Pain Diary

Name: _____

	Describe situation ⇩	Physical sensation (0–10) ⇩	Describe physical sensation ⇩	Emotional response (0–10) ⇩	Describe emotional response ⇩	Action taken, including medications ⇩
Monday						
Date:						
Time 1:						
Time 2:						
Time 3:						
	Total:		Total:			
	Average:		Average:			
Tuesday						
Date:						
Time 1:						
Time 2:						
Time 3:						
	Total:		Total:			
	Average:		Average:			
Wednesday						
Date:						
Time 1:						
Time 2:						
Time 3:						
	Total:		Total:			
	Average:		Average:			

(cont.)

Pain Diary *(cont.)*

	Describe situation ⇩	Physical sensation (0–10)	Describe physical sensation	Emotional response (0–10)	Describe emotional response	Action taken, including medications
Thursday						
Date:						
Time 1:						
Time 2:						
Time 3:						
	Total:		Total:			
	Average:		Average:			
Friday						
Date:						
Time 1:						
Time 2:						
Time 3:						
	Total:		Total:			
	Average:		Average:			
Saturday						
Date:						
Time 1:						
Time 2:						
Time 3:						
	Total:		Total:			
	Average:		Average:			
Sunday						
Date:						
Time 1:						
Time 2:						
Time 3:						
	Total:		Total:			
	Average:		Average:			

Medication List

Name: _____ List last updated: _____

Medication	How is it prescribed?	Pill dose?	Total dose per day	What's it for?	Morning	Midday	Evening	Bedtime	Prescribed by	Over the counter? (Check if yes)

Relaxation or Mindfulness Technique Diary

Complete the following weekly diary. Next to each category indicate the appropriate information about your daily practice. Use this diary for the first 3 weeks to reinforce practice.

Date							
Time started							
Time stopped							
Place							
Position (lying down, sitting)							
Degree of relaxation at end (0–10) 0 = very relaxed 10 = very tense							
Effects on pain? Decrease = D Increase = I No change = NC							
Method (CD, Technique 1–10, app, MP3, other)							

Were there any problems that prevented you from practicing a relaxation technique daily? How can you solve the problem(s)?

Increasing Activities Worksheet

Date: _____ Name: _____

Make a list of activities that increase your pain and those that decrease your pain (refer to Chapter 4).

Activities that increase my pain Example: Washing dishes (standing)	**Activities that decrease my pain** Paying bills (sitting)

Can you *delegate* any of the activities associated with pain increases? (For example, bringing dirty laundry to the washing machine.) Star (*) the ones you can.

Delegate one activity this week. It will be _____.

Choose one "increase pain" activity from your list and time how long it takes to increase pain level by 1 point. Then choose a "decrease pain" activity and time how long it takes for the pain to decrease again. Alternate between activities that increase and decrease your pain.

Example: Pain ↑ Activity = Wash dishes	Pain ↓ Activity = Pay bills
Wash dishes (10 mins.)	Sort bills from mail (15 mins.)
Wash dishes (10 mins.)	Write checks (15 mins.)
Wash dishes (10 mins.)	Address envelopes (10 mins.)

Activity that increases pain	**Activity that decreases pain**

Can you *adapt* any of the above activities so that they can be performed more easily? What would be some of the adaptations? (For example: sitting to fold laundry or peel vegetables; lying down to call a friend or listen to a book on tape; opening cabinet door under kitchen sink so that you can rest one foot on the shelf; putting bowls in sink to stir ingredients.)

Daily Record of Self-Talk (Automatic Thoughts)

Date	Situation	Self-talk	Physical response	Emotional response	Thinking error	Changed thought

Food Diary

Date: _____ Name: _____

Time started	Food/beverage	Quantity	Time ended

Weekly Feedback Sheet

Name: _____

Date: _____ Reporting for week of: _____

1. Record the daily averages of your physical sensation and emotional response below:

	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7	Weekly average
Physical sensation:	_____	_____	_____	_____	_____	_____	_____	_____
Emotional response:	_____	_____	_____	_____	_____	_____	_____	_____

If this is your first session, record your pain level now (on a scale of 0–10): _____

2. Over the past week, has your *physical sensation*:

Improved _____ Stayed the same _____ Become worse _____

Why do you think that your *physical sensation* has improved, stayed the same, or become worse?

_____

_____

Over the past week, has your *emotional response*:

Improved _____ Stayed the same _____ Become worse _____

Why do you think that your *emotional response* has improved, stayed the same, or become worse?

_____

_____

3. List all medications you are taking:

Name of medication	Dosage (mg)	Frequency*

*How many times per day or per week do you take each medication?

If you take opioids, how many pills did you take for this week? _____

(cont.)

