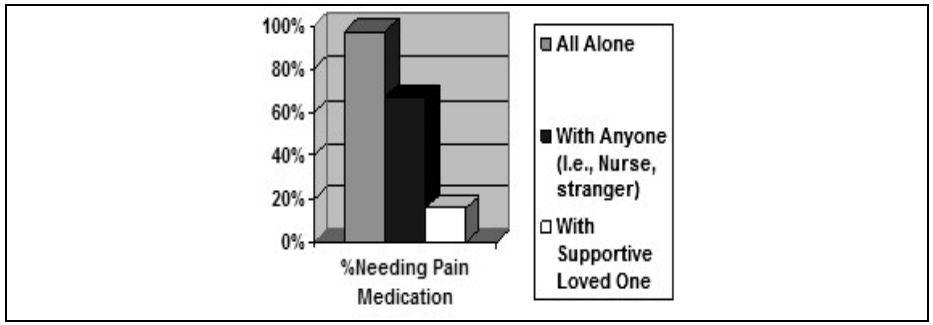
We find that individuals with chronic pain often overestimate how much they can ("should") do. Then, they create a pain flare-up and stop completely, undoing the "routine" we so much need. We need you to start so simply that you can keep up these exercises, even on a bad day – although you may need to cut down the intensity on those days.

Kinds of exercise: There are 3 major kinds of exercise: Aerobic conditioning, Stretching and Strengthening. We have found that for individuals with severe problems of pain, it is best to leave the 3rd area, until other routines are well established. Then, adding strengthening; you will help the other areas progress more quickly.

SOCIAL CONTACT & PURPOSE

What is "Social Contact"? Isn't that something you were told to avoid for fear of disease? Seriously, when people have Chronic Pain, most often they begin to withdraw for fear they will bring others down with their pain, or others have distanced themselves. We know that socialization is important in managing pain. There was one study of about 10,000 pregnant women and medications require for their delivery.

See the chart below:



What does that mean for you? It means we need you to be connected with others-outside your family-on an ongoing basis. An example of this is a group. If you were interested in reading, and the local bookstore had a reading club. Then, all members read one book per month. When you gather to review the book, on a good day, you could talk a lot. On a "bad day" you could say less but just "be there." This is the kind of regular (more than monthly, less than multiple times a week) socialization we mean.

RELAXATION EXERCISES

How you set up these exercises will make them successful. 1st get a quiet place where you won't be disturbed for a few minutes.
2nd sit in the most comfortable position you can.
3rd don't expect the effects to be immense, or to be nothing - it will likely be somewhere in between and will change with practice.

A **relaxation** exercise to begin with is muscle relaxation. Focus your mind on your forehead. As you breathe in, try to gather all the tension across your forehead so that when you release your breath, you release the tension in that muscle group. Then, move to your eyes and temples. Next, your nose and cheeks, then your jaw & chin. Remember there are more muscles in your face than the whole rest of your body. Progressively moving down the body, focus next on your shoulders, as you breathe out, let your shoulders loosen and fall more relaxed than usual. Then, your upper arms & chest, lower arms & belly, and your hands. Then, your mind focuses on your hips, thigh & calf muscles, ankles and feet. You may use a visual image of your body being filled with sand, like a sandbag.
As you focus on each muscle group, and breathe out the tension, imagine all the sand falling out of that area, leaving it loose and limp. Notice the effect on your mind and body as you practice this, perhaps writing it down (see Relaxation Log).
There are 2 simple kinds of **meditation** you can begin with, preferring one, or trading off between them. First is an exercise to try and focus on a specific thing or word. For example, Dr. Benson in The Relaxation Response suggests using the number "1." Focus your mind on that word or object as you take each breath in, and as you exhale each breath. Notice what happens in your mind & body as you do this. The other exercise is to try & Clear your mind of all thought, and just focus on your breathing. Then, you notice where, your mind goes, what kinds of things you begin thinking of.

