

34TH ANNUAL MEDICAL SEMINAR ON WORKERS' COMPENSATION

PSYCHOLOGICAL PERSPECTIVES
OF OPIOID USE AND COGNITIVE
BEHAVIOR TREATMENT

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February 24 – 26, 2013 Francis Marion Hotel, Charleston, SC

**Psychological Perspectives
of Opioid Use and Cognitive
Behavior Treatment**

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OBJECTIVES

1. Explain multidimensional aspects of chronic pain
2. Discuss problems with opioid therapy
3. Discuss physician options for assessing and treating contributing/problematic factors in opioid therapy
4. Evaluate the value of Cognitive/Behavior therapy in treating chronic pain
5. Explain treatment components of Cognitive/Behavior Therapy

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48 million people in US

Little relief from current medications

Medications have potential for harmful side effects

Depression 4% to 66%

Estimated cost Chronic pain \$215 Billion Depression \$80 Billion

Co-occurrence associated with more disability and poorer prognosis

Greenberg and Brinbaum 2003

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BIOPSYCHOSOCIAL MODEL

Most comprehensive

HOW PAIN IS ASSESSED?

1. Unique
2. Individualized
3. Complex interaction of biological, psychological, social factors

Allows for interdisciplinary treatment

Medicine, PT, Psych, Behavioral health

Getchall 2004, Turs and Rudy 1987, Wright and Getchall 2002

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BIOPSYCHOSOCIAL MODEL

Cognitive-Behavior Therapy is treatment that addresses all aspects of Bio-Psychosocial Model

Standard of care for patients with chronic pain
Better than wait list control group or medical management

Significant changes seen

1. patient's pain experience
2. Improved cognition and coping
3. Improved activity level
4. Behaviors around pain issues are better
5. Improved social role functioning

DISADVANTAGES

Regarded as last resort
All other medical interventions undertaken and failed

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NAVIGATING THE HEALTH CARE SYSTEM

1. Misuse/overuse of opioids
2. Deconditioning
3. Obesity
4. Sleep disturbance
5. Poor body mechanics and posture
6. Lack of social support, communication, social stress
7. Unhelpful coping strategies
 - a. Catastrophizing
 - b. Fear/avoidance
 - c. Overgeneralization
8. Depression and anxiety

These problems can actually increase pain by contributing to tissue damage and increasing psychosocial problems

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Case Example— Sarah 31 year old English Professor
 Likes gardening, dancing, horseback riding

- acute onset of pain while gardening
- conservative treatment – rest, stop exercises (deconditioning)
- CT Scan – herniated disc (source of nociception)
- NSAID, mild opioid (medication)
- Neurosurgeon recommended surgery
- Opted for PT and medication
- Nightmares about wheelchair confinement (sleep deprivation)
- Frightened about surgery (autonomic arousal)
- Had to stop work (short term disability)
- SURGERY able to function on increased medication
- Gradual return to work, gardening, dancing, horseback riding
- Still on medication

TWO MONTHS LATER

- Sharp pain increase (Started in leg after hiking) (sleep deprivation)
- Middle of night awakening (source of nociception)
- Back spasms (anxiety)
- Consult surgeon "Nothing abnormal on MRI"
 Non-operable, Recommends full activity
- "I am in pain, why can't they find something?" (negative thoughts)
- "Am I making this up? Is it all in my head?"

Sarah unable to do housework or pleasant activities

- Resting when not at work (deconditioning)
- Impatient with students and friends (irritable)
- Constantly talks to friends about pain (decreased social support)
- Feels exhausted, alone, defective, miserable, unlovable
- Feels out of control of body (helpless, depressed)

Second Neurosurgical Opinion

- Myelogram (no disc herniation)
- Recommends stabilization with spinal fusion
- Sarah is desperate but agrees to surgery

-no change in pain, unable to work (medication increased, disability)

-Disability insurance representative hassles her about paperwork
 -MD has not filled in paperwork (stressed, panic)

Sarah's Family Doctor tells her "Live with pain"

Referred to Psychologist "It's all in my head" (desperate, anxious)

