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Brief Cognitive Behavioral Therapy for Chronic Pain: *Therapist Manual*

Version 2.0

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BRIEF CBT-CP IS FOR USE BY QUALIFIED CLINCIANS ONLY. THIS PROTOCOL SHOULD BE REVIEWED IN ITS ENTIRETY BEFORE BEING APPLIED TO PATIENT CARE.

THIS MANUAL AND RELATED MATERIALS SHOULD NOT BE USED FOR RESEARCH WITHOUT PRIOR PERMISSION.

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PREFACE

BACKGROUND

This manual includes information regarding the development of Brief Cognitive Behavioral Therapy for Chronic Pain (Brief CBT-CP). The project is being led by contributors from CIH and James A. Haley Veterans' Hospital and developed for use by behavioral health providers who: a) identify the need for a brief, focused intervention for chronic pain, or b) are not working in a setting that can accommodate a full-length CBT-CP protocol. Incorporation of a Brief CBT-CP treatment may be most appropriate for (but not limited to) providers working in the following settings: Primary Care-Mental Health Integration (PCMHI), home-based primary care (HBPC), outpatient/specialty mental health, or individuals working in consultation-liaison roles with medical clinics (e.g., oncology, endocrinology, etc.). Individuals who are experienced in delivering specialty pain interventions may also find benefit in this protocol, particularly if briefer alternatives are needed based on setting-specific demands or patient preferences.

ORGANIZATION OF THE MANUAL

This manual is organized into multiple chapters. The initial chapters provide a rationale for developing the brief intervention and an overview of foundational material about chronic pain. The structure and components of Brief CBT-CP are summarized, and key contextual and clinical considerations for addressing chronic pain are reviewed. Two case examples illustrate indications for Brief CBT-CP. An approach to addressing measurement-based care with Brief CBT-CP is described in depth as well as a chapter regarding how to engage new patients in treatment.

Next, each treatment module is presented. The protocol requires that modules one and six are stable anchors to begin and end the protocol. *However, modules two through five can be presented in any order, depending on the preference of the patient and clinical judgment of the therapist.* An important feature of each chapter is the inclusion of **Therapist Guides**. Each module guide provides an overview of each appointment, including the key elements and general recommended structure. They provide suggested language to introduce topics and key talking points with patients. **Module Outlines** are one-page summaries of required steps to be conducted in each appointment. These can be referenced in real time during your appointments to keep you on track during your 30-minute appointment. **Patient handouts** are an integral part of this treatment and in the first appendix for easy printing or duplication. Several additional **appendices** include detailed information about pain conditions, specialty pain treatments, and relevant mobile apps that can be used as an adjunct to Brief CBT-CP.

TABLE OF CONTENTS

1. RATIONALE FOR DEVELOPMENT OF BRIEF CBT-CP

The full course of CBT-CP treatment typically requires eleven 50-minute sessions delivered by therapists with specialty training in behavioral medicine or those providers specially trained as part of the VA's EBP program. This approach of treating chronic pain as a specialty mental health intervention is time and resource intensive. Because of the widespread occurrence of chronic pain among the Veteran population, there is increased interest among VA providers to be able to offer briefer versions that can be used in more flexible formats in a wider variety of settings. **Thus, this manual serves the goal of making CBT-CP more widely available in a briefer format.** Our hope is that by offering Brief CBT-CP, the overarching goal of improving Veteran outcomes through chronic pain self-management will be met more effectively.

1.1. EVIDENCE THAT BRIEF TREATMENTS MAY WORK FOR CHRONIC PAIN

Research on briefer psychological treatments for addressing chronic pain are growing. There are multiple factors and corresponding lines of research that underlie the development of Brief CBT-CP**. First,** because chronic pain is a common condition, multiple types of interventions are necessary to treat pain in a sufficiently patient-centered way across diverse settings and populations. A brief treatment may be especially well suited for addressing pain early in the trajectory of care with the goal of preventing functional disability and distress. **Second,** prior research suggests that briefer versions of CBT-CP offered in primary care and various other non-mental health settings are effective (Ahles et al., 2006; Buszewicz et al., 2006; S.K. Dobscha et al., 2009; Lamb et al., 2010; Martinson, Craner, & Clinton-Lont, 2020; Moore, Von Korff, Cherkin, Saunders, & Lorig, 2000; Smith & Torrance, 2011; Von Korff et al., 1998; Wetherell et al., 2011). Since first developing Brief CBT-CP in 2017, subsequent evaluation has indicated that, on average, participating in Brief CBT-CP is associated with clinically significantly improvement in a composite measure of pain intensity and pain-related functional impairment (Beehler et al., 2019). Additionally, patients report high levels of satisfaction and acceptability of Brief CBT-CP (Beehler et al., in press). **Third,** providing psychological treatment in primary care is especially important given that over half of patients in primary care report chronic pain (Kerns, Otis, Rosenberg, & Reid, 2003). Primary care providers find pain management especially challenging (Matthias et al., 2010) and, according to Dobscha and colleagues, have reported dissatisfaction with their ability to provide optimal pain relief for their patients (2008). **Fourth,** chronic pain commonly co-occurs with mental health conditions such as depression, anxiety, and PTSD. Thus, mental health providers may be especially well-suited for addressing chronic pain and associated distress given the common CBT-based model of intervention. **Finally,** local availability of pain resources and interventions may vary considerably across clinics. Thus, Brief CBT-CP provides an additional, more accessible alternative.

1.2. BRIEF CBT-CP: ADAPTED FROM THE VA EBP

Brief CBT-CP as described in this manual has been adapted from the full-length VA treatment (Murphy et al.). The authors of Brief CBT-CP, who are subject matter experts in the areas of chronic pain management and integrated care, developed the protocol with several factors in mind. Research indicates that CBT-CP is an effective treatment for chronic pain, but dismantling studies do not provide sufficient guidance to suggest which specific components of CBT are responsible for effective treatment outcomes. **Thus, Brief CBT-CP includes an adapted version of each key CBT-CP element: psychoeducation/goal setting; behavioral skills: activities, pacing, and relaxation training; cognitive coping; and relapse prevention.** Brief CBT-CP mirrors the full-length CBT-CP currently disseminated throughout the VA as part of the EBP initiative (Stewart et al., 2015).

1.3. BRIEF CBT-CP EMPHASIZES PATIENT-REPORTED OUTCOMES

A key component of this protocol is the use of patient-reported outcome measures throughout the intervention. Use of brief validated measures to capture patient-reported outcomes (e.g., routine assessment of pain intensity, distress, functional interference, and others) at each module are strongly recommended in order to inform both patient and provider about patient response to treatment. Previous research has indicated that routine outcome monitoring is important for identifying patients who are not responding to treatment, with continued monitoring useful for capturing patients' response to treatment modifications (Carlier et al., 2012; Scott & Lewis, 2014). Routine outcome monitoring will also aid the provider in identifying patients who need a "step up" to a higher level of care. Specific instruction in conducting measurement-based care as part of Brief CBT-CP is provided in a later chapter.

1.4. BRIEF CBT-CP IS DESIGNED FOR A DIFFERENT SETTING AND PURPOSE

Although Brief CBT-CP is not designed exclusively for primary care settings, efforts were made to adapt CBT-CP to the PCMHI service delivery platform that has relatively unique features, such as sessions of 30 minutes or less, highly focused brief assessments, an emphasis on improving functional outcomes, and an emphasis on early detection and prevention.

Brief CBT-CP is designed to introduce patient self-management, improve pain self-efficacy, reduce functional limitations, and potentially reduce self-report ratings of pain and negative impacts of pain. Brief CBT-CP may be a used in a variety of ways depending on the clinical context, provider, and patient. For example, a PCMHI provider may wish to use Brief CBT-CP for patients with distress and functional limitations that stem from chronic pain. Specialty mental health providers, behavioral medicine providers, or those in consultation-liaison roles may wish to use Brief CBT-CP alone or as an adjunct to other medical or psychological therapies. Similarly, even a pain specialist who usually provides full-length CBT-CP may wish to use the brief version to meet the needs of patients who prefer or need a shorter treatment.

After a course of Brief CBT-CP, there are several potential options for disposition of the patient. For some, no additional treatment will be necessary. Other patients may benefit from occasional follow-up or booster sessions over the subsequent months to help with fine-tuning the application of skills developed in Brief CBT-CP. Some patients may choose to continue with their routine mental health treatment focused on depression, anxiety, or other psychiatric concerns. Other patients may ultimately benefit from continuing on with a full course of CBT-CP or additional pain-related psychosocial and rehabilitative interventions.

2. FACTORS TO CONSIDER WHEN SELECTING BRIEF CBT-CP

2.1. BEFORE BEGINNING BRIEF CBT-CP

Selection of this protocol assumes that providers have identified that brief intervention for pain-related issues is clinically indicated. Because detailed training in the foundational and functional elements of CBT clinical skills are beyond the scope of this manual, we recommend that providers who wish to implement Brief CBT-CP have completed prior training in the basic principles of CBT.

NOTE: Brief CBT-CP assumes that the patient has completed at least one appointment with a mental health provider who has conducted an initial assessment appropriate to the practice setting (e.g., functional assessment and mental health screenings typical of the PCMHI setting; psychosocial history for a specialty mental health clinic).

2.2. ADDING BRIEF CBT-CP TO YOUR CURRENT PRACTICE: PROVIDER AND SETTING FACTORS

Adopting a patient-centered stance is essential for conducting CBT-CP, including this brief version. **Following the biopsychosocial model, a patient-centered approach is required so that the therapist can use patient-identified goals to direct the course of care.** Patients are likely to have a variety of concerns that are impacted by their experience of chronic pain. Thus, it is essential to elicit from them their primary concerns. In this way, patient-centeredness is not only a general approach to engaging the patient, it is critical for ensuring Brief CBT-CP is being applied in a way that will be most useful.

This protocol has been designed to meet the needs of generalist mental health providers. It is therefore important to consider that, at times, additional support from specialists may be necessary. **We advise that you identify your clinic or facility's behavioral medicine or chronic pain specialist(s) who can provide additional clinical support to you or act as an additional referral source should your patient wish to engage in longer-term treatment or require a higher level of care.** It may also be helpful to coordinate care with the patient's prescriber who will play a key role in medical management of pain. The prescriber may find it valuable to know that the patient is working toward better self-management.