Aerobic conditioning can be done with walking, stationary bicycling, water walking etc. Three things to keep in mind: It has to be accessible enough you can do this **REGULARLY**; It has to be continuous; and you have to create success in meeting initial goals. We often recommend walking because it requires no equipment, no driving to get there, etc. However, a stationary bike from Goodwill (with no tension, just pedals that turn), or a nearby pool are ideal. You can even use more than one type of exercise, giving variety to different days of the week. We have people start walking or biking for 5 minutes (e.g., 2½ minutes out from the front door, 2½ minutes back) - sometimes as low as 2 minutes total. Then, we'll have them add 10% per week if doing this on their own, or perhaps more if doing this in group format (e.g., 1 minute more per day) until a goal level is reached (e.g., 20 minutes per day of walking).

Specific stretches are usually given by a physical therapist, to help you establish a routine. However, remember we are not trying to just work on the area of injury alone, but stretches for your entire body. (Remember "the hip bone is connected to the thigh bone", etc.).

A good starting point may be Bob Anderson's Stretching book, available at most bookstores.

Typically, we encourage **10-20** minutes stretching each day, in addition to the aerobic activity mentioned above.

RECORD KEEPING

A Diary or Log is the best way to give yourself or others feedback about how your change process is going. We have included many Logs for your use in this booklet. You may copy them, to use on a daily or weekly basis.

	TIME DONE AM	PRE-STRESS LEVEL (1-9)	POST-STRESS LEVEL (1-9)		TIME DONE PM	PRE-STRESS LEVEL (1-9)	POST-STRESS LEVEL (1-9)
SUNDAY							
MONDAY							
TUESDAY							
WEDNESDAY							
THURSDAY							
FRIDAY							
SATURDAY							

RELAXATION

Review Relaxation exercises are now known to be quite powerful aids to improving Chronic Pain. While formal scientific review of relaxation and meditation/prayer have only begun in the last 35 years, use of these methods in association with Yoga and Tai Chi exercise has gone on for thousands of years. The purpose of relaxation is twofold: First, when we have stress, our muscles tighten up in response (see The Fight or Flight Syndrome). Unless you do something to counteract it, this increased muscle tension will increase already existing levels of pain. Second, certain relaxation and medication exercises (as well as prayer) will focus your attention on something other than pain, and serve as a distraction.

The foundation of all relaxation exercise is Diaphragmatic or Belly Breathing. Simply put, when you breathe in, your belly should fill like a little round balloon, yet your chest and shoulders will not move much at all. When you release the air, your belly will fall to normal. We all used Belly Breathing when we were children, but as adult stresses increased, we tend to hold our breath or take more shallow, chest based breaths. It is essential to undo this pattern. Therefore, if you checked your own breathing, and found you are not doing belly breathing, see if you can force yourself to breathe into your belly. If so, you will likely need to practice this 20 times per day for 1 or 2 weeks, until the “habit” can resume. Once in place, you can keep it there easily without much re-checking. If you can’t get yourself to breathe there, you may *want to get someone else to see if they can help with this, or to just try the relaxation exercises without (but they work best with Belly Breathing).*

MEDICATION DIARY

Please fill out this sheet for 7 days. Record the time of day you take each pain related medication, the milligrams (mg), and the number of pills you take each time you take a medicine. Note other self- mgmt strategies (e.g., relaxation/ meditation; exercise; stretching; thought changes, pleasure and comfort activities) used prior to taking the medicines you list. List any "over the counter" drugs you take such as aspirin, Tylenol, etc. Also, list homeopathic medicines and nutritional supplements that you take to control pain. Rate your pain during the **30minute** period **prior** to taking medication and **30-minutes after** taking medication, using a scale of 0-10, where **0=None** and **10= Unbearable** pain. Bring this information to the next medical visit; We will use it to plan possible changes in medication. If you run out of space, you could re-write medications on a second sheet.

	Time AM or PM	Medication Name	# mgs or # of pills	Other Methods Used	Pre-pain level (0-10)	Post-pain level (0-10)
SUNDAY						
MONDAY						
TUESDAY						
WEDNESDAY						
THURSDAY						
FRIDAY						
SATURDAY						

PACING WORKSHEET

Review activities during the day. Start with your "baseline" pain level. List the number of minutes you engage in each activity before your pain sensation increases by 1-2 points ("uptime"). Then change activities for long enough to allow the pain sensation to decrease to baseline, and note the number of minutes this takes ("downtime"). Reassess your levels monthly, to see if you are increasing your endurance, or just planning your uptime well.