Caudill, 1995

OPIOID MEDICATIONS

****Growing use with increasing controversy**

****Side effects**

1. hyperalgesia
2. hypogonadism
3. sexual dysfunction

Despite possible benefits 2.8% to 62.2 % of patients may exhibit problematic use

CHRONIC USAGE

1. tolerance
2. dependence
3. potential for misuse or addiction

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" PROBLEMS IN OPIOID MANAGEMENT"

- Many MDs prescribing opioids have little training in addiction or aberrant drug related behavior
- Recent trend in Pain Management Physicians and Centers is preference for injections or intervention only
- Risks in writing prescriptions DHEC scrutiny of MD behaviors and license jeopardy
- Poor insurance/Medicare reimbursement for "med check" visits

Turk, Swanson, Tunks 2008
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******* TOLERANCE*******

Physiologic changes result in increased need to accomplish same level of pain relief
Can also cause side effects such as sedation, nausea, respiratory depression
Occurrence is variable and does not of itself imply addiction

*******DEPENDENCE*******

Syndrome of unpleasant physical symptoms which can occur if medication abruptly stopped
It is an expected occurrence in the presence of continued opioid use

- nausea —vomiting —sweating

Possible emotional dependence and cognitive side effects

- fear of pain —fear lack of control

If abruptly stopped , may lead to

- depression —insomnia

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***** ABUSE *****

- primary, neurobiological disease
- opioids cause changes in limbic system's mediation by dopamine
- Development influenced by genetic, psychosocial, environmental factors
- Characterized by craving, impaired control, compulsive use, continued use despite harm
- Can lead to harmful behavior with physical, social, and legal consequences

Jamison, Butler, Budman, 2010

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APPROACHES TO MANAGEMENT

- Optimal use of opioids must include evaluation of risks associated with potential abuse
- Opioid misuse may indicate treatment adherence issues or more serious behavioral problems

Screening Devices to determine risk potential

1. Screener and Opioid Assessment for Pain Patients (SOAPP-R)
24 item self-administered screening instrument (Butler, Buchner, et al 2004)
2. Prescription Drug Use Questionnaire (PDUQ)
Structured 20 minute interview with patient (Savage 2002)
3. Prescription Opioid Therapy Questionnaire (POTQ)
13 item questionnaire completed by physician (Michna, Ross, et al 2004)
4. Screening for Addiction in Patients/ Problematic substance abuse
(yes/no) questionnaire with cut off values (Compton, Darakjian, and Mlotko 1998)

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Table 1. SOAPP-R items and psychometric values (summed items from selection)

Question	Yes	No	Yes	No	Yes	No
1. How often do you take your pain pills?	2-3	4-5	6-7	8-9	10-11	12-13
2. How often do you take your pain pills when you are not in pain?	1-2	3-4	5-6	7-8	9-10	11-12
3. How often do you take your pain pills when you are not in pain?	1-2	3-4	5-6	7-8	9-10	11-12
4. How often do you take your pain pills when you are not in pain?	1-2	3-4	5-6	7-8	9-10	11-12
5. How often do you take your pain pills when you are not in pain?	1-2	3-4	5-6	7-8	9-10	11-12
6. How often do you take your pain pills when you are not in pain?	1-2	3-4	5-6	7-8	9-10	11-12
7. How often do you take your pain pills when you are not in pain?	1-2	3-4	5-6	7-8	9-10	11-12
8. How often do you take your pain pills when you are not in pain?	1-2	3-4	5-6	7-8	9-10	11-12
9. How often do you take your pain pills when you are not in pain?	1-2	3-4	5-6	7-8	9-10	11-12
10. How often do you take your pain pills when you are not in pain?	1-2	3-4	5-6	7-8	9-10	11-12
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17. How often do you take your pain pills when you are not in pain?	1-2	3-4	5-6	7-8	9-10	11-12
18. How often do you take your pain pills when you are not in pain?	1-2	3-4	5-6	7-8	9-10	11-12
19. How often do you take your pain pills when you are not in pain?	1-2	3-4	5-6	7-8	9-10	11-12
20. How often do you take your pain pills when you are not in pain?	1-2	3-4	5-6	7-8	9-10	11-12
21. How often do you take your pain pills when you are not in pain?	1-2	3-4	5-6	7-8	9-10	11-12
22. How often do you take your pain pills when you are not in pain?	1-2	3-4	5-6	7-8	9-10	11-12
23. How often do you take your pain pills when you are not in pain?	1-2	3-4	5-6	7-8	9-10	11-12
24. How often do you take your pain pills when you are not in pain?	1-2	3-4	5-6	7-8	9-10	11-12