2.3. DETERMINING WHO MIGHT BENEFIT FROM BRIEF CBT-CP

Brief CBT-CP will not be suitable for all patients, so clinical judgment must be used when determining who might be best served by Brief CBT-CP. Patients who are particularly likely to benefit from Brief CBT-CP include those with one or more of the following characteristics:

- Mild to moderate functional impairment and distress
- No severe mental health disorder or substance use disorder impacting overall function or suggesting imminent safety risk
- Patient receptiveness to non-pharmacological self-management approaches for pain

***Note: The above characteristics are comprised of suggestions only and should not be interpreted as a list of inclusion criteria*.**

Finally, we provide two prototypical examples of patients who are appropriate for Brief CBT-CP below:

2.4. BRIEF CBT-CP CASE EXAMPLE 1: PCMHI SETTING

Jeff is a 26-year-old White Veteran who recently enrolled in VA primary care services after separating from active service in the Marine Corps six months ago. Routine mental health screening by his primary care provider resulted in a referral to PCMHI staff for concerns related to mood. Further evaluation by the clinic's psychologist uncovered that chronic low back pain stemming from his combat deployment is a significant contributor to his feeling irritable, and that over-the-counter analgesics have offered limited pain relief. Jeff noted that his back pain, rated as a five on the Numeric Rating Scale, has increasingly interfered with his sleep, ability to sit through college classes, and interactions with his young son. He has become increasingly concerned that pain will impact his long-term goal of operating his own business. He is frustrated by what he describes as a near constant dull ache over the past two years, and wonders if it will improve. Considering Jeff's endorsement of moderate chronic pain and its interference with daily activities, the clinic psychologist discusses both mood and pain management options with Jeff and his primary care provider. Though Jeff has never attempted cognitive behavioral self-management of his pain symptoms, he appeared eager to learn more about managing pain, particularly through implementation of techniques that he can use on his own. Further, he wishes to receive the bulk of his medical and mental health care in his primary care clinic. Therefore, Jeff and his treatment team agree to incorporate Brief CBT-CP into their collaborative approach to care.

2.5. BRIEF CBT-CP CASE EXAMPLE 2: BEHAVIORAL MEDICINE SETTING

Paulette is a 65-year-old African American Navy Veteran who is finishing treatment for colon cancer. Her level of fatigue has increased as she completes her course of chemotherapy, which has contributed to decreased mood and limited engagement in hobbies and social activities.

She has a relatively new post-surgical abdominal pain following her initial cancer surgery six months ago. Additionally, she was diagnosed with moderate arthritis of the right knee over 10 years ago which has become more bothersome in the last several months. The infusion clinic nurse identified that Paulette's Numeric Rating Scale for pain is a seven, suggesting clinically significant pain in need of additional intervention. Upon further discussion with the infusion nurse, Paulette also reported increased frustration with her multiple sources of pain that are clearly interfering with daily routines. The infusion nurse informs the oncologist who suggests a new course of NSAIDs with the option of as-needed hydrocodone for more significant pain flare-ups. Paulette agrees to try the NSAIDs, but is disinclined to use opioids due to concerns over side effects. The oncologist also requests a referral from the behavioral medicine consultant who contacts Paulette during her last chemotherapy treatment the following week. Paulette reports that her pain is slightly better using the new medication but continues to be disruptive. She also reports moderate depressive symptoms on the PHQ-9. Paulette does not use any non-prescription drugs, but reports that she has been consuming more alcohol recently in the evenings to help with sleep. As Paulette has been reporting to the VA frequently over the last nine months since first diagnosed with cancer, she is eager to finish her treatment but does not want to engage in extended sessions of psychotherapy. She is, however, willing to try the 6-week course of Brief CBT-CP to help with pain management.

3. INTRODUCTION TO CHRONIC PAIN

3.1. WHAT IS PAIN?

According to the International Association for the Study of Pain (IASP), pain is defined as *an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage* (IASP, 1994). This definition stresses that pain is both a subjective physical experience (i.e., unpleasant bodily sensations) and emotional experience (i.e., distress related to bodily sensations).

3.2. THE DIFFERENCE BETWEEN ACUTE AND CHRONIC PAIN

Pain can be either **acute** or **chronic** in nature (Institute of Medicine, 2011) as described below:

Acute pain has a short duration and is typically characterized by an identifiable injury or disease. Some acute pain is expected to occur in response to health events, such as childbirth or following surgery. Acute pain usually subsides over time as the body heals, and often responds to standard medical treatments.

Chronic pain is an ongoing or recurrent pain lasting beyond the usual course of acute illness or injury. Chronic pain typically lasts more than three to six months and adversely affects the individual's well-being. There may not be a clear underlying physiological cause to chronic pain.

Table 1. COMMON SOURCES OF PAIN

Common Sources of Pain	
Acute	**Chronic**
Infection	Migraine/headache
Dental conditions	Arthritis
Burns	Fibromyalgia
Trauma	Irritable Bowel Syndrome
Surgery, other procedures	Trauma
Childbirth	Shingles
	Musculoskeletal disorders (e.g., low back pain)

Note: A detailed listing of additional pain conditions is located in the appendices.

Although it is important to adequately treat both acute and chronic pain, this manual focuses only on the treatment of chronic pain. Psychosocial treatment of chronic pain is especially important because of the well-established connection between chronic pain and diminished quality of life, functional limitations, and psychological distress.

3.3. ADDRESSING CHRONIC PAIN IN THE VA: THE STEPPED CARE MODEL FOR PAIN MANAGEMENT

There is a wide array of treatments for individuals with chronic pain. As shown in Figure 1, the VA has adopted a stepped care model for pain. Stepped care is designed to adjust the intensity of intervention based on patient presentation and response to care. The foundational step of the VA model reflects the importance of routine self-care, from weight management to being engaged in a safe and supportive social and physical environment. Step 1 includes care from Patient Aligned Care Teams, or PACTs, who manage the majority of patients with chronic pain. In the event that additional intervention is needed beyond services offered in PACTs, the second step of this model includes referral to chronic pain specialists. The third step of care is reserved for the most complex patients who require treatments such as coordinated interdisciplinary programs. At all levels, stepped care for chronic pain stresses the importance of a biopsychosocial perspective which considers not only traditional biomedical factors (underlying pathology, pharmacological treatment, brief advice administered by a medical provider) but also the psychological, behavioral, and social factors that impact Veterans with chronic pain. Furthermore, stepped care at all levels endorses team-based approaches to care with an increasing emphasis on patient self-management approaches.

Although the VA stepped care model suggests certain services for each step, the actual availability of these services may vary by location. For example, Step 1 includes support from the PCMHI provider in variety of ways, including Brief CBT-CP. PCMHI providers at a given facility may or may not be prepared to provide support specifically for chronic pain management. However, most are likely able to assist patients in adjusting to their pain condition or by addressing comorbid mental health conditions. Alternatively, some PCMHI providers will have behavioral medicine backgrounds that will allow them to take a more diverse role in chronic pain management. This manual is well-suited to PCMHI providers who are either new to chronic pain management or who desire to implement a brief treatment for pain adapted from an evidence-based protocol.

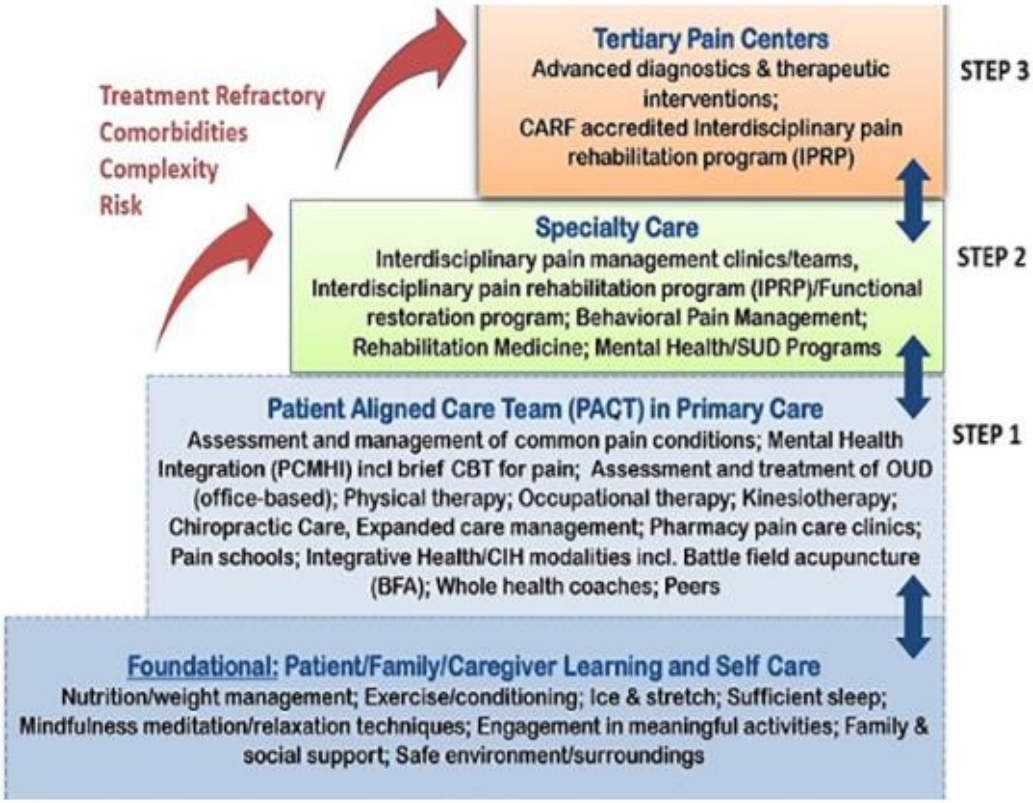

Figure 1. VA's Stepped Care Model for Pain Management

3.4. UNDERSTANDING CHRONIC PAIN

Chronic pain is a complex phenomenon. As such, there are a number of conceptual models that have been developed to explain the etiology and nature of pain. Currently, the biopsychosocial model (Engel, 1977) is the most widely accepted approach to understanding chronic pain. The biopsychosocial model (see Figure 2 below) suggests that the experience of pain is multifactorial, with a wide array of physical, psychological, social, and other environmental factors that may play a role in perpetuating pain.

For example, the biopsychosocial model suggests that in addition to the physiological basis of their pain, an individual's thoughts, behaviors, and social relationships are all important contributors. Importantly, this model suggests that there are multiple points of intervention for addressing chronic pain, from medical treatments, to psychological interventions, to modifications in one's social environment.

