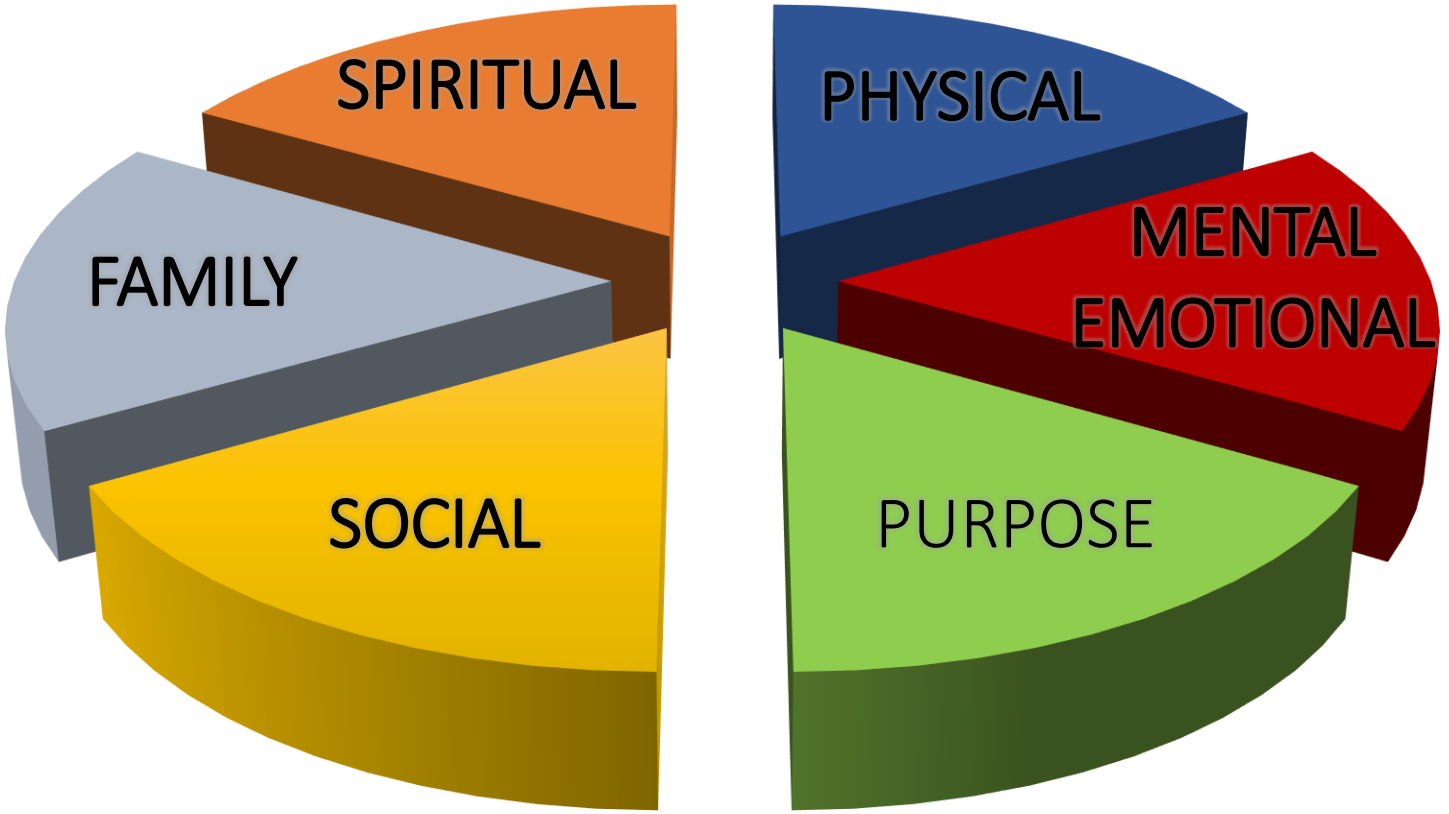
Effective Intervention for Chronic Pain



Jamie Keyes, Ph.D., ABPP

University of Washington Clinical Instructor AND

Washington State University Clinical Assistant Professor

Dedicated to:

With great appreciation

I have no Conflicts of Interest to report!

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 incompliance with your professional standards.”

ONE Other Important Thing

RESEARCH CAN BE MISLEADING

Many of you know from graduate school –

ONE result is not proof.

25 results are not proof.

Perhaps 100 results are showing strong evidence

(Watch the N – subjects in a study; and closer to “gold standard”)

BUT, I’d bank on researched results BEFORE gut feel.

WHERE ARE YOU TODAY? – Self Assessment

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

ARE YOU WILLING TO SHARE WITH OTHERS HERE?

What are “subtle things” that can change how you feel?

PHQ-9

Rate 0,1,2,3 (None, Some, Mod, Sev)

1. **Little Interest or pleasure doing things**
2. **Feeling down, depressed, hopeless**
3. **Trouble falling or staying asleep**
4. **Feeling tired; Little energy**
5. **Poor Appetite; or Too Much**
6. **Feeling bad about yourself; guilt**
7. **Trouble concentrating simple things**
8. **Moving Slow or Speeded**
9. **Thoughts of death / self-harm**

- **REMIND ME – Bernie Siegel, MD**

<u>Love, Medicine & Miracles</u> – How does he talk with patients about pain?

OSWESTRY Disability Scale *** IN BACK OF YOUR HANDOUT**

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

Personal care

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

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

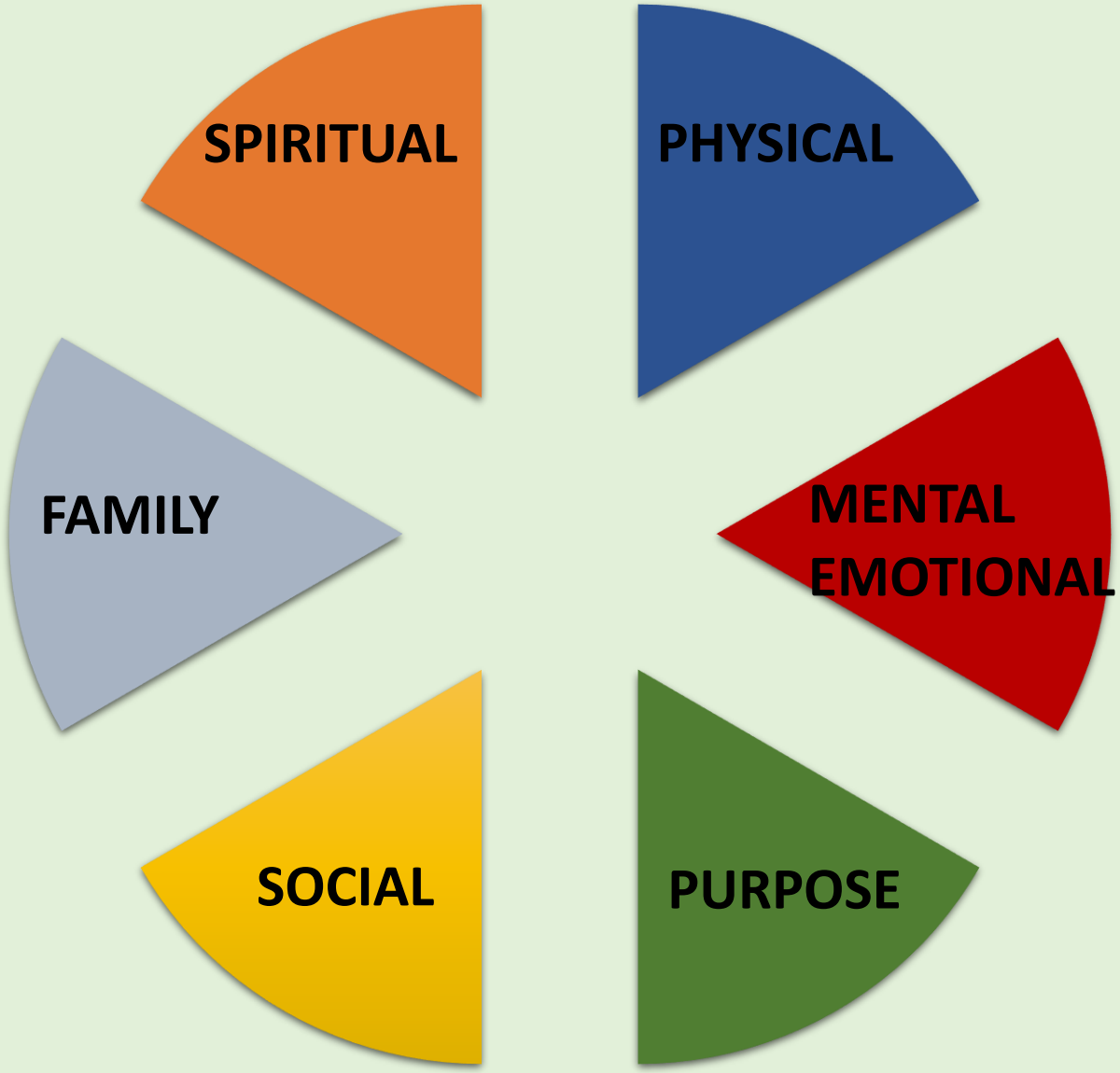
Pain prevents me from sitting more than 30 minutes

Pain prevents me from sitting more than 10 minutes

Pain prevents me from sitting at all

How do you rate your pain?
ALTERNATIVE version

THE WHOLE PERSON APPROACH TO CHRONIC PAIN



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.