Appendix 1 Prescription Drug Use Questionnaire³

Exclusion of the Pain Condition

- 1 Does the patient have more than one painful condition (i.e., chronic low back pain) complicated by acute migraines or frequent dental visits?
- 2 Is the patient treated by a pain clinic, neurologist, or orthopedist or by a family physician?
- 3 Is the patient treated with long-term or short-term use of opioids?
- 4 Is the patient treated with long-term or short-term use of opioids?
- 5 Has the patient any form of opioid or non-opioid pain management technology (i.e., patch, pump, TENS, or other device) used to manage pain?
- 6 Does the patient believe that his or her pain has been adequately treated over the past 6 months?
- 7 Does the patient report a great amount of pain lately?
- 8 Does the patient believe that his or her pain is or should be treated as a pain condition?
- 9 Does the treating physician believe that the patient is not treated as a pain condition?

Physical Function

- 10 How long has the patient been on a continuous opioid?
- 11 Does the patient have more than one prescription opioid (including Schedule I, II, III, IV, and V)?
- 12 Is there a pattern of use (increasing or decreasing)?
- 13 Does the patient report using a prescription opioid for symptoms other than those reported for the pain condition (i.e., insomnia, anxiety, depression)?
- 14 Does the patient report having received medical attention for symptoms other than those reported for the pain condition?
- 15 Does the patient report experiencing side effects or other problems from drug use (i.e., constipation, drowsiness)?
- 16 How often does the patient use the opioid?
- 17 Is there a pattern of the patient reporting using his or her opioid?
- 18 Does the patient have prescriptions for multiple opioids and/or use of other substances (e.g., IV, IM, inhalers, etc.)?
- 19 Has the patient ever reported a prescription opioid overdose?
- 20 Is there a pattern of the patient making emergency room visits for analgesia?
- 21 Has the patient ever taken a prescription opioid for a non-pain condition (e.g., anxiety)?

Family History

- 22 Has any 1st, 2nd, 3rd, 4th, 5th, 6th, 7th, or 8th degree relative ever had an opioid addiction or pain condition?
- 23 How closely related are the relatives (i.e., mother, father, brother, sister, etc.)?
- 24 How closely related are the relatives (i.e., mother, father, brother, sister, etc.)?
- 25 Is there a pattern of family members that includes the patient's grandmothers and/or aunts? How often are the relatives seen (i.e., number of times per year)?
- 26 Does the patient report having a history of alcoholism, drug abuse, or any other substance use disorder?
- 27 Has the patient ever reported a prescription opioid overdose?
- 28 Has the patient ever reported a prescription opioid overdose?
- 29 Does a family member or friend have a chronic pain condition (i.e., a family member or the treating physician)?

Pain History

- 30 Is there a positive history of addiction to any drug including alcohol in any patient's mother, father, brother, sister, or other relative?
- 31 Is there a positive family history of chronic pain in the patient's mother, father, brother, sister, or other relative?
- 32 How often does the patient use the opioid?
- 33 Has the patient ever reported a prescription opioid overdose?
- 34 Does the patient have a drug or alcohol problem?
- 35 Has the patient ever reported a prescription opioid overdose?
- 36 Has the patient ever been hospitalized with a prescription opioid overdose?
- 37 Has the patient ever been hospitalized with a prescription opioid overdose?
- 38 Has the patient ever been hospitalized with a prescription opioid overdose?
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Appendix 1 Prescription Drug Use Questionnaire³

- 61 Has the patient ever been hospitalized with a prescription opioid overdose?
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- 89 Has the patient ever been hospitalized with a prescription opioid overdose?
- 90 Has the patient ever been hospitalized with a prescription opioid overdose?