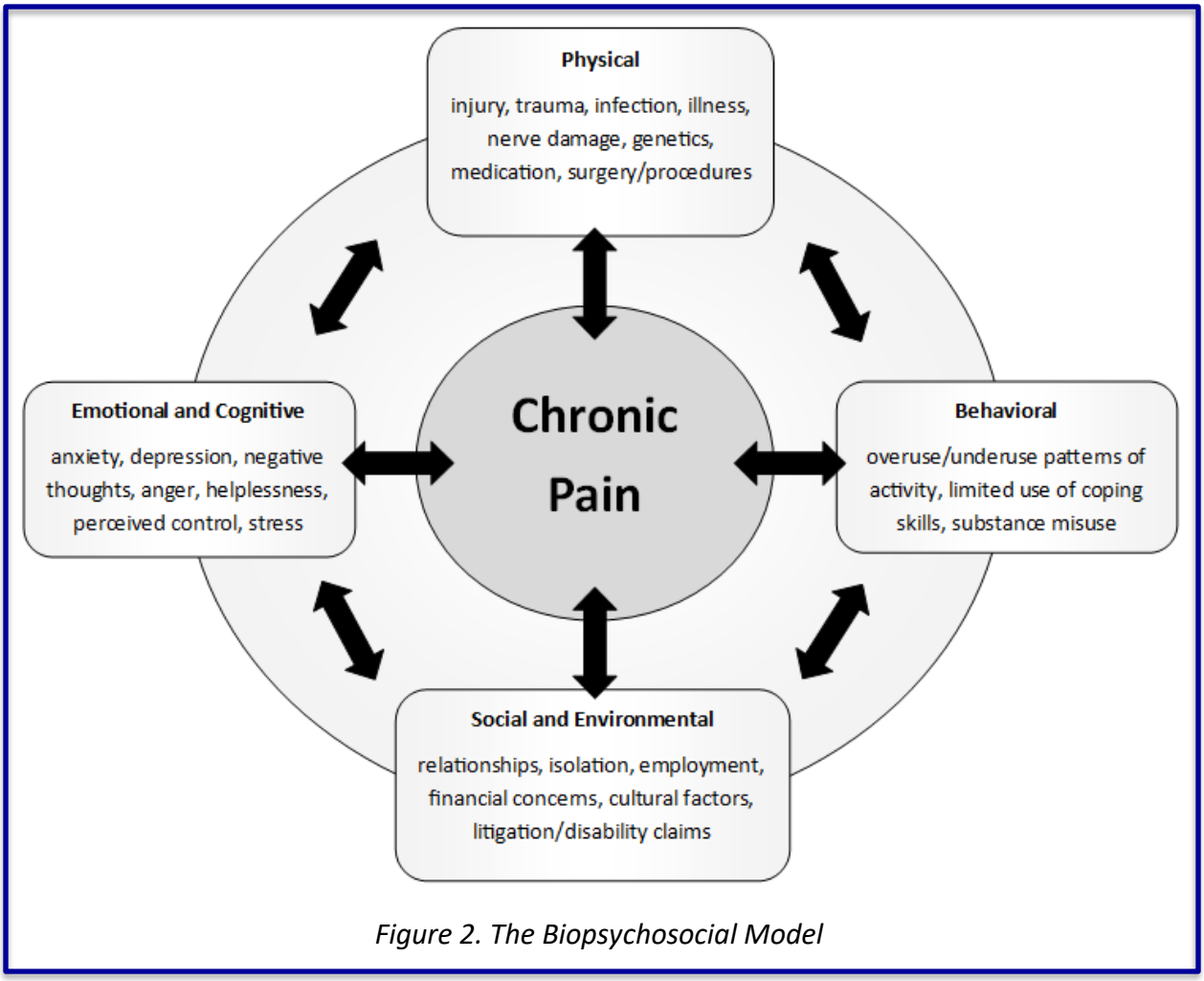

Figure 2. The Biopsychosocial Model

3.5. TREATING CHRONIC PAIN

Chronic pain can be treated through a wide array of modalities. Some of the most common biomedical approaches are summarized in Table 2, with additional details and descriptions of these approaches available in the appendices. Although treatments that address the physiological contributors to pain are important to pain management, individual responses to these treatments may vary considerably. Often, patients and providers will need to work together to identify the best approaches for optimal pain care.

In addition to these biomedical-based treatments that address the physical domain, applying self-management and relevant psychological and physical therapies are essential since all dimensions of the biopsychosocial model must be addressed.

Table 2: BIOMEDICAL MODALITIES FOR TREATING CHRONIC PAIN

Biomedical Modalities for Treating Chronic Pain
Pain-relieving medications (i.e., analgesics)
• Non-opioid analgesics
• Opioid analgesics
• Topical analgesics
• Muscle relaxants
• Adjuvant analgesics
• Headache-specific analgesics
Invasive medical treatments
• Epidural steroid injections
• Nerve blocks
Non-invasive treatments
• Physical therapy
• Cold/heat
• TENS
• Complementary and Integrative Treatments

3.6. COGNITIVE BEHAVIORAL THERAPY FOR CHRONIC PAIN (CBT-CP)

There are several evidence-based psychological therapies that have been shown to improve outcomes for patients with chronic pain. Among these, Cognitive Behavioral Therapy (CBT) is a widely researched, time-limited psychotherapeutic approach applied to numerous mental and behavioral conditions. CBT involves a structured approach that focuses on the relationships among cognitions (or thoughts), emotions (or feelings), and behaviors. Treatments based on cognitive behavioral theory have been successfully applied to the management of chronic pain, either delivered alone or as a component of an integrated, multimodal, and interdisciplinary pain management program. Evidence suggests that CBT-CP improves functioning and quality of life for a variety of chronic pain conditions (Williams, Fisher, Hearn, & Eccleston, 2020).

CBT-CP is an approach rooted in the development of a strong therapeutic relationship that encourages clients to adopt an active, problem-solving approach to cope with the many challenges associated with chronic pain (Burns et al., 2015). Currently, the VA has endorsed CBT-CP and developed a full-length treatment currently available as part of the Evidence-Based Psychotherapy program (Murphy et al.). Use this link to download the manual.

The value of CBT-CP is its focus on improving patient self-management to positively impact the chronic pain cycle shown below. The pain cycle (see Figure 3) illustrates how the experience of pain can lead to maladaptive changes in behavior that ultimately lead to increased distress, decreased activity, and a chronic course of pain. The experience of pain often leads to decreased activity out of fear of increased pain associated with movement. Limiting one's otherwise beneficial activities can lead to physical deconditioning and disengagement from pleasurable or otherwise meaningful activities and life events. The persistence of chronic pain and disengagement from valued activities can lead to increased emotional distress, negative thinking, and decreased motivation that result in further disengagement. The resulting state of disability is reinforced by ongoing maladaptive coping.

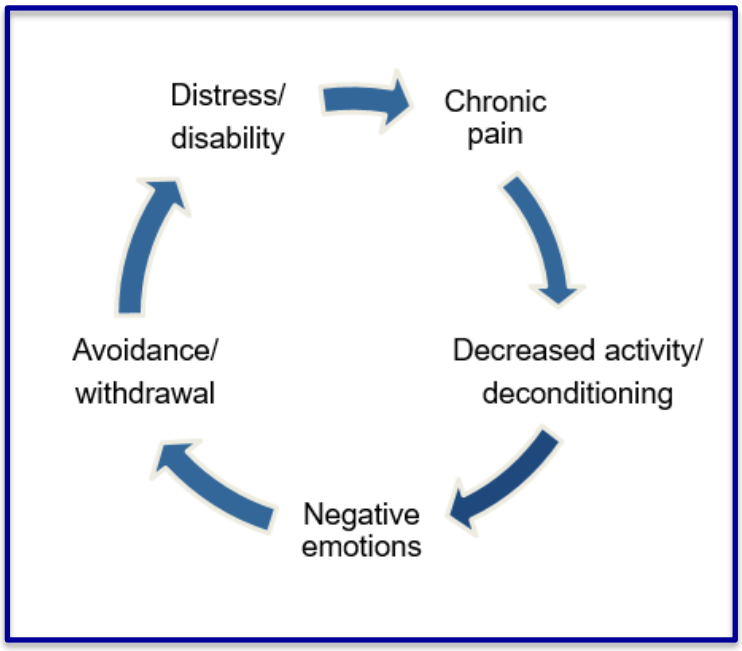

Figure 3. The Chronic Pain Cycle

CBT-CP can provide patients with both a new perspective and new coping skills to increase self-efficacy and break the cycle of chronic pain. The goal of CBT-CP is to identify and modify maladaptive cognitions and behaviors that perpetuate pain-related distress and dysfunction. CBT-CP is based on cognitive behavioral theory which focuses on the impact of cognitive processes on affective states and resulting behaviors (Beck, 1995). The suffering associated with chronic pain often leads to a maladaptive disengagement from people, places, and events.

Like all CBT approaches, CBT-CP draws from both behavioral theory and cognitive theory. Behavioral theory is based on the premise that distressed individuals get a very low rate of positive reinforcement from their environment. Because they experience few benefits of engaging in activities (and engaging in certain activities may lead to more pain), they tend to disengage. As they disengage from activities and people, they become more distressed and enter a cycle of inactivity and spiraling depression. **A key target of behavioral intervention is**

behavioral activation (i.e., helping people to re-engage in pleasurable events or find new activities).

In the case of chronic pain, certain physical movements or activities can lead to increased pain. Pain may also be interpreted as a warning sign that certain movements or activities are unsafe and result in harm or damage. It is not difficult to see why people with chronic pain stop participating in certain events. Thus, we must find new ways of engaging in favorite activities that will be less likely to produce pain. **Ways of addressing physical inactivity, such as pacing, are a key behavioral component of CBT-CP.**

According to cognitive theory, the way we perceive, think about, or interpret an event impacts our emotional experiences. **Therefore, monitoring and understanding our thoughts is essential to facilitating change.** Automatic thoughts are those that occur immediately in response to an event/situation, but often go unnoticed. Sometimes automatic thoughts occur in relation to internal events, such as increased pain. If the automatic thought is unhelpful or maladaptive, we may experience an unpleasant reaction at the emotional, physiological, and/or behavioral level.

A particularly common type of these automatic negative thoughts around pain is known as catastrophizing. **Catastrophizing is a distorted thought process of imagining or assuming that pain will lead to the worst or most intolerable outcome, such as "My pain will never go away" or "My pain will ruin my life."** Treating the cognitive components of chronic pain includes teaching patients to self-monitor and ultimately modify their maladaptive negative cognitions in favor of more balanced thinking.

3.7. SUMMARY

The key operational components of CBT-CP involve breaking the chronic pain cycle by:

- Increasing engagement in healthy and pleasurable activities
- Enhancing positive pain coping skills, such as pacing and relaxation activities
- Correcting faulty assumptions and thoughts about pain
- Improving self-efficacy regarding management of pain symptoms

4. CLINICAL CONSIDERATIONS WHEN WORKING WITH PATIENTS WITH CHRONIC PAIN

4.1. INTRODUCTION

Veterans who have chronic pain present with various levels of functional impairment and all have their own pain story. In addition to the physical strain of managing chronic pain each day, their suffering may have significant emotional and social dimensions as well. Often times, Veterans with pain have seen numerous healthcare providers regarding their condition and may feel frustrated with not receiving answers that they find satisfying regarding the etiology or treatment of their pain. Perhaps most importantly, those with chronic pain may feel as if they have not been "heard" adequately by providers. Various patient reactions can be driven by the perception that insufficient time, attention, or care has been paid by healthcare professionals when they are suffering each day.