Base pain (0-10)	Activity during uptime	Uptime minutes	Downtime minutes	Activity during downtime

EXERCISE LOG

	TIME DONE AM/PM	TYPE(S) OF EXERCISE	DURATION OF EXERCISE	STRETCH BEFORE?	STRETCH AFTER?
SUNDAY					
MONDAY					
TUESDAY					
WEDNESDAY					
THURSDAY					
FRIDAY					
SATURDAY					

Pain Diary

Monday

	Describe Situation	Sensation (0-10)	Describe Sensation	Distress (0-10)	Describe Distress	Action taken (or medications)
Time 1						
Time 2						
Time 3						

Tuesday

	Describe Situation	Sensation (0-10)	Describe Sensation	Distress (0-10)	Describe Distress	Action taken (or medications)
Time 1						
Time 2						
Time 3						

Wednesday

	Describe Situation	Sensation (0-10)	Describe Sensation	Distress (0-10)	Describe Distress	Action taken (or medications)
Time 1						
Time 2						
Time 3						

Thursday

	Describe Situation	Sensation (0-10)	Describe Sensation	Distress (0-10)	Describe Distress	Action taken (or medications)
Time 1						
Time 2						
Time 3						

Friday

	Describe Situation	Sensation (0-10)	Describe Sensation	Distress (0-10)	Describe Distress	Action taken (or medications)
Time 1						
Time 2						
Time 3						

Saturday

	Describe Situation	Sensation (0-10)	Describe Sensation	Distress (0-10)	Describe Distress	Action taken (or medications)
Time 1						
Time 2						
Time 3						

Sunday

	Describe Situation	Sensation (0-10)	Describe Sensation	Distress (0-10)	Describe Distress	Action taken (or medications)
Time 1						
Time 2						
Time 3						

REFERENCES

1. Andrews, N.E., Strong, J., & Meredith, P.J. (2012). Activity pacing, avoidance, endurance, and associations with patient functioning in chronic pain: A systematic review and meta-analysis. *Archives of Physical Medicine and Rehabilitation, 93*(11), 2109-2121. doi: http://dx.doi.org/10.1016/j.apmr.2012.05.029

2. Bahouq, H., Allali, F., Rkain, H., Hmamouchi, I., & Hajjaj-Hassouni, N. (2013). Prevalence and severity of insomnia in chronic low back pain patients. *Rheumatology International, 33*(5), 1277-1281. doi: 10.1007/s00296-012-2550-x

3. Bair, M.J., Poleshuck, E.L., Wu, J., Krebs, E.K., Damush, T.M., Tu, W., & Kroenke. K. (2012). Anxiety but not social stressors predict 12-month depression and pain severity. *Clinical Journal of Pain, 29*(2): 95-101. doi: 10.1097/AJP.0b013e3182652ee9

4. Cherkin, D.C., Anderson, M.L., Sherman K.J., Balderson, B.H., et al. (2017). Two-year follow-up of a randomized clinical trial of mindfulness-based stress reduction vs cognitive behavioral therapy or usual care for chronic low back pain. *JAMA*, *317*(6):642-644. doi: 10.1001/jama.2016.17814.

