Effective Intervention for Chronic Pain

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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 in compliance 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 Questionnaire
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?
<table>
<thead>
<tr>
<th>PHQ-9</th>
<th>OSWESTRY Disability Scale  * IN BACK OF YOUR HANDOUT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rate 0, 1, 2, 3 (None, Some, Mod, Sev)</td>
<td>Pain intensity</td>
</tr>
<tr>
<td>1. Little Interest or pleasure doing things</td>
<td>I have no pain at the moment</td>
</tr>
<tr>
<td>2. Feeling down, depressed, hopeless</td>
<td>The pain is very mild at the moment</td>
</tr>
<tr>
<td>3. Trouble falling or staying asleep</td>
<td>The pain is moderate at the moment</td>
</tr>
<tr>
<td>4. Feeling tired; Little energy</td>
<td>The pain is fairly severe at the moment</td>
</tr>
<tr>
<td>5. Poor Appetite; or Too Much</td>
<td>The pain is very severe at the moment</td>
</tr>
<tr>
<td>6. Feeling bad about yourself; guilt</td>
<td>The pain is the worst imaginable at the moment</td>
</tr>
<tr>
<td>7. Trouble concentrating simple things</td>
<td>Personal care</td>
</tr>
<tr>
<td>8. Moving Slow or Speeded</td>
<td>I can look after myself normally without causing extra pain</td>
</tr>
<tr>
<td>9. Thoughts of death / self-harm</td>
<td>I can look after myself normally but it causes extra pain</td>
</tr>
</tbody>
</table>

➢ REMIND ME – Bernie Siegel, MD  

Love, Medicine & Miracles – How does he talk with patients about pain?

<table>
<thead>
<tr>
<th>Sitting</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>I can sit in any chair as long as I like</td>
<td>Pain prevents me sitting more than one hour</td>
</tr>
<tr>
<td>I can only sit in my favorite chair as long as I like</td>
<td>Pain prevents me from sitting more than 30 minutes</td>
</tr>
<tr>
<td>Pain prevents me sitting more than 30 minutes</td>
<td>Pain prevents me from sitting more than 10 minutes</td>
</tr>
<tr>
<td>Pain prevents me from sitting more than 10 minutes</td>
<td>Pain prevents me from sitting at all</td>
</tr>
</tbody>
</table>
How do you rate your pain?

ALTERNATIVE version
THE WHOLE PERSON APPROACH TO CHRONIC PAIN

- Physical
- Mental
- Emotional
- Social
- Family
- Spiritual
- Purpose
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.

<table>
<thead>
<tr>
<th>Chronic Pain</th>
<th>100 Million Americans</th>
<th>Institute of Medicine</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td>26 Million Americans</td>
<td>American Diabetes Association</td>
</tr>
<tr>
<td>Coronary Heart Disease</td>
<td>16 Million Americans</td>
<td>American Heart Association</td>
</tr>
<tr>
<td>Cancer</td>
<td>12 Million Americans</td>
<td>American Cancer Society</td>
</tr>
</tbody>
</table>

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

- Cancer
- Heart Disease / Stroke
- Diabetes
- Chronic Pain

- Millions Visits
- Cancer
- Heart Disease / Stroke
- Diabetes
- Chronic Pain

- Cancer
- Heart Disease
- Diabetes
- Chronic Pain
Fear-Avoidance Model of Chronic Pain

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](https://www.iasp-pain.org/publications/iasp-taxonomy) 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

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)

Nociceptor → Amygdala (fear)

Spinothalamic nerve → Hippocampus (memory)

Thalamus → Somatosensory nerve (pain)

Limbic system (emotion)

Prefrontal cortex (rational thinking)
Central Sensitization thought related to:

- Fibromyalgia
- Chronic fatigue Syndrome
- Functional Gastrointestinal Disorders
- Tension Type Headaches
- Migraines
- Temporomandibular Disorders
- Myofascial Pain Syndromes
- Restless Legs Syndrome
- Multiple Chemical Sensitivities
- Primary Dysmenorrhea
- Female Urethral Syndrome/Interstitial Cystitis
- Posttraumatic Stress Disorder

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.


• 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.

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?
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 2\textsuperscript{nd} (3\textsuperscript{rd}? ) 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/1\textsuperscript{st} visit and 2\textsuperscript{nd} 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

- Physical
- Mental
- Emotional
- Social
- Purpose
- Spiritual
- Family
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 usual?
SMART GOALS

• **Specific** and significant
• **Measurable** and meaningful
• **Achievable** and action-orientated
• **Realistic** and reasonable
• **Timely / 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 hypnnosis 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]

<table>
<thead>
<tr>
<th>NO Treatment</th>
<th>SHAM Surgery</th>
<th>Surgery (artery)</th>
</tr>
</thead>
<tbody>
<tr>
<td>RECOVERY 18%</td>
<td>RECOVERY 65%</td>
<td>RECOVERY 60%</td>
</tr>
<tr>
<td>Improvement 4</td>
<td>Improvement 5</td>
<td>Improvement 5</td>
</tr>
</tbody>
</table>
Motivational Interviewing – Prochaska / Miller
Different TASKS of the therapist at each stage.