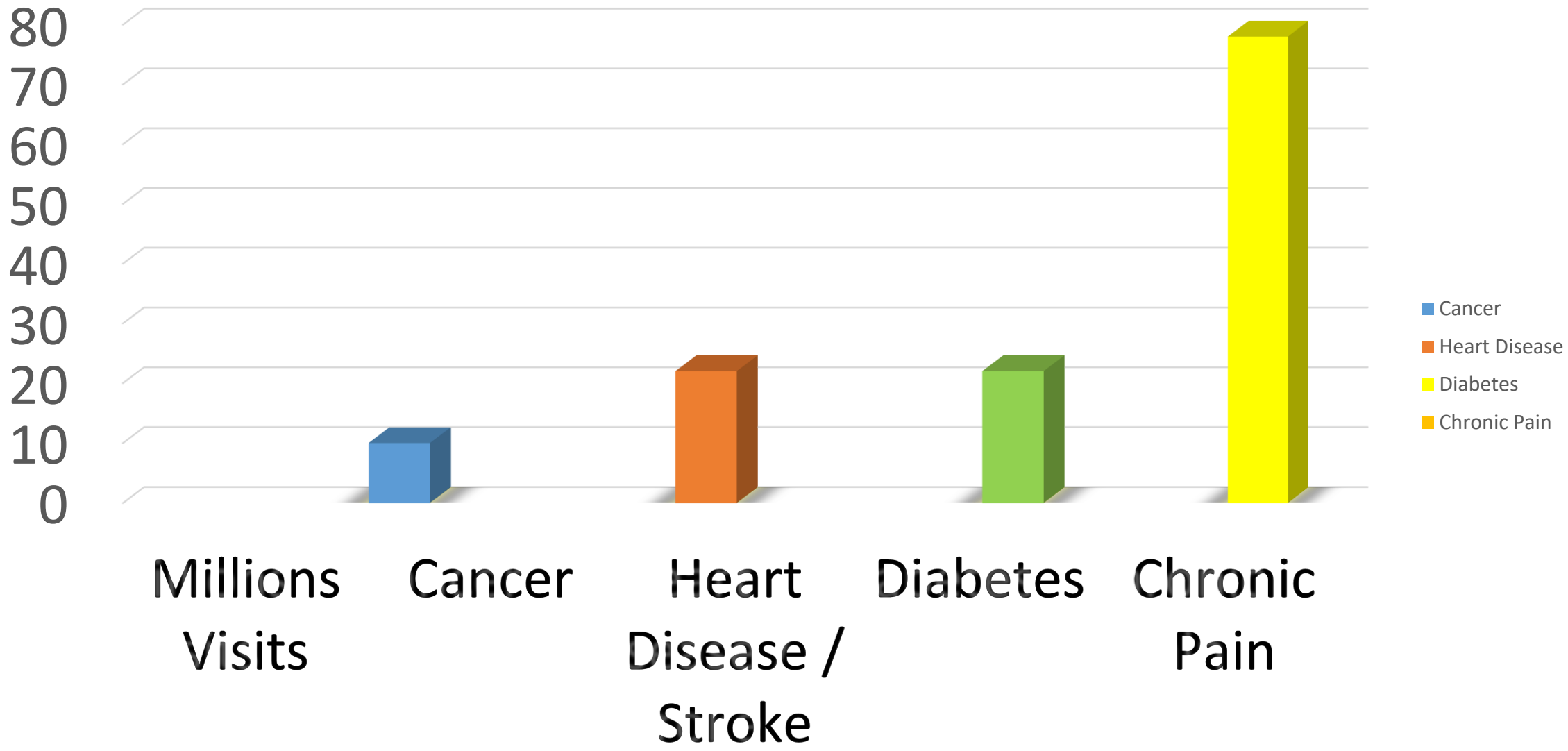
Chronic Pain	100 Million Americans	Institute of Medicine
Diabetes	26 Million Americans	American Diabetes Association
Coronary Heart Disease	16 Million Americans	American Heart Association
Cancer	12 Million Americans	American Cancer Society

Healthcare costs annually range $560 billion - $635 billion

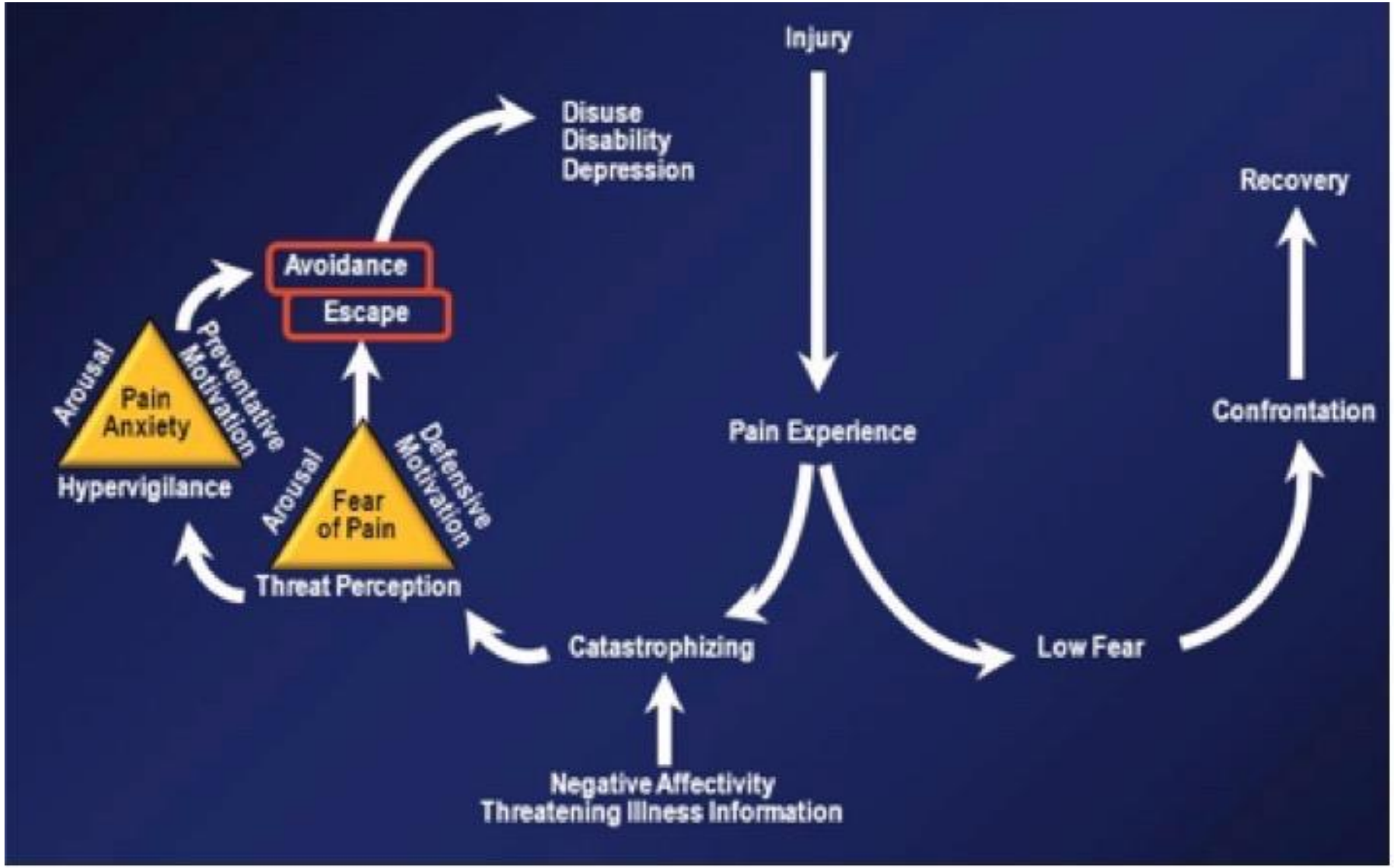
Lost productivity based on 3 estimates:

- 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).

Office Visits by Millions per year



Fear-Avoidance Model of Chronic Pain



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

Acute vs. Chronic Pain - Definitions

Chronic Pain is typically defined as:

- Someone experiencing pain greater than 3 months, *or*
- Pain that is not healing as expected.

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

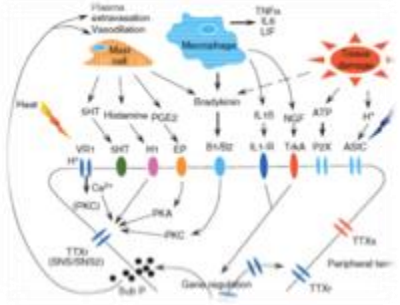
Complexity of Pain Pathophysiology

- Pain system is dynamic and intrinsically self- modulating
- Neural matrix: from nociceptor to brain
- Neurochemical regulation

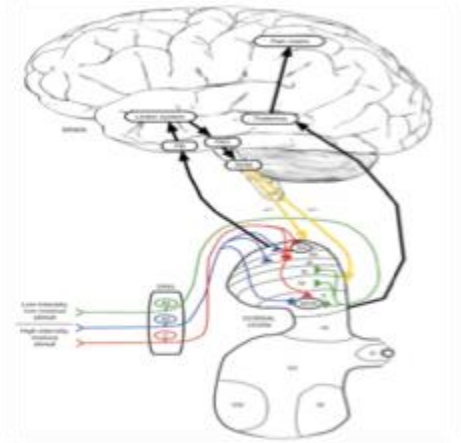
  – Opioids, monoamines, and the “channel-opathies”
- Significant geno-bio-psycho-social interactions

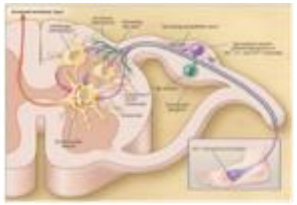
The *Pain Processing System*

NOCICEPTOR



Spinal Cord-
Corticospinothalamic pathways

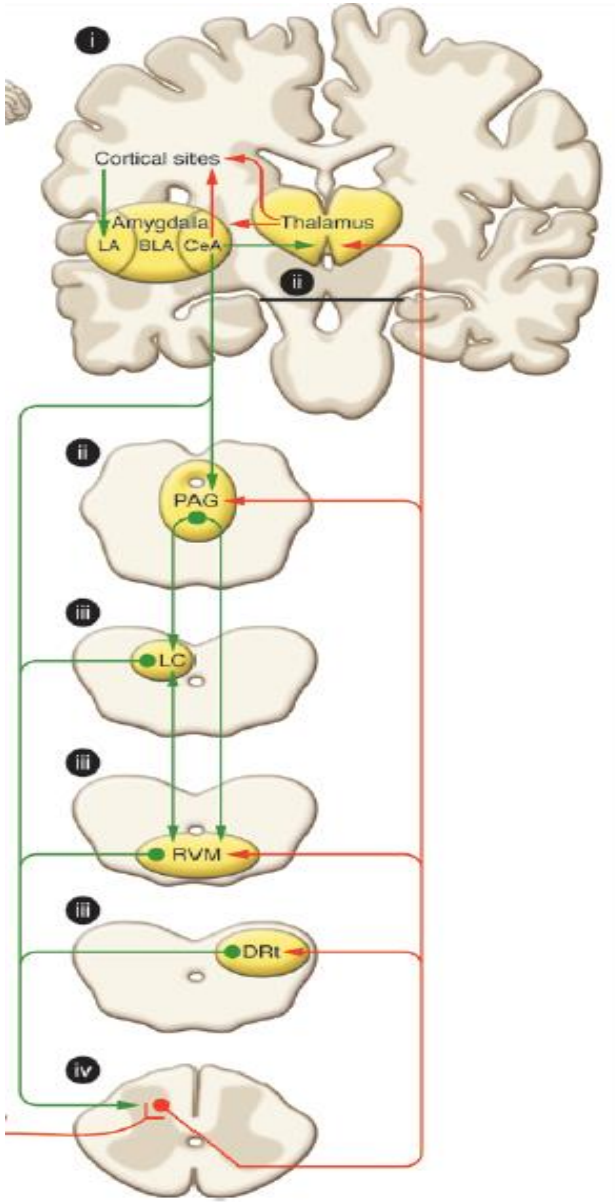




Dorsal
Root
Ganglion

Dorsal
Horn

Thalamo-subcortical-cortical-insular-networks



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

Steps of Pain Signals

- Initial Injury / Insult of some type: PAIN is meant to serve a purpose!
- Nerve and/ 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 the brain
- Note in pictures – not only is the sensory path stimulated, but the transfer centers (thalamus) and the affective centers of the brain (Limbic System) are all stimulated.
- Then, there are messages relayed back to the area of injury, surrounding muscles/bones and sometimes other hormonal releases are present in the dorsal root area of the spine.