TABLE 8. Assessment for addiction during opioid therapy of pain (looking for the four "C's")

From the negative indicator	From the positive indicator
Adverse Consequences due to use	Excessive frequency response to use
Continuing use despite	Use despite known consequences
Substantial effort to quit	Ability to tolerate activity
Temporary drug cessation	Ability to tolerate pain
Increasing pain severity	Ability to tolerate pain
Increasing tolerance dependence	Increasing tolerance
Isolated Control over use/Complete use	Ability to use as prescribed
Response to or other prescription or medication	Use as or medication indicated
Response to other medication	Use as prescribed
Response to other medication	Use as prescribed
Ability to stop drug or alcohol	Use as prescribed
Control performance/medication response	Use as prescribed
Withdrawal control of other signs	Use as prescribed
Control signs/withdrawal symptoms	Use as prescribed
Preoccupation with use due to Opioid	Use as prescribed
Preoccupation about symptoms/signs when not using	Use as prescribed
Loss of ability to perform	Use as prescribed
Control of symptoms/signs	Use as prescribed
Response to other medication	Use as prescribed
Response to other medication	Use as prescribed
Response to other medication	Use as prescribed

Many of these behaviors may occur throughout a time period using opioids. Appropriate for planning for what pain to be managed by a combination of non-pharmacologic and pharmacologic pain therapy support for well for the individual.

MANAGEMENT

- Regular urine toxicology screen
determine compliance, presence of illicit substances
- Risk Factors for Aberrant Prescription Use — 3 clusters of variables
 - History of substance abuse
 - History of legal problems
 - History of psychiatric problems

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MODIFIED TREATMENT APPROACH

One or more risk factors indicate need for modified treatment

—————Narcotic Agreement to Include—————

1. Psychological evaluation and treatment
2. Closer monitoring of behaviors including monthly urine screen and pill counts
3. Education by psychologist concerning avoiding opioids as a way to deal with anxiety, stress, or sleep disorder
4. Stress importance of compliance with "narcotic contract"
 - how to keep opioids secure
 - compliance with behavioral and cognitive regimens to control pain
 - improve coping and functioning
 - exercise -relaxation -psychotherapy

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COGNITIVE BEHAVIOR THERAPY

Why is it necessary?

1. People in chronic pain are more depressed than the general population
2. Pain interferes with mood when it interrupts important life domains work, recreation, social relations
3. Intrapersonal resources are important in coping with pain
4. Self esteem fosters control and mastery buffers against chronic stressors (Turk, Okifuji, Scharf 1995)
5. Better self esteem is linked to better adjustment, lower depression, and less helplessness in people with a variety of health problems (Tall 1999)
6. Better self esteem in pain patients associated with less pain less interference of pain in activity better mood
7. Should patients interpret pain catastrophically, they develop pain related fear/activity avoidance physical disuse and long-term disability (Leeuw, Groosseus et al. 2007)

COGNITIVE BEHAVIOR THERAPY (CBT)

- Psychotherapeutic approach that addresses
Dysfunctional emotions -depression, anxiety, anger
Maladaptive behavioral patterns
Maladaptive cognition/thinking
- Uses goal oriented, systematic procedures to return patients to work, full functioning in life
- CBT is effective in a variety of conditions
Mood, anxiety, chronic pain
Personality disorders
Fibromyalgia
Substance use disorders

AUTHORS AND DEVELOPERS
Edward Thorndike
B.F. Skinner
Cognitive Therapy of Aaron Beck
Rational Emotional Therapy of Albert Ellis

CBT and Health Care
Treatment programs for specific disorders have been evaluated for efficacy
The health care trend of Evidence Based Medicine has favored CBT over psychodynamic approaches where specific treatments for symptom based diagnoses are recommended

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MALADAPIVE BEHAVIOR PATTERNS

Strategies for change using different interventions

1. Self-instructional
2. Demonstration
3. Goal setting
4. Desensitization
5. Training in alternative positive strategies (i.e. relaxation)

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BEHAVIORAL PROBLEMS IN MANAGEMENT