5. Costa, L.C.M, Maher, C.G., Hancock, M.J., McAuley, J.H., Herbert, R.D., & Costa, L.O.P. (2012). The prognosis of acute and persistent low-back pain: A meta-analysis. *Canadian Medical Association Journal, 184*(11), 613-624. doi: 10.1503/cmaj.111271

6. Davis, M.C., Zautra, A.J., Wolf, L.D., Tennen, H., & Yeung, E.W. (2015). Mindfulness and cognitive-behavioral interventions for chronic pain: differential effects on daily pain reactivity and stress reactivity. *Journal of Consulting and Clinical Psychology*, *83*(1): 24-35. doi: 10.1037/a0038200

7. Dunn, E.W., Aknin, L.B., & Norton, M.I. (2008). Spending Money on Others Promotes Happiness. *Science, 21* (319): 1687-1688. DOI: 10.1126/science.1150952

8. Froholdt, A., Reikeraas, O., Holm, I., Keller, A., & Brox, J.I. (2012). No difference in 9-year outcome in CLBP patients randomized to lumbar fusion versus cognitive intervention and exercises. *European Spine Journal, 21*(12), 2531-2538. doi: 10.1007/s00586-012-2382-0

9. Henschke, N., Kamper, S.J., & Maher, C.G. (2015). The Epidemiology and Economic Consequences of Pain, *Mayo Clinic Proceedings, 90*(1):139-147. doi: http://dx.doi.org/10.1016/j.mayocp.2014.09.010

10. Henschke, N., Ostelo, R.W., van Tulder, M.W., Vlaeyen, J.W., Morley, S., Assendelft, W.J., Main, C.J. (2010). Behavioural treatment for chronic low-back pain. T*he Cochrane Database of Systematic Reviews*, *July 7*(*7)*. doi: 10.1002/14651858.CD002014.pub3

11. Jensen, M.P, & Patterson, D.R. (2014). Hypnotic approaches for chronic pain management: clinical implications of recent research findings. *American Psychologist*, *69*(2): 166-177. doi: 10.1037/a0035644.

12. Mack, K.A., & Paulozzi, L.J. (2013). Pharmaceutical overdose deaths, United States, 2010. *Journal of the American Medical Association, 309*(7), 657-659. doi: 10.1001/jama.2013.272

13. Kerns, R.D., Burns, J.W., Shulman, M., Jensen, M.P., et al. (2014). Can we improve cognitive- behavioral therapy for chronic back pain treatment engagement and adherence? A controlled trial of tailored versus standard therapy. *Health Psychology*, *33*(9): 938-947. doi: 10.1037/a0034406.

14. Kroenke, K., Wu, J., Bair, M.J., Krebs, E.E., Damush, T.M., & Tu,W. (2011). Reciprocal relationship between pain and depression: A 12-month longitudinal analysis in primary care. *The Journal of Pain, 12*(9), 964-973. http://dx.doi. org/10.1016/j.jpain.2011.03.003

15. McCracken, L.M., & Vowles, K.E. (2014). Acceptance and commitment therapy and mindfulness for chronic pain: model, process, and progress. *American Psychologist*, *69*(2):178-187.doi:10.1037/a0035623.

16. Morley, S., Eccleston, C., & Williams, A. (1999). Systematic review and meta-analysis of randomized controlled trials of cognitive behaviour therapy and behaviour therapy for chronic pain in adults, excluding headache. *Pain, 80*(1-2), 1-13. doi: http://dx.doi.org/10.1016/S0304-3959(98)00255-3

17. Moseley, J.B, O'Malley, K.O., Petersen, N.J., *et al*. (2002). A controlled trial of arthroscopic surgery for osteoarthritis of the knee. *New England Journal of Medicine; 347*: 81-88. doi:10.1056/NEJMoa013259

18. Murphy, J.L., McKellar, J.D., Raffa, S.D., Clark, M.E., Kerns, R.D., & Karlin, B.E. (2014). *Cognitive behavioral therapy for chronic pain among veterans: Therapist manual*. Washington, DC: U.S. Department of Veterans Affairs.

19. Nugent, S.M., Morasco, B.J., O'Neil, M.E., et al. (2017). The effects of cannabis among adults with chronic pain, and an overview of general harms: A systematic review. *Annals of Internal Medicine, 167* (5): 319-331. DOI: 10.7326/M17-0155

20. Stewart, M.O., Karlin, B.E., Murphy, J.L., et al. (2015). National dissemination of cognitive- behavioral therapy for chronic pain in veterans: Therapist and patient-level outcomes. *Clinical Journal of Pain, 31*(8): 722-729. doi: 10.1097/AJP.0000000000000151.