As with all therapies, using CBT for the management of chronic pain requires the development of a strong rapport. While Veterans may resist being introduced to another provider, especially one in the mental health field, creating an environment where the Veteran is heard and believed fully is a key to success. It is not the role of the therapist to determine the veracity of the physiology of the pain complaint - pain is a subjective experience that is affected by various factors. The functional impacts experienced by the Veteran should be the focus of treatment, with clear education and direction offered as ways to positively alter the pain experience.

While there are many challenges that may arise when treating Veterans with chronic pain, some common topics that may impede therapeutic progress (with ideas for how to address these complex issues) are reviewed in this section.

4.2. LOSS, GRIEF, AND ACCEPTANCE

Those with chronic pain may display certain responses to their condition and it can be beneficial to help them identify and understand what they are feeling. For many, adjusting to pain-related losses is one of the biggest barriers to treatment progress. Loss of identity, confidence, well-being, and relationship/vocational roles are frequently recurring issues. Since it is challenging to cope with and accept that the "old me" is gone, it is important to normalize this response when working with patients since they have experienced a difficult and unexpected shift.

It may be useful for both patient and therapist to conceptualize the advent and experience of chronic pain as a significant loss. Kubler-Ross' well-known and non-linear five stages of grieving (Kubler-Ross, 1972) can be applied to better process the emotional process. The denial stage may involve being "stuck" in the biomedical model with cognitions such as, "there must be something to fix this." Anger is common throughout the chronic pain experience. Individuals

may feel frustrated with the perception that doctors are not helping them or loved ones do not understand. They may also feel anger about the perceived injustice of their situation - dealing with pain every day that is not their fault, not being able to do what they want, finding little relief in treatments. Those reactions may be even more extreme in those that are younger since it feels particularly unfair. Bargaining and "if only" thoughts as well as feelings of depression around the reality of living with pain are often present.

Acceptance, the final "stage," does not imply that it is "okay" to have chronic pain or that the person is "fine with it." Patients may react negatively to the word "acceptance" and it is important to differentiate an active acceptance versus a passive giving up. Quite the opposite, actively accepting that life has changed and may be very different than what was previously hoped for or planned is critical in moving forward. There is no suggestion in these stages that one should "get over it" but instead be able to eventually ask themselves, "now what?"

Acceptance is a process and it takes time. While there is no right way to grieve the losses that accompany life with a chronic medical condition, it may be helpful to encourage patients to concentrate on living the life they have instead of focusing on the one that used to be. These are difficult concepts to discuss, but being open about them helps individuals feel better understood, less alone in their experience, and better able to take steps toward self-management. Life can still be meaningful and fulfilling even when someone has pain, even if it looks different than what was originally imagined.

Use of measures, such as the Chronic Pain Acceptance Questionnaire (McCraken, Vowles, & Eccleston, 2004), may provide helpful information regarding where someone is in the grieving process as well as evidence of positive progress during treatment.

4.3. MEDICATION MANAGEMENT

When treating individuals with chronic pain, issues frequently arise around medications and medical procedures. Some Veterans may be highly focused on obtaining a particular medication or treatment or they may be frustrated by pills being "pushed" on them without alternatives offered. Regardless, because medications are typically a first line treatment for pain, they are often an integrated part of daily life.

One frequent medication-related issue that arises in the context of treating individuals with chronic pain involves the use of opioid analgesics. Opioids have increasingly been prescribed to treat chronic pain in recent years, but an increased risk of adverse events (including accidental overdose) has led to heightened regulation around their use. A lack of evidence supporting long-term opioid therapy as well as side effects such as sedation, constipation, and the possible need for tolerance-related dose escalation are all areas of concern. Veterans who have had opioids decreased or discontinued may be opposed to these changes, upset, and angry. When this is the case, medications may become a focus area by the patient, leaving clinicians feeling a sense of helplessness and desire to "resolve" the issue.

Not specific to opioids is the more general belief by Veterans that "there must be something" that can reduce their pain. This manifests in many forms, from a medication that they have seen advertised on television to a firmly held conviction that they “need” surgery because a physician mentioned it many years ago. Regardless of the details, this supports a belief that pain is unidimensional and that a medically driven “fix” exists.

Educating patients about the biopsychosocial approach to pain and the many factors that can impact the pain experience can be helpful. Allowing Veterans to vent about their medical frustrations may be necessary, but allowing sessions to be derailed by these tangents is problematic. Clinicians should acknowledge patient frustrations, encourage them to speak to a prescriber, and then redirect the focus back to the skills that can be addressed in this treatment. While therapists sometimes feel as if they are being insensitive or unsupportive by providing such clear redirection, it is most therapeutic for patients to focus on what they can change and control versus external factors.

4.4. OPIOID USE DISORDER

Opioid Use Disorder (OUD) is a DSM-5 diagnosis signifying a problematic pattern of opioid use associated with impairment and distress. In addition, at least two of a group of other symptoms must be present, including taking more or using more for than intended, ongoing or repeated attempts to control use, related physical or psychological problems, and spending excessive time in opioid-related activities. Due to the nature of opioid analgesics, developing physiological dependence over time as one does with nicotine is expected and does not indicate problematic use by patients. However, once opioids become a focus of attention with various related adverse consequences, patients should be evaluated for OUD.

Some Veterans on opioids may struggle with suggested changes in their medication regimen. They may resent feeling labeled as “drug seeking” when they request increased doses to feel better, often a result of tolerance. They may be angered with suggestions to decrease or discontinue opioids for risk mitigation when they are pleased with opioids’ effects, even if those do not include significant pain reduction. Furthermore, since opioids were typically initiated by a prescriber, they may feel “punished” with alterations in dosing schedules. In these cases, it is again important to acknowledge and normalize Veterans’ feelings. The focus should then return to the message that pain is multidimensional and must be addressed from various approaches. While medication may provide limited relief, the skills being reviewed in Brief CBT-CP can help improve overall quality of life. When Veterans are fixated on idealizing medications, it may be useful to return to the facts that have been gathered from them regarding their less than ideal level of functioning. Finally, it may be helpful to remind patients that they are in control of using the skills in this treatment - they do not need to rely on a provider and can self-manage their symptoms.

4.5. SLEEP

Sleep problems are among the most common complaints voiced by individuals with chronic pain and the relationship between sleep and pain is complex. The presence of pain may make falling and staying asleep more difficult, and disturbed. Insufficient sleep may increase next day pain. Sleep conditions such as insomnia are linked with inflammatory processes, which may also impact the bidirectional relationship between sleep and pain. It is not unusual for poor sleep to be identified as the most frustrating issue for those with chronic pain due to its negative physical and emotional effects. Therefore, it is important to discuss sleep and evaluate the needs of the Veteran related to this topic.

While basic education around sleep hygiene may be conveyed and incorporated into treatment, as it often would be in the primary care setting, it is important to determine if triage is necessary. For example, if sleep disordered breathing may be present and has not been assessed, a consult for a formal sleep study is likely in order, particularly as the prevalence of sleep apnea is significant in the chronic pain population. If sleep issues are severe enough to meet the diagnostic criteria for insomnia, a referral for local Cognitive Behavioral Therapy for Insomnia (CBT-I) treatment is indicated. Use of the Insomnia Severity Index (ISI) may be helpful in differentiating whether a consult for more intensive sleep intervention is appropriate. Completion of CBT-I prior to engaging in CBT-CP may increase successful outcomes, but determining the preferred order should be evaluated and determined individually with the patient's preferences in mind.

4.6. WORKING WITH RESISTANCE

Those with chronic pain may be resistant to psychological interventions for pain for a variety of reasons. One strategy that may be beneficial when encountering resistance is the use of Motivational Interviewing (MI) techniques which are highly patient-centered. MI can be used to facilitate Veterans' motivation to make positive health behavior changes. Because it assumes that individuals are ambivalent about change, it seeks to help them uncover their own internal motivation. Using open-ended questions so that they can share about pain openly, affirming their strengths, reflecting empathically, and summarizing their perspective and the next logical steps may help minimize resistance to treatment.

As always, it is important to remember that Veterans with chronic pain are hurting, often emotionally as well as physically. Although they may exhibit defensive attitudes initially, acknowledging the difficulty of their situation, including potential lack of compassion by providers, can help establish a more open and trusting working alliance.

5. AN OVERVIEW OF BRIEF CBT-CP MODULE STRUCTURE

5.1. TREATMENT MODULES

Brief CBT-CP assumes that a standard initial PCMHI session following the 30-minute schedule has been completed prior to starting Module 1. Brief CBT-CP consists of six modules. The brief protocol requires that modules one and six are stable anchors to begin and end the protocol. **However, modules two through five can be presented in any order, depending on the preference of the patient or best clinical judgment of the therapist.** If there is no alternative order preference identified, the modules should be delivered as listed in Table 3.

Table 3: BRIEF CBT-CP MODULES

Brief CBT-CP Modules	
Module	**Content**
1	**Education and Goal Identification:** Pain education and development of treatment goals
2	**Activities and Pacing:** Importance of engagement in activities using a thoughtful approach
3	**Relaxation Training:** Relaxation benefits and techniques
4	**Cognitive Coping 1:** Recognize unhelpful thoughts that negatively impact the pain experience
5	**Cognitive Coping 2:** Modify thoughts that are unhelpful when managing pain
6	**The Pain Action Plan:** Plan for independent implementation of CBT-CP skills and identify additional follow-up needs

Because CBT-CP is based on a model of intervention that emphasizes education and skill development, educational handouts have been developed for use within the modules and to be applied during homework modules. **Patient handouts are an integral component of this protocol and included in the appendices.**

5.2. MODULE STRUCTURE

The structure of the Brief CBT-CP protocol is similar across modules and includes:

1. **Introduce the module and confirm the agenda**
2. **Ask about mood, complete the PEG, and discuss findings**
3. **Review material from the previous module, including home practice**
4. **Introduce the new material and answer questions**
5. **Discuss new home practice opportunity**
6. **Module wrap-up**

5.2.1. Introduce the module and confirming the agenda (1-2 minutes)

Offering a brief introduction to the module helps orient the Veteran to the topics that will be covered while also providing the opportunity to ask Veterans if they have anything to add to or modify about the topic. This allows the Veteran to influence the agenda and emphasizes the collaborative nature of Brief CBT-CP. Because the Brief CBT-CP protocol is highly structured and works under time-limited modules, *it is important to acknowledge that events may occur that warrant discussion and that may result in adjusting content covered in a specific module.*

5.2.2. Ask about mood, complete the PEG, and discuss findings (3-4 minutes)

In addition to briefly and informally asking about current mood, completion of patient-reported outcome measures is an essential component of this protocol. *The next chapter of this manual provides detailed instruction in how to engage in measurement-based care using the PEG (Krebs et al., 2009).* Briefly, the PEG is a well-validated three-item measure that assesses pain intensity (P), interference in enjoyment of life (E), and interference with general activity (G). Because the PEG is so brief, it should be administered at each session as part of measurement-based care. Additional measures can be added at the discretion of the provider.