DECONDITIONING

- Even after extensive workup, 85% of cases lack established cause for musculoskeletal pain (Hicks, et al 2002)
- Pain at multiple sites leads to increased likelihood of chronic pain (Coff, et al 2006)
- Pain at multiple sites associated in linear fashion with poor physical condition, impairment, psychological problems, poor sleep quality (Kalmaleli et al, 2008)
- Leads to increased risk of long term work disability and treatment and disability costs

Deconditioning Solutions

- Alternate behaviors
- Daily stretching exercises
- At least 3 times weekly strengthening and aerobic exercising on land or using aqua therapy
- Activity pacing
- Concept of "uptime" and "downtime"
- "threshold vs tolerance"
- Alternate behaviors = sit, stand, walk, recline

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OBESITY

Greater body mass index (BMI) associated with greater number of pain complaints

- Increased number of pain sites
- Tender point sensitivity
- Poorer quality of life
- Reduced physical functioning in patients with chronic pain (fibromyalgia) (Yunas, Arslan, Aldag 2002)

WEIGHT LOSS PROGRAMS

- Weight Watchers
- Paleo diet
- Medical supervision of liquid diet
- Bariatric Surgery

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SLEEP DISTURBANCE

- chronic pain patients show decrease in REM sleep associated with
 - impairment of attention control
 - impairment of working memory
 - impairment of mental flexibility
 - impairment of problem solving
- disturbed sleep architecture contributes to
 - increased sensitivity of pain sites
 - increased sensitivity of tender points
 - increased fatigue
 - increased depression
 - increased stress

SOLUTIONS

- Sedating Anti-Depressant Medication
- Evaluation of sleep postures (pillows, mattress, postural alignment)
- Relaxation, Guided imagery, Self-hypnosis

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POOR BODY MECHANICS AND POSTURE


- Antalgic Gait
Shoulder up with cane
Weight shifted one leg
Shortened steps
- Guarding
Shift weight to avoid painful area (sit or stand)
- Bracing
Muscle tension in response to pain or in anticipation of pain

INSURING CORRECT SPINAL ALIGNMENT IS VERY IMPORTANT

STAND — weight balanced on both feet
ear over shoulder over hip
load balanced on spine, pelvic tilt (flexion vs extension)

SITTING —90 degree angles at waist, at knee
use footstool, lumbar support, cervical support

LIFTING — leg broad base, lift with knees, head up and spine straight
Gaffer's lift



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PREMISE OF MAINSTREAM CBT ————— Change dysfunctional thinking


Dysfunctional thinking (influences person's mood, behavior, physiologic functioning)
Leads to change in affect or behavior (remember Sarah?)

Patients develop automatic/habitual thoughts—"I can't accomplish anything!"
Can lead to reaction of feeling sad (emotion) or retreating to your bed (behavior)
If this process occurs repeatedly, it can lead to physical deconditioning and distorted sleep pattern. (Judith Beck, 2008)

The GOAL:

1. Recognize "errors" or negative thought patterns
2. Replace these patterns with realistic more effective thoughts
3. Decrease emotional distress and self-defeating behavior

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**Life is Painful,
Suffering is Optional.**

Sylvia Boorstein

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Common Negative Thought Patterns Seen in Chronic Pain Patients

1. **Catastrophizing – Fortune Telling** – one predicts worse outcome
Learn to look at realistic odds, and ask what else can happen?
2. **Overgeneralization** – take one negative experience and generalize.
One bad situation predicts similar bad experience in a similar situation
Look for evidence for or against your conclusion, then alter your conclusion
3. **Mindreading** – you assume from small piece of information what someone's thoughts/motivations are
Check it out and require evidence for your conclusion

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NEGATIVE THOUGHT PATTERNS — "SELF TALK"

Patterns are automatic, occur quickly, like incomplete sentences

Example: Wake up, first attempt to get out of bed. The pain is still there.
"I can't stand it anymore!" "No one cares!" "I am useless/worthless"

Result: worry, sadness, depression

This is negative "self talk" – inaccurate, irrational, exaggerated, catastrophic, all or nothing

SOLUTION: Challenge exaggerated statements –

There are things you can do even with pain

You don't have to let your day be miserable

What does that have to do with people caring for you?