21. Siegel, D. (2010). *Mindsight*. New York: Bantam Books.

22. Turk D.C., Dworkin R.H., Revicki D., et al. (2008). Identifying important outcome domains for chronic pain clinical trials: An IMMPACT survey of people with pain. *Pain, 137*(2), 276-285. doi:10.1016/j.pain.2007.09.002

23. Turk, D. & Gatchel, R. (2002). *Psychological Approaches to Pain Management.* New York: Guilford.

24. Turk, & Winter, F. (2006). *The Pain Survival Guide: How to reclaim your life.* Washington D.C.: APA Press.

25. Undurraga, J. & Baldessarini, R.J. (2012). Randomized, Placebo-Controlled Trials of Antidepressants for Acute Major Depression: Thirty-Year Meta-Analytic Review. *Neuropsychopharmacology, 37*(4): 851-864. doi:10.1038/npp.2011.306

26. Vlaeyen, J.W., & Linton, S.J. (2000). Fear-avoidance and its consequences in chronic musculoskeletal pain: a state of the art. *Pain*, *85*(3), 317-332. PMID:10781906

Oswestry - Pain Disability Questionnaire

Section 1 – Pain intensity

- I have no pain at the moment
- The pain is very mild at the moment
- The pain is moderate at the moment
- The pain is fairly severe at the moment
- The pain is very severe at the moment
- The pain is the worst imaginable at the moment

Section 2 – Personal care (washing, dressing etc.)

- I can look after myself normally without causing extra pain
- I can look after myself normally but it causes extra pain
- It is painful to look after myself and I am slow and careful
- I need some help but manage most of my personal care
- I need help every day in most aspects of self-care
- I do not get dressed, I wash with difficulty and stay in bed

Section 3 – Lifting

- I can lift heavy weights without extra pain
- I can lift heavy weights but it gives extra pain
- Pain prevents me from lifting heavy weights off the floor, but I can if they are placed e.g., on a table
- Pain prevents me lifting heavy weight, I can manage *light to medium* weights if conveniently positioned
- I can lift very light weights
- I cannot lift or carry anything at all

Section 4 – Walking

- Pain does not prevent me walking any distance
- Pain prevents me from walking more than 1 mile
- Pain prevents me from walking more than ½ mile
- Pain prevents me from walking more than 100 yards
- I can only walk using a stick or crutches I am in bed most of the time

Section 5 – Sitting

- I can sit in any chair as long as I like
- I can only sit in my favorite chair as long as I like
- Pain prevents me sitting more than one hour
- Pain prevents me from sitting more than 30 minutes
- Pain prevents me from sitting more than 10 minutes
- Pain prevents me from sitting at all

Section 6 – Standing

- I can stand as long as I want without extra pain
- I can stand as long as I want but it gives me extra pain
- Pain prevents me from standing for more than 1 hour
- Pain prevents me from standing more than 30 minutes

- Pain prevents me from standing more than 10 minutes
- Pain prevents me from standing at all

Section 7 – Sleeping

- My sleep is never disturbed by pain
- My sleep is occasionally disturbed by pain
- Because of pain I have less than 6 hours sleep
- Because of pain I have less than 4 hours sleep
- Because of pain I have less than 2 hours sleep
- Pain prevents me from sleeping at all

Section 8 – Sex life (if applicable)

- My sex life is normal and causes no extra pain
- My sex life is normal but causes some extra pain
- My sex life is nearly normal but is very painful
- My sex life is severely restricted by pain
- My sex life is nearly absent because of pain
- Pain prevents any sex life at all

Section 9 – Social life

- My social life is normal and gives me no extra pain
- My social life is normal but increases the degree of pain
- Pain has no significant effect on my social life apart from limiting my more energetic interests e.g., sport
- Pain has restricted my social life and I do not go out as often
- Pain has restricted my social life to my home I have no social life because of pain

Section 10 – Travelling

- I can travel anywhere without pain
- I can travel anywhere but it gives me extra pain
- Pain is bad but I manage journeys over two hours
- Pain restricts me to journeys of less than one hour
- Pain restricts me to short necessary journeys under 30 minutes
- Pain prevents me from travelling except to receive treatment