Factors Negatively Related to Return to Work

Common factors associated with negative return-to-work outcomes:

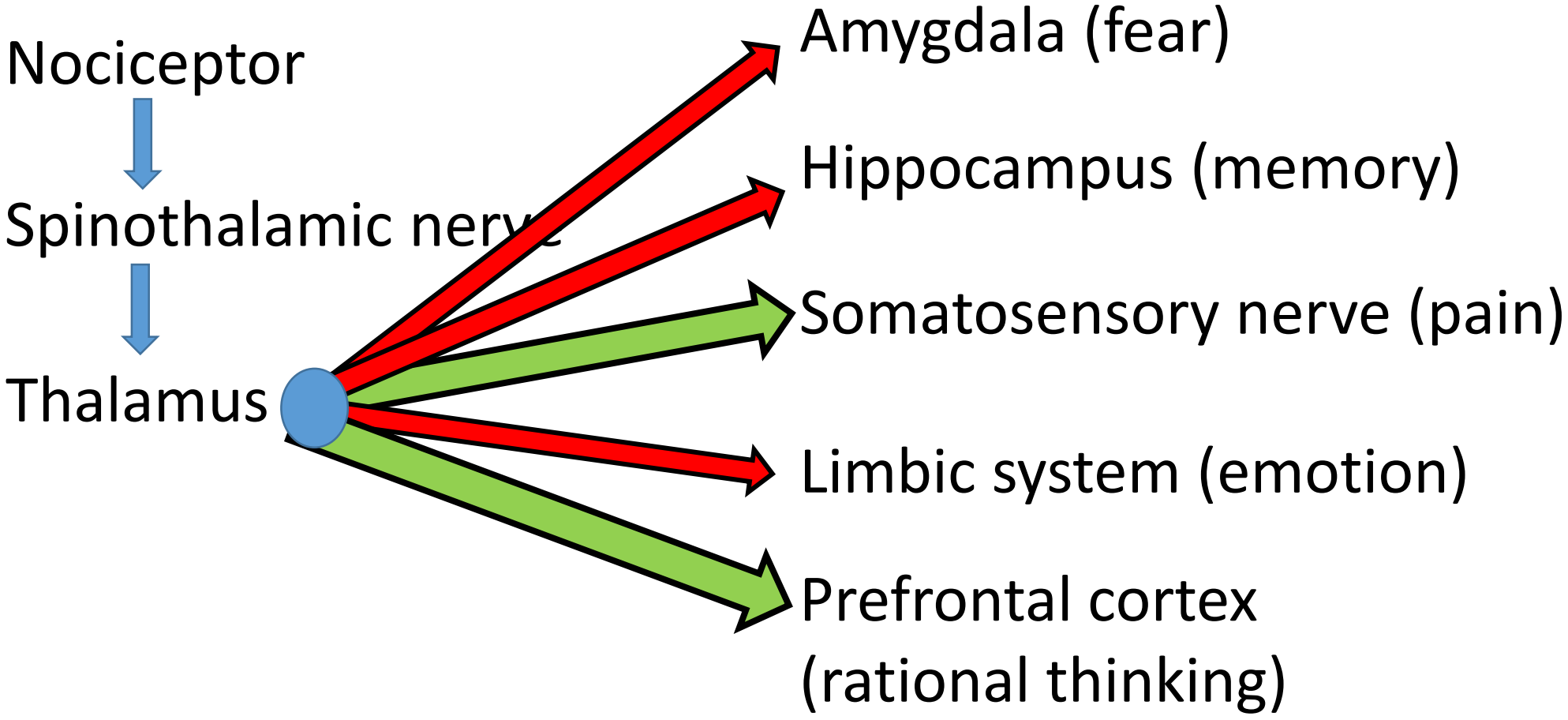
- OLDER AGE
- FEMALE
- HIGHER PAIN OR DISABILITY RATINGS
- DEPRESSION
- HIGHER PHYSICAL WORK DEMANDS
- PREVIOUS SICK LEAVE (OTJ'S) AND UNEMPLOYMENT
- ACTIVITY LIMITATIONS.

HOWEVER – Injuries happen to PEOPLE

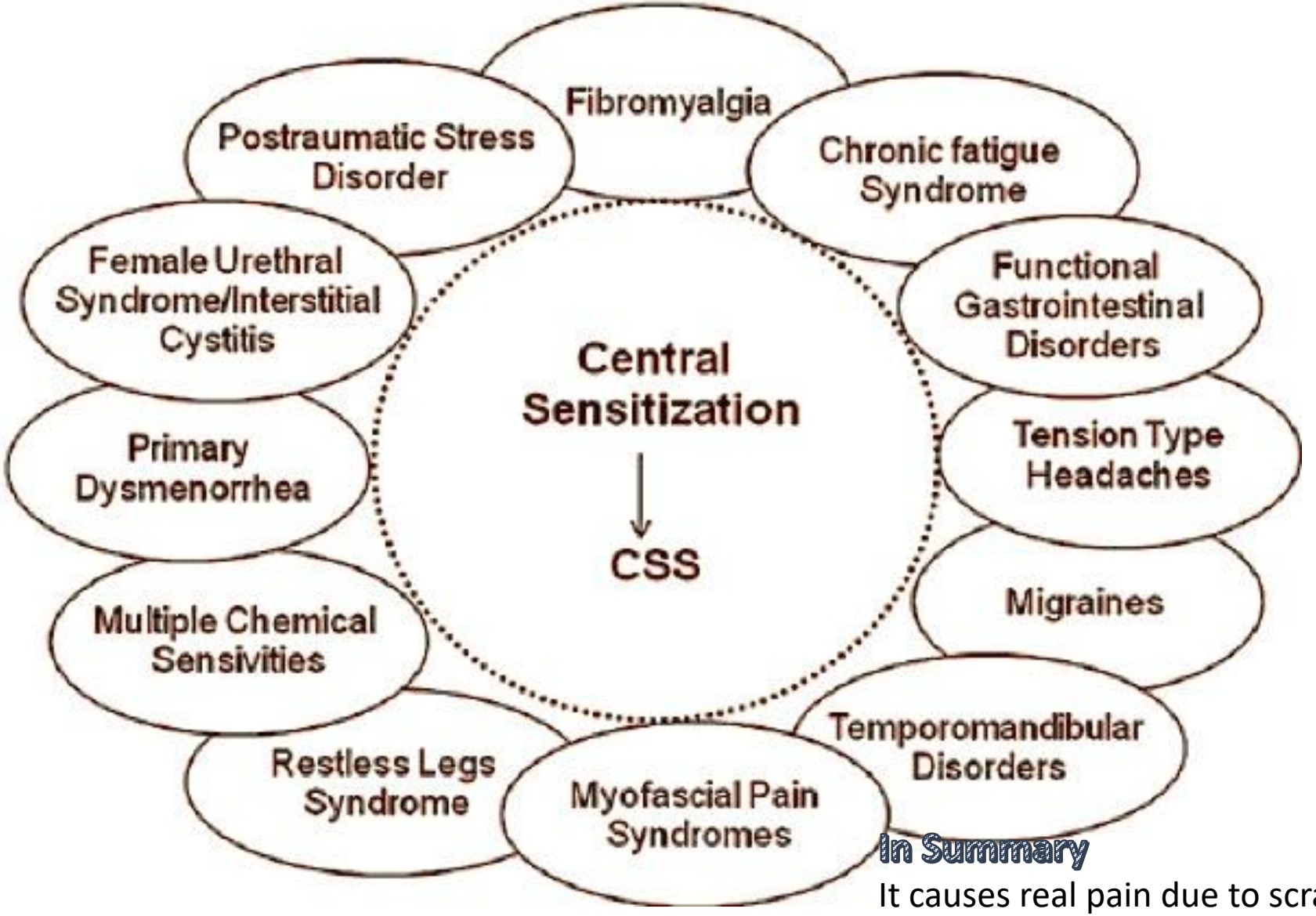
Factors likely to impact someone's response to pain:

- Severity of the Injury
- Race; Ethnicity; Gender; Age
- Socioeconomic status
- Past Experiences
- Response Bias

Pain Pathways (in Central Sensitization)



Central Sensitization thought related to:



In Summary

It causes real pain due to scrambled signals in the brain

Therapy is the only thing that helps

ACES – Adverse Childhood Experiences scale

Significant Events:

- 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

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

Statistics from FIRST CDC / KAISER STUDY

17000 Patients studied from So. California KP from 1994-1997

- 28% had Physical Abuse; 21% had Sexual Abuse
- 40% of members had 2 or more Adverse Experiences
- 12.5% had 4 or more Adverse Experiences

- DOSE SPECIFIC RESPONSE BETWEEN NUMBER OF EVENTS & SYMPTOMS

What about RESILIENCE?

- Supportive relationships and constructive activity promote resilience.