Caudill 2002
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REFRAMING TECHNIQUE

State the problem: "I am awakening in pain."

State why it is a problem: "I had planned to visit a friend today."

IDENTIFY:

What can I do? I will see how I feel after taking a shower, stretching, practicing my relaxation, using ice and TENS unit

What do you need? I could ask my friend to come here, or we could meet somewhere close, or we could visit at another time.

Realistic self calming – Pain flare-ups do happen
Flare-ups are usually self-limited
I know what I can do to take care of myself

How do you feel? Sad but hopeful; In control

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PROGRESSIVE MUSCLE RELAXATION

1. Comfortable position either seated or reclining
2. Eyes closed, internal gaze
3. Flex-relax slowly through muscles of body
feet, legs, hips, abdomen, hands, shoulders,
neck (3 directions), forehead, around eyes, jaws
4. Abdominal breathing
5. "strong" "calm"
6. Pleasant place – sealed comfortably, warmth of sun on chest and arms,
beach, meadows, mountains with stream, "Special Place" that only patient
knows about

Suggestion For mastery: Breathe "strong-calm"

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GUIDED IMAGERY

Comfortable position – eyes closed

5 deep breaths

Shape – pain is what shape?
Color – pain is what color?
Texture – pain is what texture?

Shape, Color, Texture grow as large as it can – finger signal
Shape, Color, Texture gets smaller and smaller – finger signal

Repeat process 2 more times

Shape, Color, Texture – smaller – See it roll down one leg all the way to toe,
then kick it into the far distance.

3 more deep breaths
Open eyes

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******* SELF-HYPNOSIS *******

State of "inner absorption", concentration, focused attention

Allows concentration and focus therefore using more potential

Act of self-control

Differing views on how it works

1. "hypnotizability" as a trait
2. Strong cognitive / interpersonal component – response to suggestion
3. Dissociation – people with early trauma, personality disorder
hypnosis can be an abusive tool with them

Fairgrounds

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USES FOR CLINICAL HYPNOSIS

1. Imaginative, mental imagery – Powerful in focused state
Mind is capable of using imagery (often symbolic) to bring out capabilities, person is imagining (sports, achieved goals)
2. Unconscious exploration to better understand or identify whether past events or trauma are associated with exacerbation or contributing to present emotional state or problems
Avoids critical conscious thought
Allows personal intention for change to take effect
Trauma associated memories are not admissible as evidence in court
3. Medical hypnosis can be used to assist with –
pain control/ pain associated with severe burns
gastrointestinal disorders (ulcer/irritable bowel syndrome)
headaches
hypertension
Medical Procedures –surgery, child birth, dentistry

Brain imaging studies using functional MRI and PET scans demonstrate a number of brain structures associated in pain perception (e.g. somatosensory cortex, anterior cingulate cortex, insula) are demonstrably changed through hypnotic suggestion.

(Straebl, Mollen, Jensen, et al 2008)

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SELF-HYPNOSIS PROCESS

Teaches person to put themselves in a trance

Induction – eye fixation, eye roll, arm levitation, arm catalepsy, relaxation

Deepening – walk down stairs, ride escalator, float on cloud, counting

Pain control Techniques

- Anesthesia – cold/numbness (painful leg in cool stream or lake, glove anesthesia)
- Dissociation -- putting self in another time and place
Vivid daydream – floating on a cloud or in a boat
- Altered Sensation/ transformation – cover area of pain with thick layers of padding – Pain turns to pressure
- Displacing pain -- displace pain to another area of body, then to outside the body
- Post Hypnotic Suggestion – Cues – associate relief to deep breathing, seeing number 11 or two parallel lines
- Anchoring – touch self on shoulder or make "OK" finger sign when in trance and re-experience pain relief

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CONCLUSIONS

1. Chronic pain is a multifaceted problem involving biological, social, psychological factors
2. Research shows optimal treatment of chronic pain is from an early onset team approach which addresses all patient needs (not just medication, epidural blocks)
3. Physicians will best manage opioid therapy if psychological/social background issues are assessed and treated from the onset
4. Cognitive/Behavior Therapy provides a value added component in returning patients to work, helping physicians manage patients, and moving their treatment forward

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