Weekly Feedback Sheet *(cont.)*

4. Did you receive any other pain treatments this week—for example, nerve blocks, physical therapy, acupuncture, etc.? _____

_____

_____

5. How many times this week did you do the following?

Relaxation techniques _____ Mindfulness techniques _____ Mini-relaxations _____

6. For how long and how often did you do physical exercise this week?

Aerobic _____	Time _____	How often? _____
Stretching _____	Time _____	How often? _____
Strengthening _____	Time _____	How often? _____

7. What goal did you set for the week?

Did you accomplish it? (Y/N) _____ If you did not accomplish it, can you come up with a contingency plan that might help you succeed by identifying the obstacle and a solution to the obstacle?

Obstacle	Solution
_____	_____
_____	_____
_____	_____
_____	_____

8. Where did you find your pleasure this week?

_____

_____

9. Do you have any questions or problems?

_____

_____

_____

10. To health care professionals: Is there any other information you wish to collect? Fill in before copying.

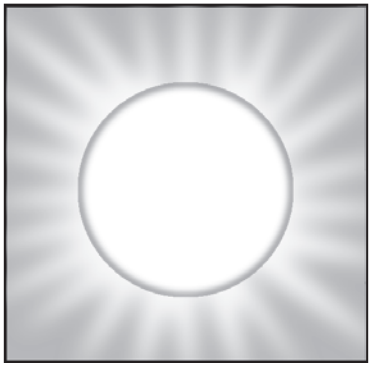
_____

_____

_____

_____

Please Do Not Disturb



I'm relaxing per my doctor's orders

Letter to Health Care Professionals

Dear Health Care Professional:

Managing Pain Before It Manages You is a practical, patient-oriented workbook. It provides information on basic pain mechanisms, medical treatment of chronic pain, and multiple cognitive and behavioral skills that can assist patients with coping and functioning. Although a patient can use this book on his or her own, it can be even more effective if supported by a health care professional who can guide the patient through the program and reinforce the book's information. The workbook was originally written to supplement a 10-visit group medical program for chronic pain management, but it can be used in individual therapy as well.

If you are a physician, nurse practitioner, or physician assistant, this book can supplement the pharmacological, interventional, and surgical treatments recommended to patients with chronic pain.

If you are a psychologist, social worker, nurse, or counselor, this workbook offers a complete, self-guided cognitive and behavioral therapy program for your clients or patients. It can be used in patient education, in conjunction with other medical therapies, and in psychotherapy. Patients can use the workbook independently or as a formal 8- to 10-week individual or group program.

Efficacy of This Approach

A growing body of evidence supports the individual components of a biopsychosocial approach to the management of chronic pain. The approach is further supported by evidence-based treatment guidelines, such as those found in the *Cochrane Database of Systematic Reviews* (*www3.interscience.wiley.com/cgi-in/mrwhome/106568753/HOME*), *BMJ Clinical Evidence* (*www.clinicalevidence.com/ceweb*), the U.S. government's Effective Health Care Program (*www.effectivehealthcare.ahrq.gov*), and through such evidence-based search engines as the Trip Database (*www.tripdatabase.com*).

The best approach to chronic pain syndromes is a comprehensive one that includes a thorough history and physical exam to understand the source of pathology or pain etiology, a stepwise approach to address the multiple sources of pain and distress, and repeated reassessment to assure responsiveness to treatment. Chronic pain is either perpetuated through central nervous system mechanisms (non-nociceptive) or related to underlying chronic painful diseases (nociceptive). Both types of pain are essentially incurable at this time unless the underlying pathology can be eliminated. As such, addressing the biological, psychological, and sociological consequences benefit both by reducing symptoms, increasing activity, and assisting patients in coping with chronic illness and managing their symptoms. The materials presented in this book are grounded in the principles of chronic disease management. They are a synthesis of medical and behavioral approaches to symptom and disease management that have been shown to decrease symptoms and decrease clinic utilization (Caudill et al.,

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1991; Becker et al., 2000). Furthermore, this intervention program can increase self-efficacy, an important mediator of pain-related disability and depression symptoms (Arnstein et al., 1999).

The Professional's Role in Facilitating This Program

Those who do not feel pain, seldom think that it is felt.
—Samuel Johnson, MD, 1708–1784

Progress has been made in the understanding of pain mechanisms, but there is much that remains a mystery. Chronic pain is always a subjective experience, and its consequences, both psychological and medical, have social ramifications. Although there is no objective measure of pain at this time, it is important to believe patients who report their pain experience. It is important for you and your patient to acknowledge that, although living in pain is a challenge, there are many things that can be done, both nonpharmacological and pharmacological, to decrease symptoms and improve quality of life. If you do not feel comfortable evaluating and treating chronic pain, you are obligated to refer the patient to someone who can assist in providing direction.