5.2.3. Review material from the previous module, including home practice (3-5 minutes)

Providing a brief review of material covered in the prior module can create continuity between modules and allow the Veteran to raise questions as needed. Taking a moment to discuss potential questions reinforces the collaborative nature of the intervention and reduces the chance of important messages being misconstrued. Review of home practice is an essential component of Brief CBT-CP and serves to build competency in the use of adaptive pain coping strategies. It should also enhance Veterans' sense of self-efficacy to manage their chronic pain condition by implementing acquired skills in the "real world".

5.2.4. Introduce the new material and answer questions (12-15 minutes)

The majority of time in each module should be spent introducing and discussing the new material for the module. Provide a clear rationale to the Veteran for each topic. To ensure understanding, elicit reactions from the Veteran to material covered. Through discussion that involves active listening, cuing, and reinforcing learning in a supportive and collaborative environment, the Veteran is able to acquire adaptive pain management skills.

5.2.5. Discuss new home practice opportunity (2-3 minutes)

After a new topic has been reviewed in the module, it is important for the Veteran to be able to practice building and implementing the skill independently. Discuss helpful areas for home practice with the patient. It is important that the Veteran understands the potential benefits of engaging in the coping technique and how it is related to better managing the effects of chronic

pain. Practice should be discussed collaboratively to ensure that it is manageable for the Veteran.

5.2.6. Module wrap-up (1-2 minutes)

Each module should include a concise summary of key points that emphasizes the value of outside practice. This wrap-up also signals the end of the module and allows for the patient to ask any remaining questions about content addressed or next steps.

6. MEASUREMENT-BASED CARE (MBC) WITH THE PEG

6.1. WHY MBC?

Limiting excessive use of assessment tools in the context of everyday integrated care practice is critical given time constraints; however, outcomes measurement is essential. Measurement allows the clinician to better understand the Veteran's experience of pain and the functional domains that are impacted. Measurement also allows assessment of progress throughout treatment and information generated can indicate when a change in practice is indicated. MBC refers to the use of screening and ongoing symptom monitoring to guide treatment selection and treatment modifications to improve outcomes for chronic health conditions (Morris, Toups, & Trivedi, 2012). The aims of MBC are to rapidly and precisely diagnose conditions and to evaluate patients' response to intervention in order to improve treatment planning between providers and patients (Harding, Rush, Arbuckle, Trivedi, & Pincus, 2011). Furthermore, it offers patients a mechanism by which to track their progress and identify quantifiable goals for treatment. The information from MBC can facilitate shared decision-making which includes exploring options with the patient, weighing pros and cons of potential choices, and making informed decisions in line with patient preference. MBC typically guides treatment for common medical conditions in primary care, such as hypertension and diabetes, and has demonstrated effectiveness in improving patient outcomes for these and other disorders (Klonoff et al., 2011; Pickering et al., 2005). Similarly, routine monitoring of patient outcomes for mental health conditions is associated with improvement in provider documentation of diagnosis, more rapid treatment modifications, improved communication between patients and providers, and improvement in patient mental health symptoms (Carlier et al., 2012). The VA strongly endorses MBC for mental and behavioral health concerns and has been promoting the use of MBC across mental health treatment settings since 2016 as part of a national initiative.

6.2 ADMINISTERING THE PEG

For Brief CBT-CP, the PEG (Krebs, et al., 2009) should be administered at every session, as indicated in the module structure outline. The PEG includes three items. One item of the PEG assesses pain intensity, and two items assess pain-related interference (i.e., enjoyment of life and general activity). The PEG usually takes just a few minutes for patients to complete. The measure can be completed on paper by the patient or administered verbally by the provider. Scores should, however, be entered into the progress note for documentation. (Note that the PEG is not included in this manual but is available as a supplemental *.pdf* document.) As a helpful point of reference, research with primary care samples has estimated an average PEG score of 6.1 (*SD* = 2.2) in this population, indicating a moderate level of overall pain and pain-related interference (Krebs, et al. 2009).

6.3 CASE EXAMPLE: USING THE PEG IN EVERYDAY PRACTICE

A case example will be used to illustrate how to administer the PEG as part of Brief CBT-CP. Jeff is a 26-year-old White Veteran who recently enrolled in VA primary care services after separating from active service in the Marine Corps one year ago. Routine mental health screening by his PACT provider and subsequent referral to PCMHI staff determined that chronic

low back pain stemming from his combat deployment is a significant contributor to his irritability and depressed mood. Jeff's back pain was rated as a 7 out of 10 on the Numeric Rating Scale. He reports that pain negatively impacts his sleep, ability to sit through college classes, and interactions with his young son. He is concerned that pain will impact his long-term goal of operating his own business.

6.3.1. Establishing a baseline PEG and communicating findings

At Jeff's first session of Brief CBT-CP with his PCMHI provider, his PEG scores were as follows:

Item	Score
Pain Intensity	7
Interference with life enjoyment	6
Interference with general activity	7

To determine Jeff's baseline PEG score, simply compute an average score using the following formula: (Item 1 + Item 2 + Item 3)/3 = average score. For convenience during clinical use, round decimal points to the nearest whole number. This procedure is illustrated below:

To compute an average PEG score	
Formula	(Item 1 + Item 2 + Item 3)/3
Example	**(7 + 6 + 7)/3 = 6.6 = 7, if rounding up**

In this case, Jeff's score is a 7 out of a possible 10, with 10 indicating the greatest severity. A general guideline for interpreting 0-10 pain scales like the PEG is listed here:

PEG score ranges	Qualitative description of level of pain/interference
1-3	Mild
4-6	Moderate
7-10	Severe

In this case, Jeff was reporting severe overall pain and pain-related interference. Keep in mind that scores of ≥4 indicate pain/interference that could benefit from intervention. *Optionally,* consider reviewing the three PEG items separately, especially if they vary greatly (e.g., Pain intensity = 8, Interference (life enjoyment) = 2, Interference (general activity) = 3). This variability in items should be discussed to explore with the patient why there is a difference between intensity and interference.

Part of establishing a useful baseline for Jeff is to utilize the score to enhance communication with both the patient and the PCP. Scores at baseline (or any point in time) can convey current status:

> *"Jeff, your score of seven on the PEG is in the severe range. This score, along with the information you provided during our discussion, indicates that you could benefit from starting Brief CBT-CP…"*

A discussion that incorporates patient-reported outcomes can also help fuel motivation to engage in treatment:

> *"Over the next several weeks, we will use the PEG again to monitor any changes in your pain ratings. These scores will help us plan our next steps together. We will aim to have your score go down over time as you apply new skills as part of Brief CBT-CP…"*

This discussion can set a norm of using measurement as part of shared decision-making between the patient and provider, while maintaining the focus of care on pain management and restoring functioning.

In addition to discussing scores with the patient, conveying PEG scores to the primary care provider (PCP) is also important. This type of communication not only improves flow of information between providers, but ideally prompts the PCP to reinforce your plan for using Brief CBT-CP when he or she interacts with the patient (e.g., motivating the patient to re-engage in balanced, structured physical activity to avoid de-conditioning). The PCP may also consider adjusting his/her own treatment plan (e.g., medication changes, adding adjunctive services such as referral to physical therapy) depending on the information you convey.

6.3.2. Assessing for change over time

As mentioned previously, a primary reason for engaging in measurement at each session is to be able to assess for meaningful changes in scores over the course of treatment. Stability of or changes in scores are important for assessing response to treatment and can suggest times when modification to a treatment plan is necessary. Assessing for change between two time points is simple and can be computed quickly as follows:

To compute change in PEG scores	
Formula	$\frac{\text{(Average PEG score at time 1 – Average PEG score at time 2)}}{\text{Average PEG score at time 1}}$

Multiplying the resulting figure by 100 will provide an estimate of percentage change in scores. As a general rule, a 30% change (improvement) in pain-related scores, including the PEG, is considered clinically significant in response to a course of treatment. Although a 30% decrease

is ideal, other meaningful patterns are also important to consider given the relatively short time frame inherent to integrated care settings.

In Brief CBT-CP, less dramatic but potentially meaningful changes have been identified in our pilot work (Beehler et al., 2019). Previously, as part of a clinical demonstration project, we found, on average, a statistically significant 1-point decrease in PEG scores between session 1 and session 3. Although additional research is needed to replicate these findings under the conditions of a rigorous randomized controlled trial, initial support for Brief CBT-CP is encouraging.

Assessing for change can be done at any time frame, including when comparing the first and third required modules. For example, note Jeff's PEG scores below:

Module	PEG score
Module 1 (Education and Goal Setting)	7
Module 2 (Activities & Pacing):	7
Module 3 (Relaxation)	6
(7-6)/7 = 0.14 * 100 = 14% improvement	

During this relatively short time frame common in PCMHI, these measures suggest no dramatic changes, but a decreasing trend. This trend is encouraging in that there are no large fluctuations in PEG scores that would suggest worsening of symptoms. If Jeff were to continue on this course with additional Brief CBT-CP modules, the following pattern may emerge:

Module	PEG score
Module 1 (Education and Goal Setting)	7
Module 2 (Activities & Pacing):	7
Module 3 (Relaxation)	6
Module 4 (Cognitive 1)	7
Module 5 (Cognitive 2)	6
Module 6 (Pain Action Plan)	5
(7-5)/7 = 0.29 * 100 = 29% improvement	

In this case, additional improvement in PEG scores was realized by continuing with the remaining Brief CBT-CP modules. Having reached a 29% decrease in PEG scores suggests a clear, clinically significant improvement in outcome.

Of course, this is only one example of what you might find with the PEG. Below we discuss how to address three different situations (i.e., beneficial change, no change, or worsening of symptoms) over time. It is important to then discuss these changes with both the patient and PCP in determining next steps.