  Schofield, G., Biggart, L., Ward, E., & Larsson, B. (2015). Looked after children and offending: An exploration of risk, resilience and the role of social cognition. Children and Youth Services Review, Vol. 51, 125-133. https://doi.org/10.1016/j.childyouth.2015.01.024

- *Design skills-based interventions suitable across cultures*
- *Re-learn to "Pay Attention" to body sensations (Breathing; Heart rate)*
- *ACTIVE vs. passive or cognitive ways of responding*
- *Particularly needed are interventions that use practical skills to promote the capacity for self-regulation.*

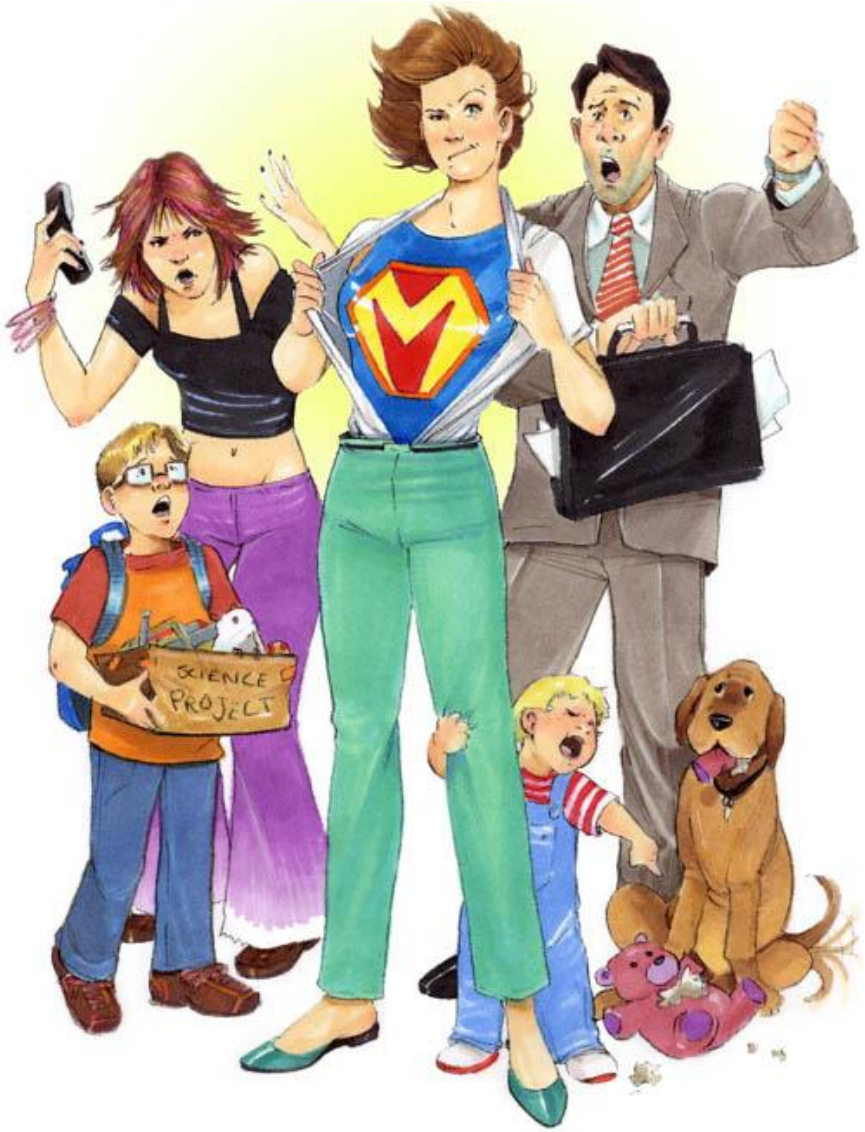
  Leitch, L. (2017). Action steps using ACEs and trauma-informed care: a resilience model. *Health & Justice* ***(5**:5)* *https://doi.org/10.1186/s40352-017-0050-5*

Overview

- Case Examples (Functional vs. Dysfunctional)
- Looking at a “Framework” for how to view Function
- Where to Start? – Where is the most likely Shift?
- Physical Arenas – you need to know!
- Mental / Emotional Arenas – most familiar
- Purpose
- Social
- Family & Spiritual

Functional Means Different things

…functional



Dysfunctional Might mean Different Things

Under Activity

Over (doing) Activity

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

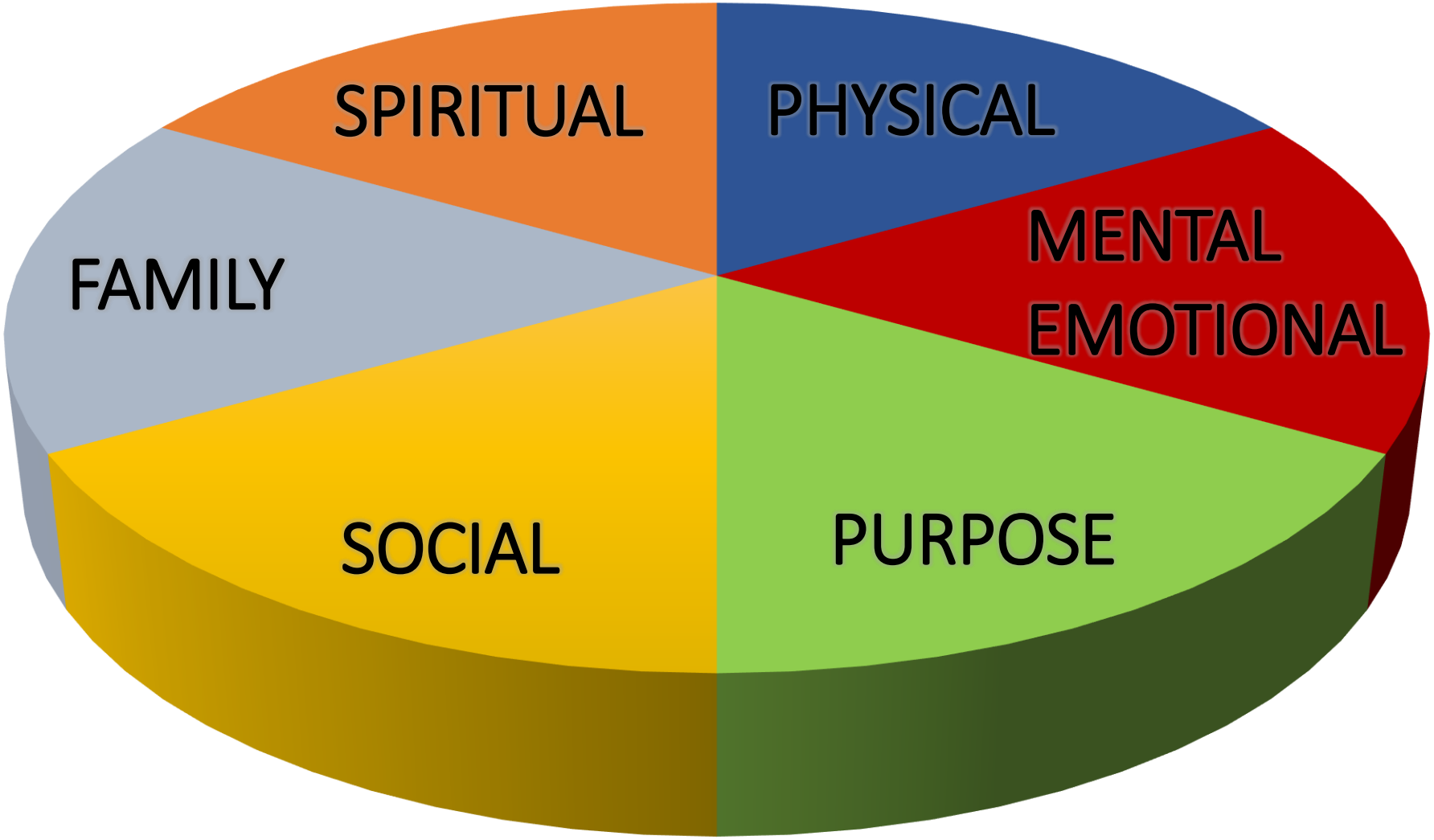
Time of Day	Date:
6 a.m.	
7 a.m.	
8 a.m.	PAIN
9 a.m.	
10 a.m.	PAIN
11 a.m.	
noon	PAIN
1 p.m.	
2 p.m.	PAIN
3 p.m.	
4 p.m.	PAIN
5 p.m.	
6 p.m.	PAIN
7 p.m.	
8 p.m.	PAIN
9 p.m.	
10 p.m.	PAIN
11 p.m.	
midnight	

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.

WHOLE PERSON APPROACH TO *RECOVERY* IN CHRONIC PAIN



Nonpharmacologic Treatment Options – CDC guidelines for treatment chronic pain

- **Exercise Therapy**
- **Cognitive Behavioral Therapy (CBT)**
- **Multimodal Approach and Multidisciplinary Therapies**

Exercise therapy encourages active patient participation in the care plan and provides the opportunity to address the effects of pain in the patient's life. Exercise therapy addresses posture, weakness, or repetitive motions that contribute to pain; reduces lower back pain; improves fibromyalgia symptoms; and reduces hip and knee osteoarthritis pain. Exercise therapy can also be used as a preventative treatment for migraines.

CBT addresses psychosocial issues of fear, avoidance, distress, and anxiety, and improves patient function. CBT trains patients in behavioral techniques to help modify situational factors and cognitive processes exacerbating pain. CBT engages patients to be active, teaches relaxation techniques, supports patient coping strategies, and often includes support groups, professional counseling, or other self-help programs.

Multimodal / multidisciplinary therapies coordinate medical, psychological, and social aspects of care and should also be considered for patients not responding to single-modality therapy or those having several functional deficits. These strategies can reduce long-term pain and disability more than single-modality care alone but cost more and may not be available to every individual.

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?