Many health care professionals feel unsure about how to evaluate or treat pain. It is challenging without a pain meter or other objective measure of pain. Such uncertainty has helped to drive the inappropriate prescribing of opioids in the past decade (Caudill-Slosberg et al., 2004) and precipitated the public health crisis of opioid abuse, addiction, and diversion. At the same time, there has been a dramatic increase in pharmaceutical advertising in popular media as well as to physicians. This marketing program has created unrealistic demands for pharmacological cures by patients who understandably feel quite desperate to be free of pain. It is therefore crucial that the health professional and the patient understand the proposed pain mechanisms and treatment rationale described in Chapter 2 of this workbook. This information can help explain both the limits of pharmaceutical, surgical, and interventional therapies and the need for physical activity, good nutrition, and effective coping strategies.

Assessing and Encouraging Patient Readiness for Change

Teaching an appreciation of the biopsychosocial process at the time of the initial evaluation lends validity to treatments such as cognitive-behavioral therapies. Explore what other symptoms patients are experiencing in addition to their pain. The professional can help identify stress-related symptoms such as fatigue, memory problems, irritable bowel, muscle tension, shortness of breath, palpitations, irritability, and insomnia. Questions about the patient's psychosocial history can help identify other influencing issues and provide more mind–body connections for discussion. For example:

- "What activities have you changed because of your pain?" Humans are incredibly adaptable and are quite capable of using denial for coping. Detailing which

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work and leisure activities have been curtailed inside and outside the home offers evidence for the consequences of the pain experience.

- "Where do you get your emotional support? Who or what helps you to problem-solve?" Behavioral medicine research has documented the positive power of support through close friends, spouses, and religious/spiritual affiliation. However, many patients with chronic pain also suffer from isolation and despair.
- "In addition to your pain and the problems it causes, what other stresses do you have to cope with right now?" This can be a very revealing question. The losses incurred from unemployment or decreased work capacity alone can have economic, social, and self-esteem consequences of enormous importance. Family illness, impending bankruptcy, or homelessness can make coping with pain even more challenging.
- "Have you ever been abused, physically, emotionally, or sexually? Have you experienced a trauma?" There is a very high positive response to this question among chronic pain patients who are having difficulty adjusting to the problem. Such histories are important to uncover because they influence the way in which relaxation skills are taught. Patients with a history of trauma or abuse may require individual treatment to distinguish the emotional consequences of these events from similar feelings common to chronic pain, such as feeling vulnerable or out of control, or that no one believes them.
- "Do you have any fears or concerns about your pain? What do you think is going on?" The majority of patients have ideas (or fears) about the source or cause of their pain. For obvious reasons, addressing these concerns may go a long way in getting them to recognize their part in pain management.
- "What do you want to get from your visit today?" This question sends the message that the patient has a right to have expectations for a visit. It is also a good starting point for clarifying unrealistic expectations. It can be the perfect opening to discuss the roles of the health care professional and patient in reaching a common goal.
- "If I can't cure your pain today, how can I help you to manage it?" This question expands on a common response of many patients. They will say, "You don't understand, Doctor, I don't want my pain, so why would I want to *manage* it?" This again allows for discussion of the nature and reality of chronic, persistent pain. Early in treatment many people feel that acceptance of pain management is a condemnation to a life of pain even if a cure comes along. They somehow think they will be excluded because they have accepted their pain. This misunderstanding is important to clarify. Acceptance means dealing with the here and now; pain may be mandatory because there isn't a cure at this time, but the suffering is definitely optional.

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These questions can elicit a quick overview of an individual's pain experience and lay the groundwork for establishing that pain is both stressful and affected by stress. It also sends the message that you are concerned about the pain and the person in pain. Listening to the patient's responses to these questions helps set up realistic treatment expectations and orients treatment to the patient's level of understanding.

Patients in the precontemplation stage of change (Biller et al., 2000; Rollnick et al., 2008) who have not thought about the relationship between their behavior and pain or who are not ready to hear that they have a role in pain management can be asked just to read the Summary at the end of each chapter in this book. The Quick Skill sections provide a sample of skills or reflections that may capture their interest; they allow patients to dangle a toe in the water if they are not yet ready to plunge into the pond. Patients can also begin by just keeping a Pain Diary, as described in Chapter 1, which might help them focus on how their pain experience is affected and altered by their daily activities and mood.

Patients are most ready to start *using* this workbook when they can acknowledge (1) that what they have been doing to date is not helping them to cope with or manage their pain, and (2) that they need new skills to handle the physical, emotional, and cognitive effects of pain on their lives—effects of which they may not even have been aware before your discussion.