<table>
<thead>
<tr>
<th>Stages of Change</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1 Precontemplation</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>2 Contemplation</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>3 Preparation</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>4 Action</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>5 Maintenance</strong></td>
<td>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.</td>
</tr>
</tbody>
</table>
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 “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

Delicate Art of Pushing Back

Say what you want, not what you don’t want.

Assume positive intent.

Begin on a positive note.

Don’t reward unwelcome behavior.

- Say what you want, not what you don’t want. Avoid a finger-wagging session. If your answer is asking many questions about your day-to-day shopping choices, it’s saying, “Let’s talk about our longer-term plans to save.”

- Assume positive intent. A sister who asks, “Are you two ever going to have kids?” can sound mean, but she may be trying to show she cares. The sister without children may have encouraged her interest by sharing personal details.

- Begin on a positive note. To a grandparent offering unwelcome parenting advice, start the conversation by saying, “I know how much you care about books and my son’s academic development, but...

- Don’t reward unwelcome behavior. A parent who expects her adult child to be more independent should avoid giving instructions in an act like a child. Reinforce positive behavior, such as household chores and job seeking.
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

1. The Pain Survival Guide: How to Reclaim Your Life
   - Dennis C. Turk, PhD
   - Frits Winter, PhD

2. Treatments That Work: Managing Chronic Pain
   - A Cognitive-Behavioral Therapy Approach
   - John D. Otis

3. Cognitive Behavioral Therapy for Chronic Pain
   - Therapist Manual
   - Jennifer L. Murphy, Ph.D.
   - John G. McKeever, Ph.D.
   - Susan D. Raffa, Ph.D.
   - Michael S. Clark, Ph.D.
   - Robert D. Kerr, Ph.D.
   - Brantley E. Kohn, Ph.D.
RESOURCES – Websites & Groups

- International Association for the Study of Pain (IASP)
- American Pain Society
- American Academy of Pain Medicine
- AAPM 34th Annual Meeting
- American Chronic Pain Association
Questions?

• What / How will you put this information into practice next week?

• Motivational Interviewing - Modeling
What is Chronic Pain, and does this apply to you?

Chronic Pain is a painful condition that has begun to get better within 3 months of starting treatment. The goal is to help you feel better as soon as possible. The treatment plan can be one that has a clear diagnosis, or one that has no diagnosis been reached.

How would a Guidebook help me?

There are certain strategies of managing chronic pain that apply to everyone. If there has been thorough medical work-up, and there are no findings that the pain cannot be helped, then it is safe to exercise. That is, even though you may have done any “damage” with exercise. [Hurt you wait until you feel “better” to exercise, if you can.]

Therefore, we have to create an exercise plan that can be followed. The key is to start with exercises that are easy to do. Light exercises are now known to be quite powerful aids to subdue Chronic Pain. While formal scientific review of relaxation and meditation/prayer have only been in the last 50 years, these methods in association with yoga and Tai Chi have gone on for thousands of years.

A purpose of relaxation is twofold: First, it is clear that when you have stress, your muscles tense up in response. (See The Flight or Fight Syndrome.) Unless you do something to counteract it, this increased muscle tension will only amplify your pain levels. Second, certain relaxation and meditation exercises (as well as prayer) will focus your attention on something other than pain, and serve as a distraction.

A foundation of all relaxation exercises is Diaphragmatic or Breathing. Simply put, when you breathe in, your belly should fill a little like a round balloon, yet your chest and shoulders will not move. When you breathe out, your belly will fall to normal. We all used belly breathing when we were children, but as adults, the body becomes trained to take in more air than necessary, chest breathing. It is possible to undo this. When you first start doing this, you may find that it is a little difficult. But if you do this for a few minutes each day, you will find that your breathing becomes more normal.

If you are having difficulty increasing the amount of time you can breathe this way, try the following:

1. Get a quiet place where you can sit for 5 minutes. 2. Sit in the most comfortable position you can, either sitting or lying on your back. 3. Close your eyes, if possible. 4. Breathe slowly and deeply, feeling your belly rise and fall with each breath. 5. Focus on your breathing, and try to ignore any other thoughts that may come to mind.

As mentioned earlier, there are specific routines that you may find helpful. For example, you may find that you feel better when you take a warm bath and do some gentle stretching exercises. Or you may find that you feel better when you lie down and rest for a while. Whatever works best for you, try it and see if it helps. Remember, it is important to do what feels right for you, even if it is different from what others recommend.