6.4 USING THE PEG TO IMPROVE SHARED DECISION-MAKING

Discussing PEG scores, including changes in scores over time, can facilitate shared decision-making in which the provider (or providers) work collaboratively with the patient to determine the best course of treatment. Although a full description of the nature of shared decision-making is beyond the scope of this chapter, there are a few general principles that should be considered. According to Elwyn and colleagues (2012; 2017), shared decision-making is a process that includes three general areas: 1) working as a team to identify choices in light of patient goals; 2) discussing alternatives, such as the advantages and disadvantages of each option; and 3) making an informed decision that aligns with patient preference. PEG scores can help initiate the process of decision-making when the data indicate that change (or lack of change) in symptoms is evident during or at the conclusion of treatment. Outlined below are some general guidelines for using PEG scores to generate options for treatment decisions.

When PEG scores show sufficiently meaningful improvement over time, first confirm if the patient concurs with this assessment. If the patient's experience of pain or disability does not appear to be reflected by the PEG scores, additional assessment may be necessary to determine why there is a discrepancy. However, if the patient feels that sufficient improvement has been achieved and treatment goals have been met, no additional treatment may be necessary. Explore with the patient what an end to Brief CBT-CP means in terms of follow-up options.

> *"One of the options for us to consider includes wrapping up your treatment at this time. Based on the improvement we've seen in your PEG scores and the fact that you're meeting your main goal of getting through your classes at college, you're likely in a good position to begin applying these skills on your own. If we decide to end for now, my door remains open should you need to reconnect with me, or another provider, regarding your pain or any other concern that impacts your wellness..."*

For many patients, knowing that they can return to PCMHI as-needed is sufficient. Other patients may prefer to address additional concerns with you or another provider outside of PCMHI now that their pain-related interference is under control.

In situations where PEG scores suggest that no meaningful change is evident, again confirm if this finding is consistent with the patient's experience. Additional discussion may be necessary if the patient's verbal report of response to treatment differs from PEG scores. If the patient agrees that insufficient progress is being made, first discuss potential treatment barriers and other factors that could have impacted patient adherence (e.g., not engaging in home practice, change in patient goals for treatment). If the patient has had a difficult time with treatment receipt (i.e., learning CBT skills) or enactment (i.e., using CBT skills outside of session), consider if revisiting prior modules would be valuable for enhancing skills development.

"Let's talk a little bit amore about what might be getting in the way of moving forward. It sounds like it's been a challenge to find the time to apply the strategies we've discussed in session. One option for us to consider is spend a moment to find times during the day that might be best to apply one or more skills…"

Also consider if optional modules of Brief CBT-CP are appropriate. If additional discussion suggests that Brief CBT-CP was not effective despite adequate patient adherence and interest, consider stepping up the level of care for the patient to include referral to a pain specialty provider or behavioral medicine expert.

When PEG scores suggest the patient is getting significantly worse over time, be certain to confirm if this trajectory is consistent with the patient's experience. Discrepancies should be explored with the patient to determine why declines in PEG scores may not be reflective of the patient's experience. Depending on the extent of the decline, first consider issues related to patient safety and well-being. Additional suicide risk assessment should be conducted with appropriate follow-up action taken as needed. Further assessment should be focused on determining the cause of increased pain and disability, which may be transient (e.g., temporary but repeated pain flare-ups due to overexertion) or stable (e.g., significant re-injury, new medical or mental health diagnoses, negative life event/psychosocial factors).

"As you know, your PEG scores show that your pain and its negative impact has become more significant since we first started working together. I'd like to take a minute and talk with you a bit more about what might be contributing to this situation from your perspective. I'd also like to ask some questions about your safety and well-being given how down you've been feeling. We might want to consider adding some additional help alongside Brief CBT-CP. Alternatively, we might consider whether or not services with another provider who can offer more intensive support might be a good option…"

Such factors likely suggest that stepping up to a higher level of care (e.g., referral to the specialty pain clinic) or adding additional services (e.g., psychiatry) to the current course of treatment may be indicated.

7. THE HOOK: OFFERING PATIENTS BRIEF CBT-CP

7.1. INTRODUCTION

The goal of offering an orientation to Brief CBT-CP is to provide the Veteran with a roadmap for what can be expected during treatment and to establish clear expectations for both the therapist and the Veteran. Brief CBT-CP can be introduced to patients any time chronic pain management surfaces as a key concern for the patient's wellbeing, provided that safety-related concerns (e.g., lethality, significant neurocognitive disorder, psychosis) are absent or otherwise addressed. Regardless of when Brief CBT-CP is introduced, it is helpful to provide a persuasive but honest portrayal of the nature of the intervention and its potential to benefit the patient

The **Therapist Guide** that follows was designed to illustrate how to engage in a conversation with the patient that can be addressed in 10 minutes or less as part of a brief, 30-minute standard initial appointment or intake (Figure 4). **We strongly recommend using this guide to enhance motivation for treatment engagement.** Of course, conversations about Brief CBT-CP may need to be modified based on the level of patient receptivity.

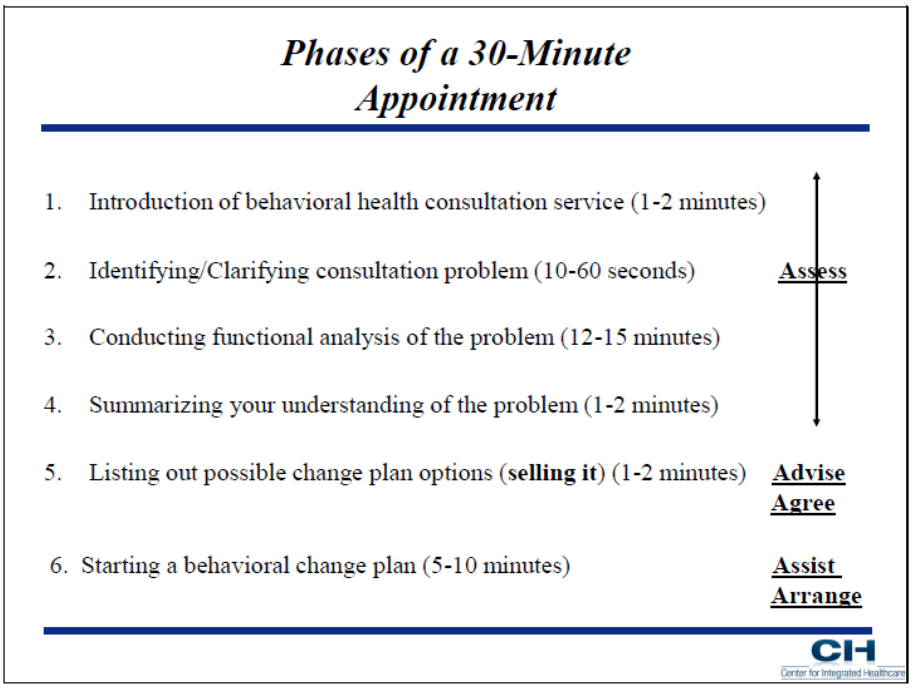

Figure 4. Phases of a 30-Minute Appointment

The 5-A's module structure for initial PCMHI appointments (Figure 4) provides an excellent approach for how to introduce and educate patients about Brief CBT-CP. In short, after conducting a routine assessment of patient functioning and summarizing your understanding of the patient's concerns (that include the need for chronic pain management), the remaining time can be used to introduce the patient to Brief CBT-CP, answer questions, and address potential barriers to full participation. If your treatment setting allows for appointments of longer than 30 minutes, then the remaining time can be devoted to beginning the first module of Brief CBT-CP.

If the patient ultimately decides not to engage in Brief CBT-CP, it is valuable to consider other options that may be available. Some patients simply need more time to consider their treatment options. For this kind of situation, we include a two-page patient handout entitled **Before You Go: Additional Information about Chronic Pain Treatment Options**. This handout includes the following: *a quick summary of Brief CBT-CP; a short relaxation exercise; links to freely available mobile apps that can address health and wellness topics; space for the provider to summarize next steps regarding chronic pain management, such as referrals to other clinical services; and a space for the provider's contact information.*

Offering Patients Brief CBT-CP: Therapist Guide

Although adopting an empathic stance is not unique to CBT, it is nonetheless important when working with patients experiencing chronic pain. Often, patients will be referred to you for treatment when their pain is most distressing or when biomedical treatments have been insufficient. Empathy is especially useful for building rapport and trust.

What is Brief CBT-CP?

- Brief CBT-CP targets thoughts, emotions, and behaviors in order to improve pain-related functioning.

- Brief CBT-CP promotes the adoption of self-managed tools by patients so that they can take an active role in effectively addressing chronic pain and its negative effects.

- *Use the **Brief Cognitive Behavioral Therapy for Chronic Pain** handout to illustrate the CBT-CP model***.**

Scripting includes:

1. *"Living with chronic pain can be very challenging. It can negatively impact how we live our lives, including our ability to participate in activities and important relationships with others. Individuals with chronic pain often struggle to find ways to manage their pain and feel that they lack the know-how to move forward with their lives."*

2. "*Brief cognitive behavioral therapy, or CBT, for chronic pain is designed to help us respond to chronic pain in a way that will help us live a more fulfilling life. Patients learn new pain management skills that can keep us connected to the people and daily routines that we value."*

3. *"An important piece of Brief CBT for chronic pain is the teamwork between the patient and therapist. My goal is to work closely with you in a way that you find supportive and empowering."*

4. *"This intervention is designed to be brief so it's not a long-term commitment. Of course, if we decide that additional support will be beneficial, then I will help connect you to additional services."*

What does Brief CBT-CP Include?

- The treatment structure of Brief CBT-CP includes six appointments that last about 30 minutes each.

- Topics covered reflect the key components of full-length CBT for pain:

    - Pain education and goal setting
    - Activities and pacing
    - Relaxation training
    - Cognitive coping (covered in two sessions)
    - The Pain Action Plan

- Treatment is structured, but decision making is collaborative between patient and therapist.

Scripting includes:

1. *"Brief CBT for chronic pain includes six modules of 30 minutes each. We will cover a new pain management skill each week based on your preference. This means that we will work closely and stay focused to make the most of our time together."*

2. *"Our first module will provide some important background information about chronic pain itself and setting new goals for moving forward. Then we will decide together about the order of our remaining topics. We will choose from the following: activity planning and pacing, which will help us avoid a common pitfall of overexerting ourselves and causing a pain flare up; relaxation training which will cover several ways to reduce tension in our bodies and feeling distressed; and cognitive coping, which helps us address unhelpful thought patterns -we learn to feel better by changing the way we think about pain and ourselves. Our final module will focus on reviewing the skills we learned and developing a plan for how best to use those skills."*

3. *"At the end of each module, we will talk about ways you can begin to practice each skill. Practice is very important as we want these new approaches to become good habits. We will find a way to make practice doable even during a busy day."*

What are the Advantages of Brief CBT-CP?