Guiding Patients through the Workbook

When patients are ready, this workbook can provide a guide for change. It is helpful to set a start date with the patient to begin implementing this program. It is also useful to review the patient's goals both to demonstrate your interest and to ensure that the patient's goals are realistic and achievable.

Patients consistently report the benefits of techniques that elicit the relaxation response, pacing activities, exercise, challenging negative self-talk, and diary keeping. If time is limited, focusing on these skills may be most productive. Otherwise, a chapter a week is a realistic pace to set.

With each week and each chapter, more observations and skills are added to the coping repertoire. Encourage patients to keep using and adding to the skills—with the hope of achieving a synergism—not just to do them one at a time.

To encourage action, ask at follow-up visits what patients are learning from their diary keeping, relaxation techniques, and activity pacing. Because the cognitive therapy skills can begin to challenge some basic assumptions and beliefs, patients may be reluctant to do the writing exercises. These are crucial to changing cognitive distortions and ineffective patterns of thinking. Encourage patients to bring these exercise sheets to their follow-up appointments or to keep a journal. Journaling can help patients become more comfortable with what goes on inside the mind and how it reacts to the world. Growing self-awareness can gently move patients into action. This movement toward maintenance of action over time is essential for behavioral change to occur and set the stage for a new standard of living.

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The sequence of chapters in this workbook reflects the way the program is taught. The arrangement of topics is geared toward encouraging patient adherence to the program through the gradual build-up of pain management skills. Techniques that are easier to learn and provide more immediate results—such as relaxation techniques and physical exercise—are presented first. Quick skills are available in each chapter and facilitate access to rapid insights. Successfully adopting these skills provides reinforcement for continuing with the more complex techniques taught in later chapters, including mindfulness drawn from mindfulness-based stress reduction, that require long-term practice, introspection, and self-reflection.

Maintenance and Management of Pain Flare-Ups

Chapter 10 of the workbook addresses relapse prevention and pain flare-up management. Whichever technique the patient chooses to employ, either "coping with stages of pain" or the "panic plan," a copy of the plan should be kept in his or her record and periodically updated. Referral to the plan can then be made, should he or she experience a pain flare-up. However, if the patient insists that a particular pain flare-up is different from what he or she usually experiences, a reassessment is necessary to rule out other developments. I have found that once patients become active participants in pain management through this program, they are the best judges of their own pain experience.

From here on, periodic inquiries about maintenance of skills such as relaxation and mindfulness techniques (Chapter 3), mini-relaxations (Chapter 3), pacing activities (Chapter 4), strategies for response to negative emotional states (Chapters 5 and 6), reduced caffeine and alcohol consumption (Chapter 7), and communication skills (Chapter 8) will also serve to reinforce behavioral change maintenance. If patients have stopped practicing these skills and are having increased difficulty with pain management, it may be necessary for you to identify the specific problems holding them back. For example, has a setback occurred because the patient was secretly hoping this program would cure his or her pain, and it didn't? Did the patient stop the program because it was going so well it didn't seem necessary anymore? Or is a separate life crisis distracting the patient from the pain management program? Once you have determined what issues are involved, you can set a date for the patient to get back into the program and then reinstitute a schedule of periodic checks on skills practice.

A Final Note

I do appreciate the challenge of working in medicine today: the increased time pressures associated with trying to manage the complicated issues inherent in chronic disease management and the use of opioids. Working as a team with advanced nurse practitioners, nursing staff, or psychotherapists on supporting elements of the program can help manage the changes over time that are necessary to establish new behaviors. In the original program

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from which this book sprang, I had the amazing experience of working with nurse practitioners, psychologists, and physical therapists. Each brought their expertise and experience to the issues. Although this multidisciplinary approach is not supported in today's insurance environment, it does not make it a less viable solution. Follow-up visits by the patient with these support disciplines may be as effective.

My personal practice is not to recommend opioids for the vast majority of chronic pain patients I see. This decision is not made lightly, as I have been at both ends of the prescribing spectrum. In most cases I evaluate, the use of opioids rarely changes the reporting of pain levels. Without the additional behavioral changes or willingness to engage in more effective coping strategies, the quality of life with opioids alone is not improved. Short-term opioids to accomplish specific goals or for pain flare-ups *do* have a role, however. These are difficult conversations to have with those who insist that opioids are the only answer.

I cannot emphasize enough what a rewarding experience it is to see people change, improve their quality of life, and feel more empowered in the face of some of the most difficult pain problems. It is critical to start from where the patients are at in terms of their level of information, beliefs, and readiness to consider new directions in behavior and lifestyle practices. Your important role in facilitating this process will have its own rewards.

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