SCORING: Questions are scored from 0-5 in each section. Divide Answered Total

Add the total from each section completed HERE:_____ by Possible Total to get

What would the maximum score be for all sections answered: _____ PERCENTAGE _____

Percentages:

0-20%	**No treatment indicated, other than PT Demonstration. Coping with most activities of daily life**
21-40%	**Patient has more difficulty coping; can be managed by conservative means**
41-60%	**Pain becomes primary problem – Comprehensive assessment indicated**
61-80%	**Pain affecting all aspects of life; Significant positive intervention required**
81-100%	**Patient is either bed-ridden, or exaggerating symptoms**

Short-Form - Coping Strategies Questionnaire

How frequently do you use the following strategies in coping with pain?	Never	Rarely	Some	Often	Frequent	Always	
1. I try to feel distant from the pain, almost as if the pain was in somebody else's body.	1	2	3	4	5	6	
3. I try to think of something pleasant.	1	2	3	4	5	6	
4. I don't think of it as pain but rather a dull or warm feeling.	1	2	3	4	5	6	
5. It is terrible and I feel it is never going to get any better.	1	2	3	4	5	6	c
11. It is awful and I feel it overwhelms me.	1	2	3	4	5	6	c
13. I feel my life isn't worth living.	1	2	3	4	5	6	c
16. I try not to think of it as my body, but rather as something separate from me.	1	2	3	4	5	6	
20. I tell myself I can't let the pain stand in the way of what I have to do.	1	2	3	4	5	6	
23. No matter how bad it gets, I know I can handle it.	1	2	3	4	5	6	
24. I pretend it's not there.	1	2	3	4	5	6	
25. I worry all the time about whether it will end.	1	2	3	4	5	6	c
26. I replay in my mind pleasant experiences in the past.	1	2	3	4	5	6	
27. I think of people I enjoy doing things with.	1	2	3	4	5	6	
29. I imagine the pain is outside my body.	1	2	3	4	5	6	
30. I just go on as if nothing happened.	1	2	3	4	5	6	
31. I see it as a challenge and don't let it bother me.	1	2	3	4	5	6	
32. Although it hurts, I just keep on going.	1	2	3	4	5	6	
33. I feel I can't stand it anymore.	1	2	3	4	5	6	c
37. I feel like I can't go on.	1	2	3	4	5	6	c
38. I think of things I enjoy doing.	1	2	3	4	5	6	
39. I do anything to get my mind off the pain.	1	2	3	4	5	6	
40. I do something I enjoy, such as watching television or listening to music.	1	2	3	4	5	6	
41. I pretend it's not part of me.	1	2	3	4	5	6	

Catastrophizing Index: _____
[Sum 5, 11, 13, 25, 33, 37]

Diversion Index: _____
[Sum 3, 26, 27, 33, 38, 39, 40]

Reinterpreting Index: _____
[Sum 1, 4, 16, 24, 29, 41]

Cognitive Coping Index: _____
[Sum 20, 23, 30, 31, 32+20%]

Harland, N.J. & Georgieff, K. (2003) Rehabilitation Psychology, 48(4). 296–300.

CENTRAL SENSITIZATION INVENTORY – PART A

Please circle the best response to the right of each statement.

1 I feel tired and unrefreshed when I wake from sleeping.	Never	Rarely	Sometimes	Often	Always
2 My muscles feel stiff and achy.	Never	Rarely	Sometimes	Often	Always
3 I have anxiety attacks.	Never	Rarely	Sometimes	Often	Always
4 I grind or clench my teeth.	Never	Rarely	Sometimes	Often	Always
5 I have problems with diarrhea and/or constipation.	Never	Rarely	Sometimes	Often	Always