- There are number of advantages to applying Brief CBT-CP, both practical and research-supported. Based on what you know about the patient, it's helpful to emphasize the match between patient needs/goals and what Brief CBT-CP can offer.

Scripting includes:

1. *"CBT for pain has been studied by researchers for many years. Overall, these studies show that patients experience less distress and disability after using what they learn in CBT. Some patients even report that their pain intensity has decreased."*

2. *"CBT for pain is safe for almost anyone. There are no known negative side effects and the focus is educational and skill-building."*

3. *"The brief version of CBT for pain that we will use is less than three hours of treatment time and is spread out over several weeks. This minimizes the amount of travel and time you spend in treatment."*

What are the Limitations of Brief CBT-CP?

- Discussing the limitations of Brief CBT-CP can be helpful in setting realistic expectations about what treatment can and cannot accomplish.

Scripting includes:

1. *"Brief CBT-CP can be very helpful, and it requires that we work together as a team to help manage your pain more effectively. Part of your treatment will include assessing your pain and distress using one or more brief, easy to complete surveys. These will help us determine what is going right in treatment and other areas that may need more focus."*

2. *"Brief CBT for pain is primarily about helping with pain management. This does not mean eliminating your pain but responding to your pain in a more helpful way so that it feels less overwhelming."*

3. *"Sometimes during treatment we will need to talk about some difficult experiences you have had in relation to pain so that you are able to respond in beneficial ways in the future. Over the course of treatment, the goal will be to use the skills we learn to address distressing pain-related experiences."*

Before You Go: Additional Information about Chronic Pain Treatment Options

Today we discussed some of the challenges of living with chronic pain. We also discussed some options available to help manage chronic pain. One option that may be a good fit for you is Brief Cognitive Behavioral Therapy for Chronic Pain, or Brief CBT-CP. Some key information about Brief CBT-CP is summarized here, in case you would like to begin this treatment at a future time:

1. *Brief CBT-CP can help decrease distress and disability from pain and is safe for almost anyone.*
2. *Brief CBT-CP includes six, one-to-one meetings of about 30 minutes each. Treatment can be spread out over 6 to 12 weeks.*
3. *A new pain management skill is covered each week based on the order you prefer. Key topics and skills include:*
    - *Activity pacing, which helps with avoiding a common pitfall of overexertion that causes a pain flare-up.*
    - *Relaxation training, which will help to reduce tension in your body and manage distress.*
    - *Cognitive coping, which will help with managing unhelpful thought patterns.*
    - *Developing an action plan, which will help you move forward with meeting important personal goals based on new pain management skills.*

Here's a quick deep breathing exercise to consider that can help manage the stress that comes with living with chronic pain:

1. *Find a safe, quiet place to sit or lie in a comfortable position for at least five minutes. Use soothing music to block out distracting noises, if necessary.*
2. *Breathe in deeply, but comfortably, taking a moment to focus your thoughts on your breathing.*
3. *Count to yourself "one" at your next inhale, and exhale at your own pace. Continue to count (e.g., "two"…, "three"…, "four"…) each time you inhale until you get to ten.*
4. *Take a moment to notice your breathing as it slows and develops a new rhythm. If disruptive thoughts enter your mind, re-focus on counting each inhalation.*
5. *Count in sets of ten breaths for as long as you feel comfortable. Practicing two to three times a day for short periods can be helpful when first learning this skill.*

Visit the VA mobile app store (**https://mobile.va.gov/appstore)** to download free apps to help with stress management and healthy lifestyles. These are a few examples of the health topics these apps address:

- *Chronic pain*
- *Sleep*
- *Weight loss*
- *Smoking cessation*
- *Stress management*
- *Coping with depression, anxiety, PTSD, and other mental health concerns*

We discussed several options that can help you with better pain management and overall wellness. Here is a summary of next steps to follow:

Provider: *Include helpful information below on referrals to other services initiated today.*

1._____

2._____

3._____

Living with chronic pain can be very challenging. It can negatively impact how we live our lives, including our ability to participate in activities and important relationships with others. Treatment options are available that can lead to new ways of coping with pain to maintain connections to the people and daily routines that we value. My goal is to work with you in a way that you find supportive and empowering.

If you would like more information about your treatment options for chronic pain or related concerns, please contact me at the number below:

Provider/Clinic name: _____

Phone number:_____

Additional information: _____

BRIEF CBT-CP PROTOCOL AND THERAPIST GUIDES

1. BRIEF CBT-CP MODULE ONE: EDUCATION AND GOAL IDENTIFICATION

In the context of primary care and other settings, the first contact with the Veteran is typically used for the collection of information and to determine an appropriate treatment plan. At the point of engaging in **Brief CBT-CP**, it is assumed that the initial functional and symptoms assessment have been completed and that the Veteran has pain-related concerns that can be best served in primary care.

1.1. Module Agenda

1. Introduce the module and confirm the agenda
2. Ask about mood, complete the PEG, and discuss findings
3. Review material from the previous module, including home practice
4. Introduce the new material and answer questions
5. Discuss new home practice opportunity
6. Module wrap-up

1.2. Module Materials

- PEG self-report measure
- Patient handouts (see appendix):
    - Factors That Impact Pain
    - The Chronic Pain Cycle
    - Brief Cognitive Behavioral Therapy for Chronic Pain
    - SMART Goal Setting

1.3. Module Content for the Provider

1. Chronic Pain Education

Understanding the difference between acute and chronic pain is the beginning of effective management of persistent pain. While *acute pain* is a symptom and requires adjustments in behavior so that appropriate healing can take place, *chronic pain* is an ongoing condition that no longer signifies that damage or harm is actively occurring. Even though these two different types may *feel* exactly the same, the *meaning* has changed. While withdrawing from what causes pain is adaptive in acute pain as it allows the healing process to occur, that response is maladaptive in chronic pain. Even in the case of conditions such as arthritis where there is a gradual degeneration occurring, pain is not a sign of an acute injury and there are no expectations of resolution or healing. Thus, it must be addressed in the same way.

Because of these differences, chronic pain must be managed as a chronic condition in much of the same way as other disorders such as diabetes or heart disease. The biomedical model, which works well with problems that resolve such as a broken arm, does not work well with chronic pain. Since chronic pain has not responded adequately to treatment and resolution is no longer expected, a different model for understanding it must be applied: the biopsychosocial model.

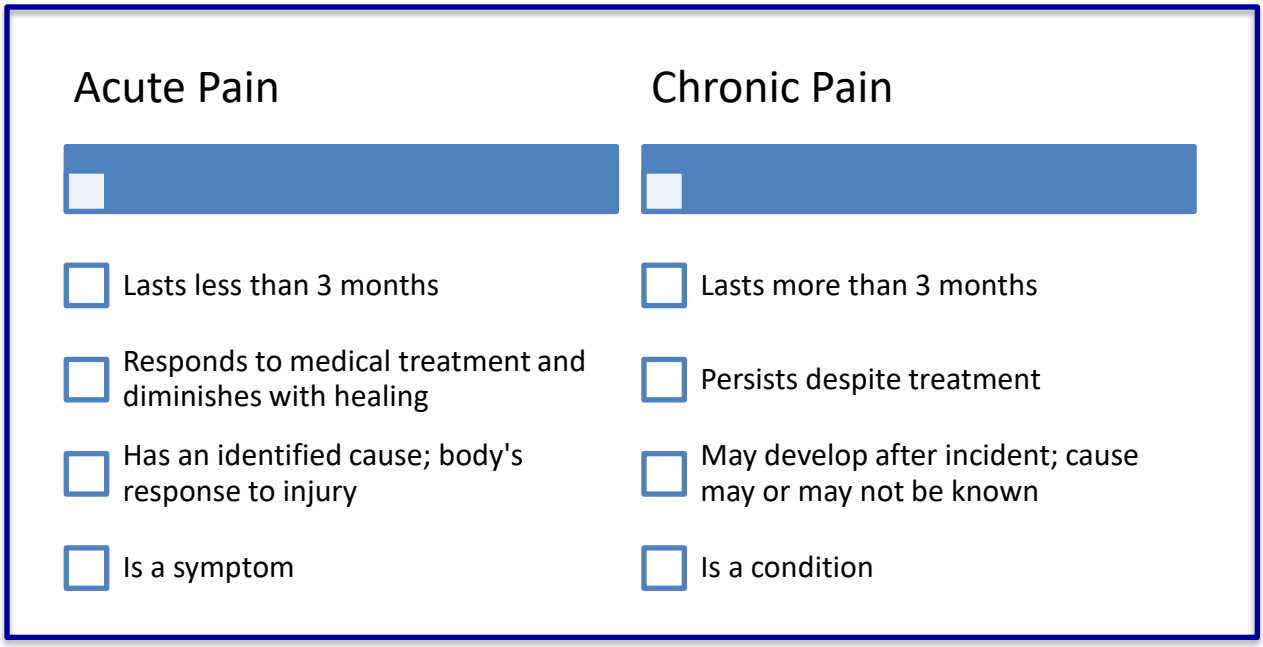

Figure 5. Acute and Chronic Pain

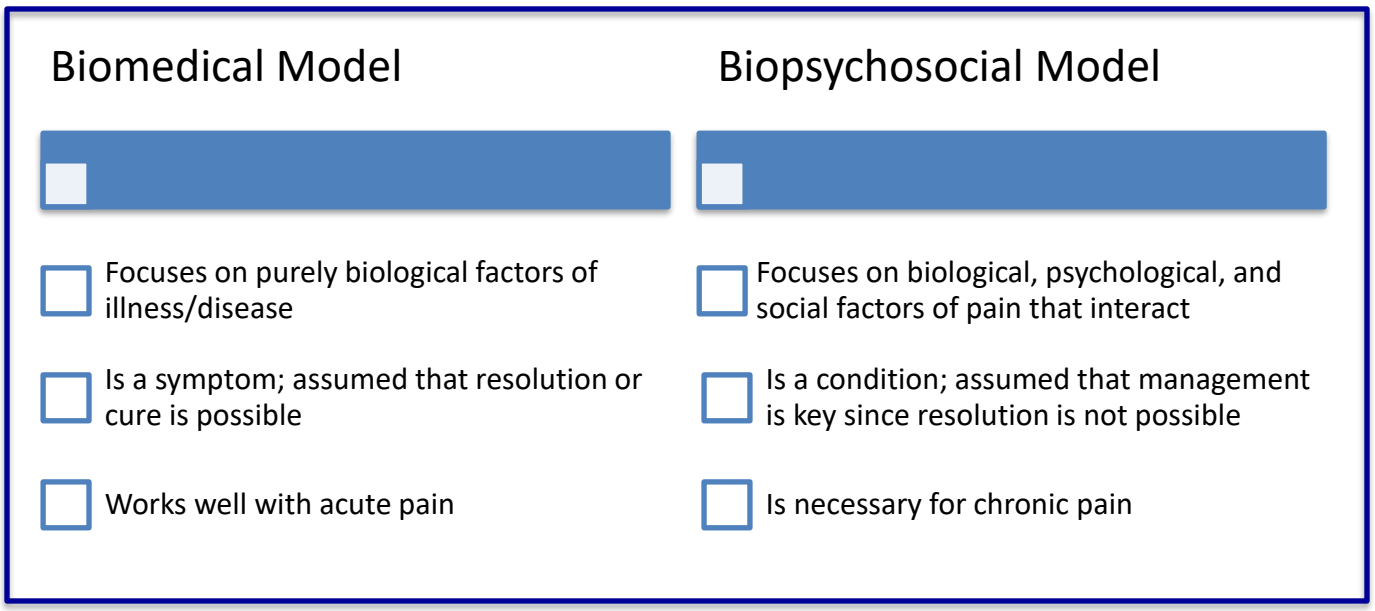

Figure 6. Biomedical and Biopsychosocial Approaches to Pain

2. Effects of Pain

Chronic pain affects many different areas of life. The interaction between biological/physical (pain and medical issues), psychological (cognition, affect/emotion, behavior), and social influences helps to explain the variability between individuals and their reports of pain. Figure 7 shows the overlap between these areas.