SMART GOALS

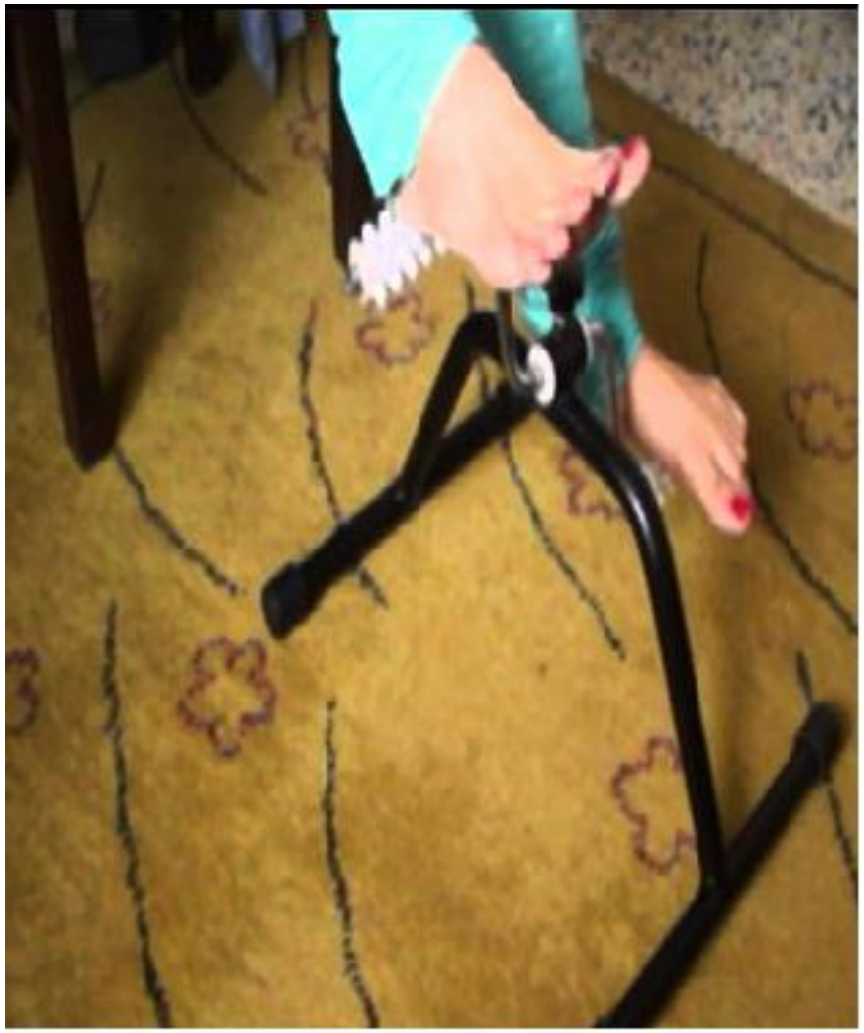
- **S**pecific and significant
- **M**easurable and meaningful
- **A**chievable and action-orientated
- **R**ealistic and reasonable
- **T**imely / time-limited

- 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?

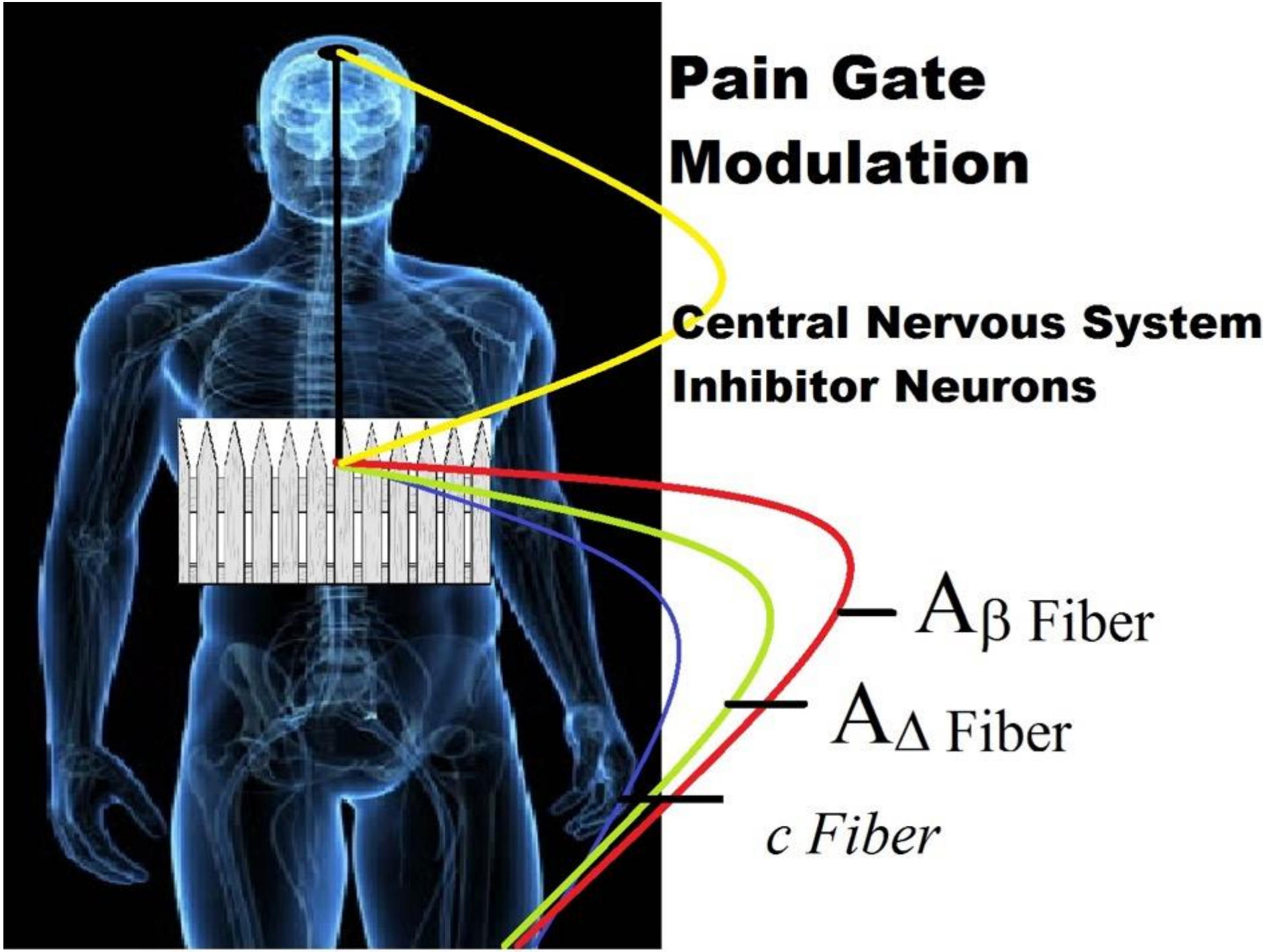
Physical – YOU have to know

- 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.*

Physical Activities



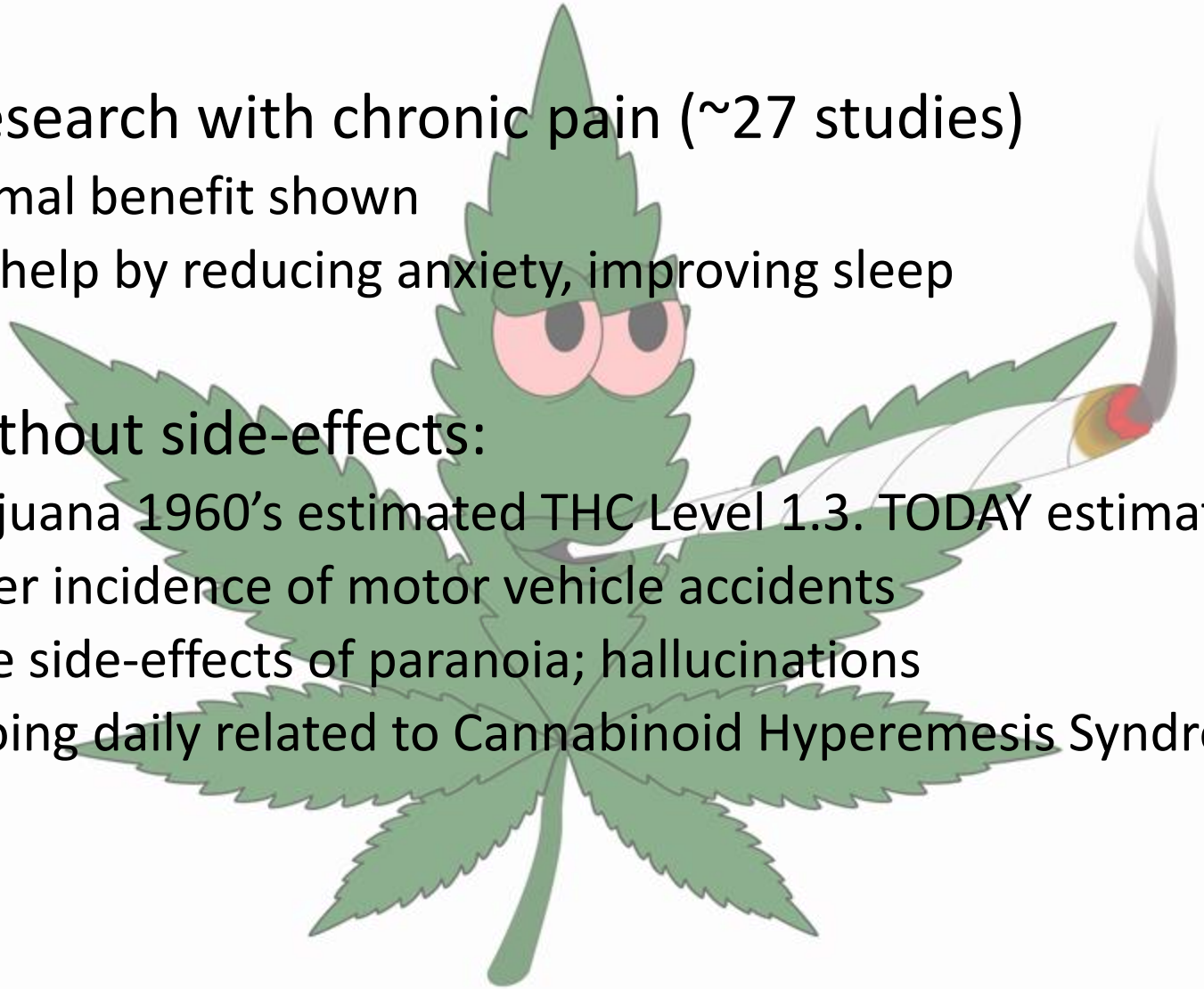
Use the
GATE THEORY
of Pain
to help.



MEDICATIONS for PAIN (Pain Killers)

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

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

OTHER MEDICATIONS / SUBSTANCES

What about other medications or substances?