6 I need help in performing my daily activities.	Never	Rarely	Sometimes	Often	Always
7 I am sensitive to bright lights.	Never	Rarely	Sometimes	Often	Always
8 I get tired very easily when I am physically active.	Never	Rarely	Sometimes	Often	Always
9 I feel pain all over my body.	Never	Rarely	Sometimes	Often	Always
10 I have headaches.	Never	Rarely	Sometimes	Often	Always
11 I feel discomfort in my bladder and/or burning when I urinate	Never	Rarely	Sometimes	Often	Always
12 I do not sleep well.	Never	Rarely	Sometimes	Often	Always
13 I have difficulty concentrating.	Never	Rarely	Sometimes	Often	Always
14 I have skin problems such as dryness, itchiness, or rashes.	Never	Rarely	Sometimes	Often	Always
15 Stress makes my physical symptoms get worse.	Never	Rarely	Sometimes	Often	Always
16 I feel sad or depressed.	Never	Rarely	Sometimes	Often	Always
17 I have low energy.	Never	Rarely	Sometimes	Often	Always
18 I have muscle tension in my neck and shoulders.	Never	Rarely	Sometimes	Often	Always
19 I have pain in my jaw.	Never	Rarely	Sometimes	Often	Always
20 Certain smells, such as perfumes, make me feel dizzy and nauseated.	Never	Rarely	Sometimes	Often	Always
21 I have to urinate frequently.	Never	Rarely	Sometimes	Often	Always
22 My legs feel uncomfortable and restless when I am trying to go to sleep at night.	Never	Rarely	Sometimes	Often	Always
23 I have difficulty remembering things.	Never	Rarely	Sometimes	Often	Always
24 I suffered trauma as a child.	Never	Rarely	Sometimes	Often	Always
25 I have pain in my pelvic area.	Never	Rarely	Sometimes	Often	Always

STAGES OF CHANGE

Pre-contemplation	At this stage, the individual does not believe a problem exists, and is not interested in engaging in treatment. The individual must become *concerned about the problem* and interested in treatment. The individual needs evidence of the problem and its consequences.
Contemplation	At Contemplation, the individual recognizes that a problem exists and considers treatment. While considering treatment, the individual must complete the tasks of analyzing the balance of risks and rewards of treatment. The person needs support and information to understand treatment options.
Preparation / Readiness Determination	At Preparation, the individual is ready to begin treatment, but needs help finding appropriate treatment. During this time, we help create an effective / acceptable treatment plan. Justice and health professionals may work with the person to develop the treatment plan.
Action	At the action stage, the individual has done something to show they are changing their behavior – attending treatment, changing some routine in their life. Continued need to reaffirm commitment to the treatment plan; follow-up with providers and continue to review / revise the plan as necessary. Ongoing support from family; community; health & justice help sustain commitment to change.
Maintenance	The primary focus in maintenance is commitment to sustaining new behavior. In this stage, support systems develop a continuing care plan with the person, including relapse prevention planning. Even if relapse occurs, professionals can re-assess the person; evaluate what triggers are at play; and determine the best course of action for the person and their support network.

MOTIVATIONAL INTERVIEWING - TASKS OF THE PROVIDER BY STAGE

PRE-CONTEMPLATION	Offer *factual* information Explore the *meaning of events* that brought them to treatment Explore *results of previous efforts* at change Explore *Pros & Cons* of Targeted behavior EMPHASIZE any *change talk*
CONTEMPLATION	Explore *expectations* – regarding what change will entail Explore person's sense of self-efficacy (do they need help in the process) Summarize self-motivation (change talk) statements Continue exploring *pros & cons* Emphasize *discrepancy* – what they want and where they are
PREPARATION / Readiness/ Determination	Offer a menu of options for change Help identify pros & cons of various change options Identify & lower barriers to change Help person enlist social support Encourage person to publicly commit to change
ACTION	Support a realistic view of change through small steps Help identify high risk (trigger) situations and develop coping plans Assist in finding new reinforcers of positive change Help access family & social support
MAINTENANCE	Help identify and try alternative behaviors (sources of pleasure) Maintain supportive contact Help develop escape plan when triggered/ settings of temptation Work to set new short and long term goals for the person Frame Relapse as expected; part of a learning process. Explore antecedents / triggers to relapse Review Stages of Change and encourage person to stay in the process