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

What about Ketamine Withdrawal Program from Opioids; just 1 weekend

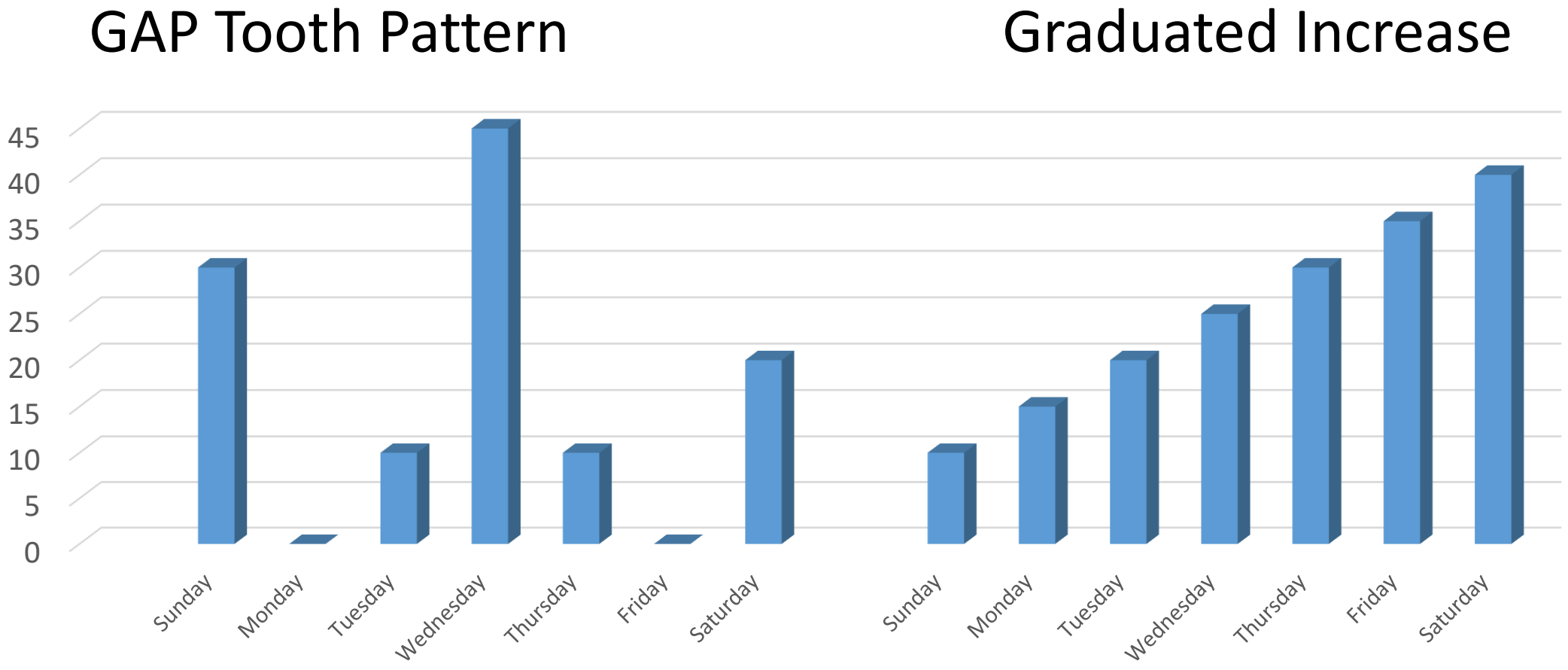
Newest Non-Opioid Medication will help with your pain…

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

Mental / Emotional
– where *we* have most experience

- 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

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



Mirror Neurons / Functional MRI

Just EXPECTATIONS of pain light up areas of the brain that signal pain

For Example: Watching VIDEO of someone straining their back lights up in the brain area associated with pain in the individual lying still.

(Positive) EXPECTATIONS

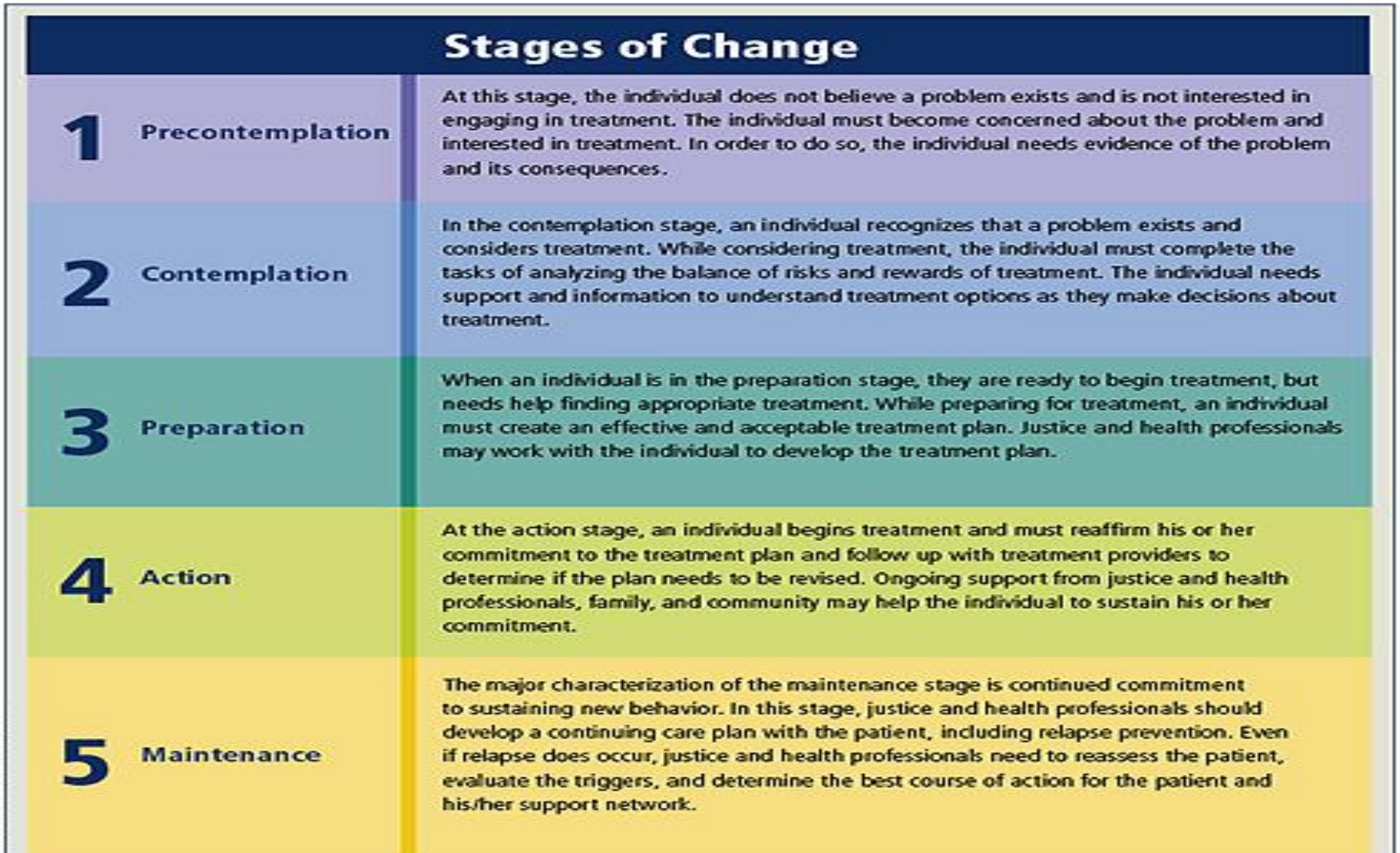
On the other side: Those with experience of pain randomly divided into 3 groups: No Intervention; Sham Surgery; Actual Surgery (1958 – Chest / Angina pain).

[BUT ALSO redone in 2002 – Knee Meniscus Surgery]

NO Treatment	SHAM Surgery	Surgery (artery)
RECOVERY 18%	RECOVERY 65%	RECOVERY 60%
Improvement 4	Improvement 5	Improvement 5

Motivational Interviewing – Prochaska / Miller

Different TASKS of the therapist at each stage.



Stages of Change	
1 Precontemplation	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. In order to do so, the individual needs evidence of the problem and its consequences.
2 Contemplation	In the contemplation stage, an 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 individual needs support and information to understand treatment options as they make decisions about treatment.
3 Preparation	When an individual is in the preparation stage, they are ready to begin treatment, but needs help finding appropriate treatment. While preparing for treatment, an individual must create an effective and acceptable treatment plan. Justice and health professionals may work with the individual to develop the treatment plan.
4 Action	At the action stage, an individual begins treatment and must reaffirm his or her commitment to the treatment plan and follow up with treatment providers to determine if the plan needs to be revised. Ongoing support from justice and health professionals, family, and community may help the individual to sustain his or her commitment.
5 Maintenance	The major characterization of the maintenance stage is continued commitment to sustaining new behavior. In this stage, justice and health professionals should develop a continuing care plan with the patient, including relapse prevention. Even if relapse does occur, justice and health professionals need to reassess the patient, evaluate the triggers, and determine the best course of action for the patient and his/her support network.

Cognitive Therapy

AWARENESS of and CHANGING types of thinking

ABCDE (Simpler is Ellis or Burns) or Beck Standard

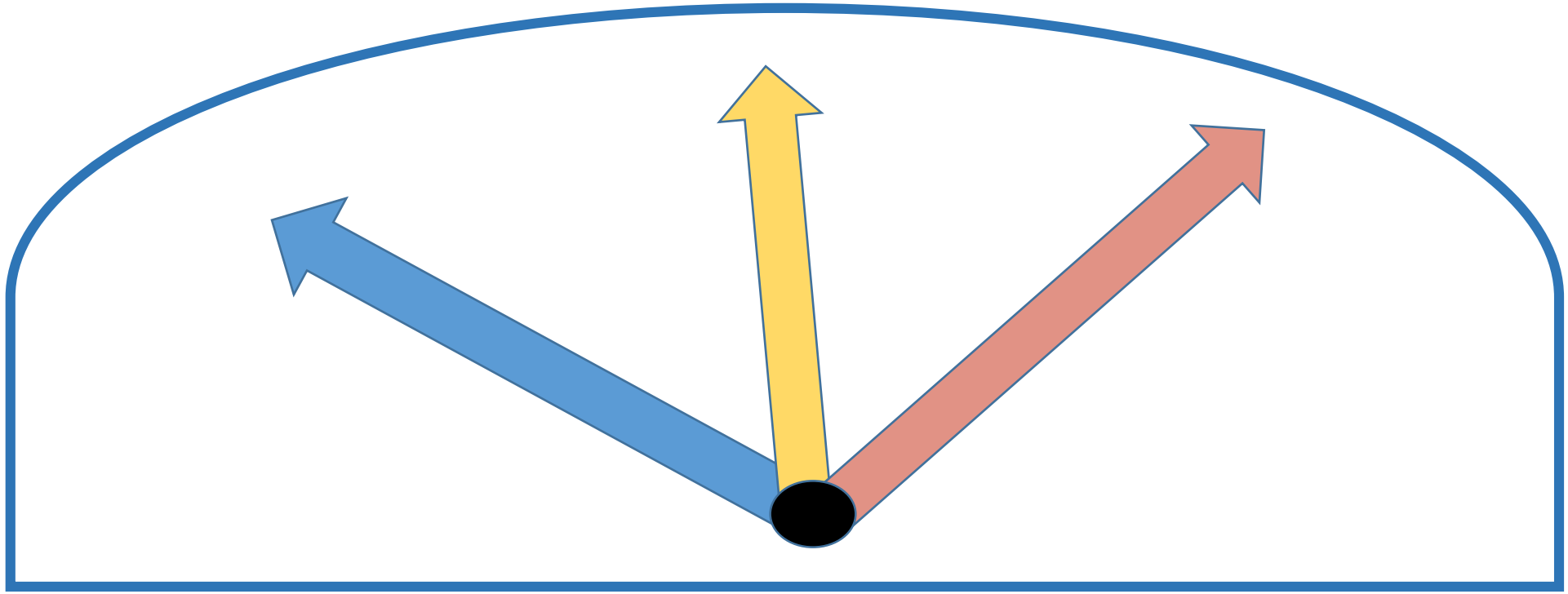
Event / Beliefs/ Consequences / Distortions/ Reframed thought/ Effect

Ways of thinking about / relating to the pain

make it worse / better

Continuum of Relaxation, Meditation, Hypnosis

RELAXATION **MEDITATION** **HYPNOSIS**



Relaxation “go to’s”

- SHAPES
  - THERMOMETER
  - (upside down) TRIANGLE
  - SQUARE
- Progressive Muscle Relaxation Training (PMRT)
- The Body Scan
- Guided Imagery
- Others?

Meditation

Popular in the US since the 1960's; Popular since the BC era elsewhere

The RELAXATION RESPONSE (Benson)

Coming of age of "Mindfulness Practice"

Raisin

Siegel

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?

Purpose

- Used to be called work – until I started dealing with 75 year olds.
- This feeling that you are contributing to something bigger than you
- 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

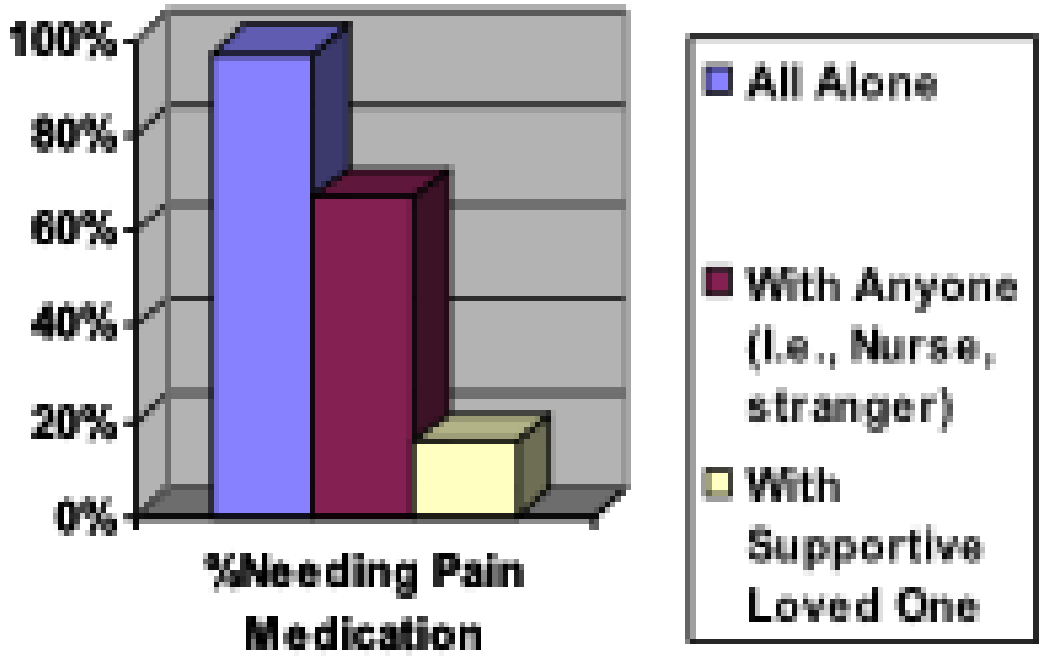
Social

- 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)

Social Connections

In patient handout, Effect of OTHER person on pain (noted by medication use, in this instance with childbirth)

Significant Factor – EMPATHY



Significant Other (18%)

Caring Person Nearby (63%)

All Alone (perceived) (97%)

Teach Assertiveness

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

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)

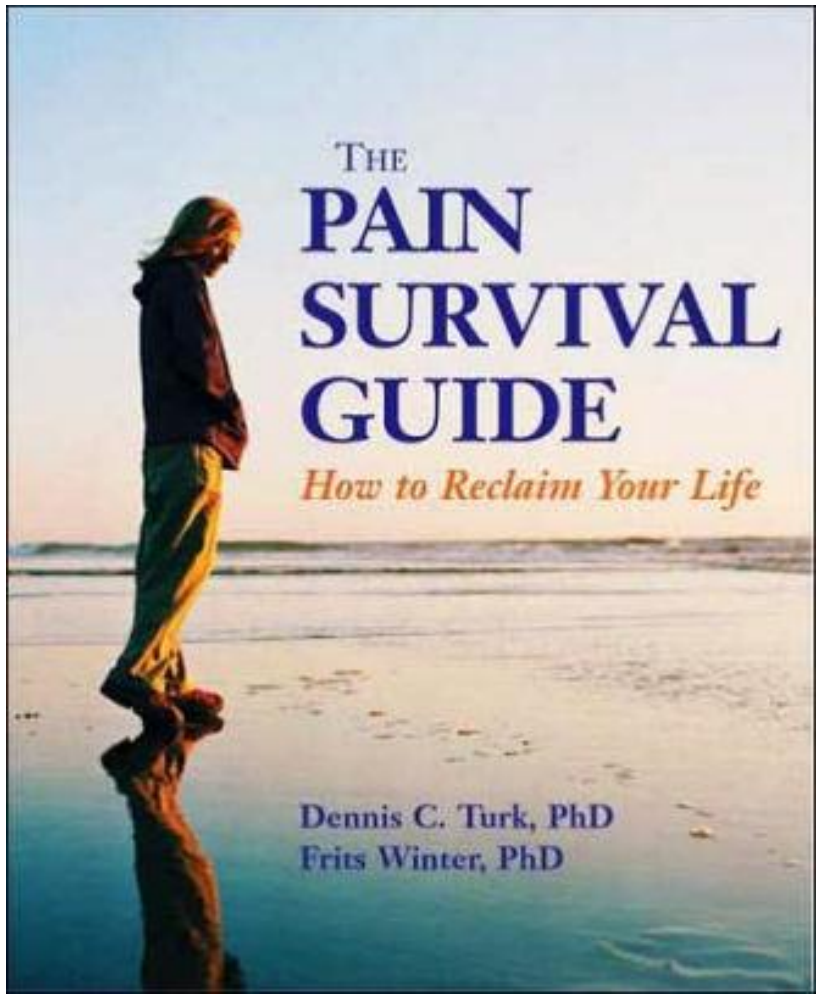
Self vs. Other directed care seems quite important.

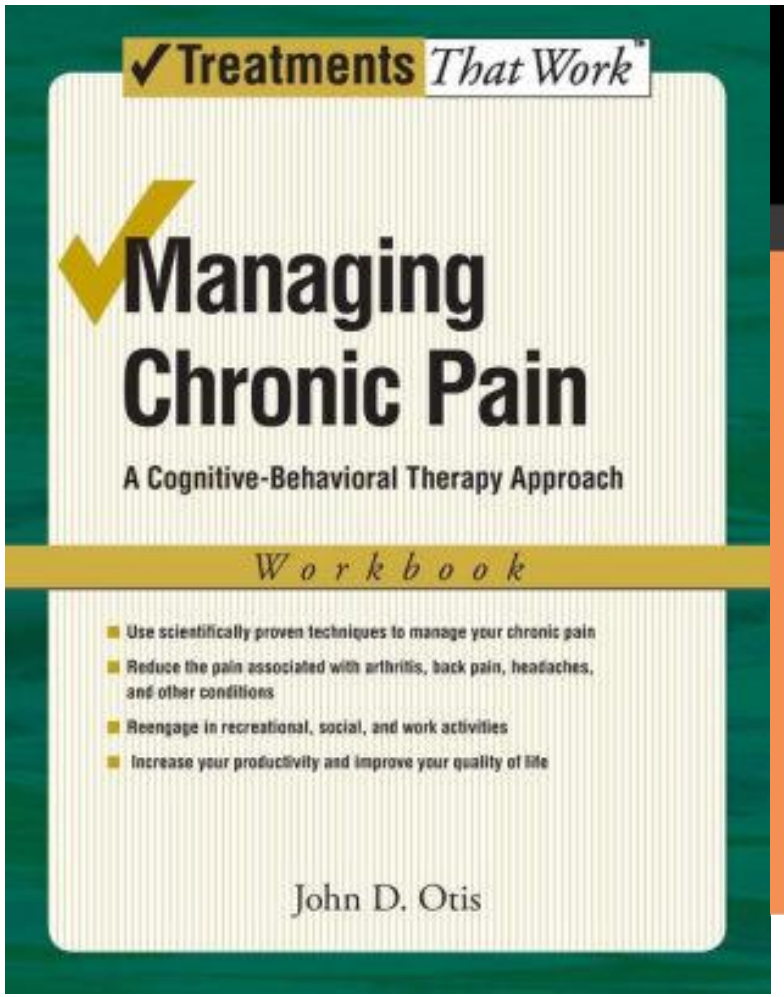
Likelihood of Functional Improvement – Lower than other areas (30%?)

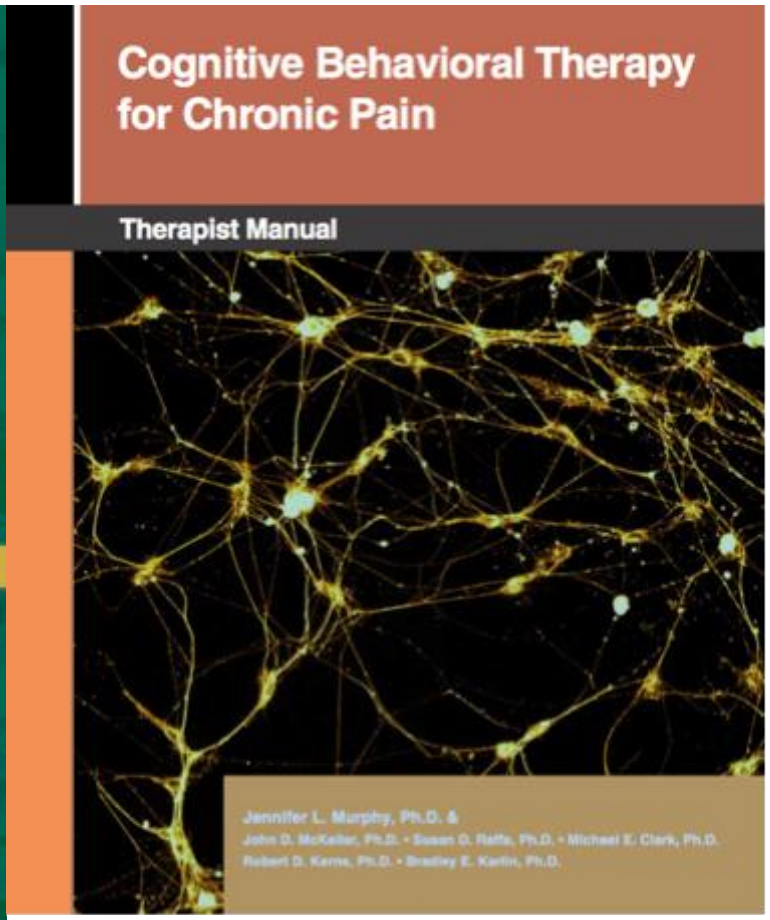
Set provider expectations accordingly

Can you create a “*Virtual Multi-Disciplinary Team*” to work on these issues?

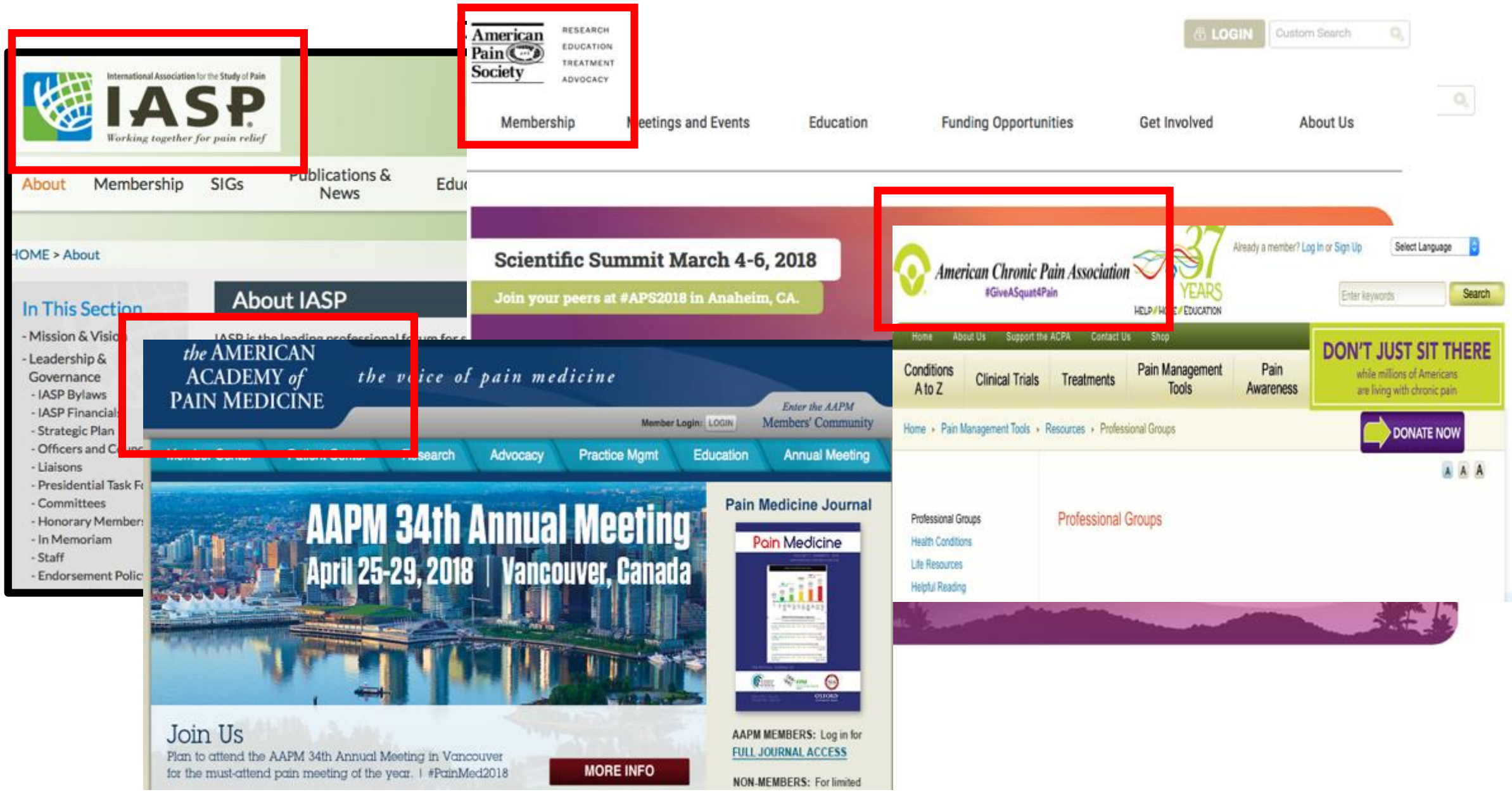
Resources - Books







RESOURCES – Websites & Groups



Questions?

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

What is Chronic Pain, and does this apply to

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

How would a Guidebook help ME?

There are certain strategies of managing ch
pain that apply to everyone. If there has bee
thorough medical work-up, and there are no

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, and they've lost all "normal" routines. Therefore, to help get the pain back under control, we have to re-establish "Routine." What is

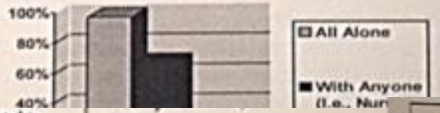
What is routine? It is the creation of a scheduled way of doing things, that is not effected by how you feel, by other things that happen, etc. For example, you may have an aerobic exercise routine of 20 minutes stationary bicycling. When you have a pain flare-up, it is essential that you not NOT exercise.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

xercise

The 1st routine we're going to c
exercise. Many people with ong
tell us, "How can I exercise
hurting all the time?" First, we
make sure you're safe. This w
at your practitioner tell you it is SAFE t
ercise. That is, even though you may hur
t doing any "damage" with exercise. [Hurt
u wait until you "feel better" to exercise, it
ppen. Therefore, we have to create
ough exercise plan that you can begin N
en being SUCCESSFUL with

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 required for their delivery. See the chart below:



axation exercises are now known to be quite powerful aids to roving Chronic Pain. While formal scientific review of xation and meditation/prayer have only begun in the last 25 rs, use of these methods in association with Yoga and Tai exercises has gone on for thousands of years.

e purpose of relaxation is twofold: First, it is clear that when have stress, our muscles tighten up in response (see The t or Flight Syndrome). Unless you do something to nteract it, this increased muscle tension will increase already ting levels of pain. Second, certain relaxation and itation exercises (as well as prayer) will focus your attention something other than pain, and serve as a distraction.

foundation of all relaxation exercise is Diaphragmatic or y Breathing. Simply put, when you breathe in, your belly uld fill like a little round balloon, yet your chest and ulders will not move much at all. When you release the air, ar belly will fall to normal. We all used Belly Breathing when were children, but as adult stresses increased, we tend to our breath or take more shallow, chest based breaths. It is ential to undo this pattern. Therefore, if you checked your breathing, and found you are not doing belly breathing, see u can force yourself to breathe into your belly. If so, you will

1st get a quiet place where
minutes. 2nd sit in the most c
expect the effects to be imme
somewhere in between and w

A **relaxation** exercise to begi

Focus your mind on your fore
all the tension across your for
breath, you release the tensio
to your eyes and temples. N
jaw & chin. Remember there
the whole rest of your body.
focus next on your should
shoulders loosen and fall m
upper arms, lower arms, and
and your belly. Then your
muscles, calf muscles, ankle
image of your body being fille
focus on each muscle group,
all the sand falling out of that
the effect on your mind and
writing it down (see Relaxatio

Many individuals with chronic pain, begin to have negative thinking styles which can actually increase pain. Look through these styles to see if there are any you do. If so, you may want to figure out a system for creating more neutral or positive thoughts.

10 Types of Cognitive Distortions

1. **All or Nothing Thinking**
This refers to the tendency to evaluate personal qualities or situations in extreme, black or white categories. For example, before you developed 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 to master.

2. **Overgeneralization**
This refers to the tendency to see a single negative event as a never-ending

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. I had so much to do and I'll never get it all done."

6. **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 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."

Record Keeping
A Diary or Log is the best way to give yo
We have included a number of Logs for
or weekly basis.

Relaxation Diary

	AM Time	
	Stress Level PRE	Str
Sunday	1 2 3 4 5 6 7 8 9 10	12
Monday	1 2 3 4 5 6 7 8 9 10	12
Tuesday	1 2 3 4 5 6 7 8 9 10	12
Wednesday	1 2 3 4 5 6 7 8 9 10	12
Thursday	1 2 3 4 5 6 7 8 9 10	12
Friday	1 2 3 4 5 6 7 8 9 10	12
Saturday	1 2 3 4 5 6 7 8 9 10	12

Pacing Worksheet
Review activities during the day. Sta
you engage in each activity before y
change activities for long enough to
number of minutes this takes ("down
increasing endurance, or are plannin

Name: _____ **GHC Consumer #** _____

Directions: Please fill out this sheet for 7 days. Record the time of day of pills you take each time you take a medicine. Note other self-thought change, pleasure and comfort activities) used prior to taking the aspirin, Tylenol, etc. Also, list homeopathic medicines and nutritional minute period prior to taking medication and 30-minutes after taking pain. Bring this information to the next medical appointment; space, you could re-write medications on a second sheet. Thank you.

Day	Time of Day	Name of Drug	# mg (Milligrams)
Monday			
Tuesday			
Wednesday			
Thursday			
Friday			
Saturday			

Diary

Dates: _____ to _____

you take each pain related medicine, the milligrams (Mg), and the number management strategies (e.g., relaxation/meditation, exercise, stretching, medicines you list. List any "over-the counter" drugs you take, such as supplements that you take to control pain. Rate your pain during the 30 medication, using a scale of 0-10, where 0=None and 10= Unbearable We will use it to plan possible changes in medication. If you run out of

# of Pills / Capsules	Pain Management Strategies Used Today	Pain Before*	Pain After*