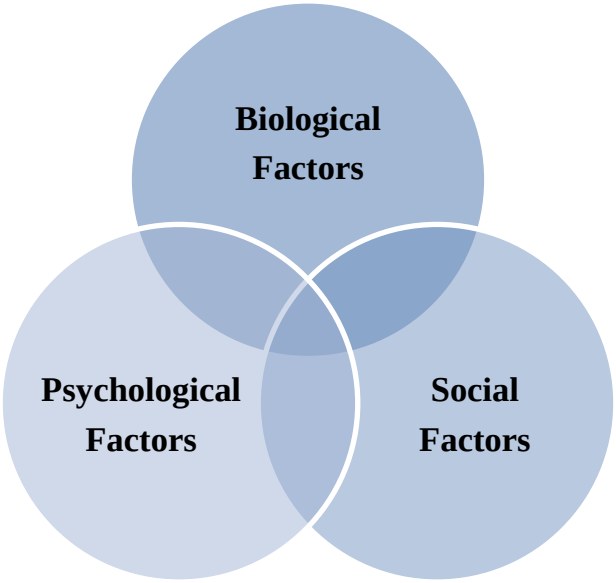

Figure 7. The Biopsychosocial Model

Use the **Factors That Impact Pain Handout** to review some of most important biological, psychological/behavioral, and social variables that may influence chronic pain. Discuss with Veterans how pain has impacted their lives from all aspects:

- Biological or medical factors (e.g., pain condition, comorbidities)
- Psychological factors (e.g., negative mood, lowered self-esteem, activity engagement)
- Social factors (e.g., relationships, employment)

Explain that since chronic pain is a complex problem, it must be approached in a comprehensive way. While some factors such as previous injuries cannot be changed, emphasize that many of the factors that impact pain can be adapted with the assistance of Brief CBT-CP. This treatment helps Veterans change the way that they *react* to pain so that it has less of a detrimental impact on their lives.

Now that the various areas of life that pain affects have been identified, use the **Chronic Pain Cycle** handout (see Figure 8) to discuss the process and stages that may occur over time for

those with chronic pain. As the figure illustrates, the onset of chronic pain often leads to a decrease in activities, which leads to physical deconditioning. Dealing with constant pain may also lead to negative thoughts (i.e., “I can’t do anything when I have pain like this”) and emotions such as frustration and depression. These factors contribute to increased avoidance of family and friends and anything that involves movement since it hurts to move. This combination means more distress and disability, leading to increased pain. Many Veterans will be able to recognize this pattern in their own lives.

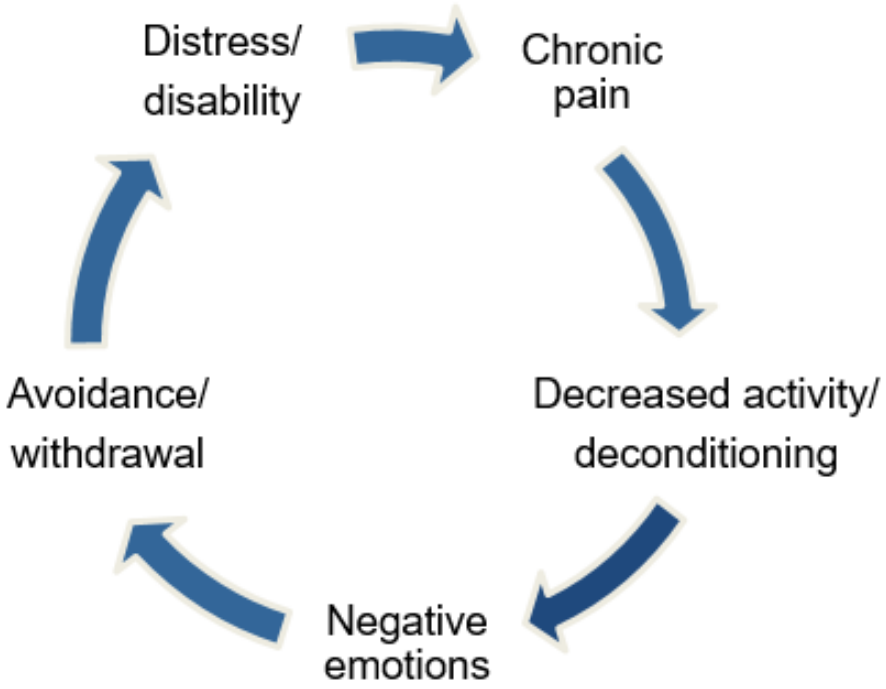

Figure 8. Chronic Pain Cycle

3. Goal Identification

The general objectives of Brief CBT-CP are to improve quality of life through the steps listed in Table 5:

Table 5. OBJECTIVES OF BRIEF CBT-CP

Reducing the negative impact of pain on daily life
Improving physical and emotional functioning
Increasing effective coping skills for managing pain
Reducing pain intensity

Reducing the negative effects of pain on daily life by engaging in more activities, improving mood, and increasing coping skills should be highlighted. While decreased pain intensity may occur, try to help Veterans shift their preoccupation away from pain and towards functioning. The hope is to make life more fulfilling so that pain feels less overwhelming.

The identification of individualized, Veteran-centric goals is critical for tailoring modules and for helping the patient increase motivation for treatment engagement. Developing personally meaningful treatment objectives that are achievable provides a framework to guide therapy. It can be introduced to the Veteran with a simple statement such as:

- *Let's get you back to doing more of what is important to you.*

It is sometimes difficult for individuals to produce specific goals on their own, so it can be helpful to ask questions to guide the discussion, such as:

- *What is something specific that you would like to see change in your life in the weeks to come?*
- *What would you like to be able to do (better, more of, etc.)?*
- *If this treatment were successful, how would that look in your day-to-day life?*
- *Are there relationships that you would like to improve?*

In order to assist in goal setting, the SMART model will be used to develop individualized goals that are outlined in Table 6.

Table 6. INDIVIDUALIZED SMART GOALS

Specific	Identifies a specific action or event that will take place.
Measurable	Should be quantifiable (countable) so progress can be tracked.
Achievable	Should be attainable and realistic given resources.
Relevant	Should be personally meaningful.
Time-Bound	State the time period for accomplishing the goal.

Adapted from Doran, 1981

The **SMART Goal Setting** worksheet should be used with the Veteran in session. This worksheet includes both short-term goals that can be accomplished over the course of the Brief CBT-CP treatment timeline, as well as long-term goals that may span over the next year but are important in serving as a motivator. While engaging in Brief CBT-CP requires time and effort, these goals should help illuminate why the long-term benefits outweigh the short-term investment.

Once individualized treatment goals are established, they should be monitored on an ongoing basis for positive reinforcement and to adjust goals and treatment as indicated. It is recommended that both the Veteran and therapist have a copy of the goals sheet available throughout the course of treatment so that it can be referred to regularly.

4. Home Practice

Ask Veterans to continue to contemplate both short- and long-term goals. Stress the importance of following the SMART formula reviewed during the session. Remind Veterans that the general Brief CBT-CP objectives will be the framework for all modules, while the individualized objectives will help motivate Veterans to engage in activities that will improve the quality of their life and reduce the negative consequences of pain. The **SMART Goal Setting** worksheet should be completed at home prior to the next module.

Brief CBT-CP Module 1 Therapist Guide: Education and Goal Identification

Note to provider: Scripted statements are provided below as suggestions, rather than rules, of how to introduce topics to patients. Scripting can be especially helpful for those providers who are new to the content of Brief CBT-CP. Feel free to modify the scripting as needed as you become more comfortable with core elements of each module.

1. Introduce the module and confirm the agenda

Scripting includes:

1. *"Today we will begin brief cognitive behavioral therapy for chronic pain. This treatment will help you develop new skills to use at home between modules and in the future. One of the first things we will do at each appointment is work together to establish an agenda for our time together. I have found that having this agenda helps to ensure that we both get to talk about the items that we would like to discuss."*

2. *"First, I would like you to complete a brief pain measure, and I will also check in on your mood. Next, we will discuss some background on chronic pain itself and develop a plan for how we will address some of your goals related to pain management. How does that sound to you? Are there other things relevant to our pain work that you want to be sure to cover today?"*

Note to provider: If the patient is inclined to add items to the agenda that are not related to pain management, the first effort on behalf of the therapist may be to link the topic back to pain. For example, a statement such as the following may be helpful to refocus the patient: "That sounds like it was stressful. Did you notice that your pain worsened during that time?"

2. Ask about mood, complete the PEG, and discuss findings

Scripting includes:

1. *"First off, how are you feeling today and how has your mood been?"*
2. *"Next, I would like you to complete these three quick questions today. These items will help us track your progress over the course of treatment. They can also help us identify if we need to provide additional help along the way. After you complete the measure, we'll review the results."*

Note to provider: Informally checking on mood will give you a sense of how the patient is currently coping while also providing the patient with the opportunity to express any significant distress that might need immediate attention. Do not hesitate to further assess for significant safety concerns, such as suicidal ideation, when indicated and by using standard local procedures for your clinic. Assuming no safety concerns are present, briefly review the PEG scores with patient as described in the chapter on measurement-based care.

3. Review material from the previous module

Although this is the first module of Brief CBT-CP, it is a good time to check in with patients about any final questions or concerns they have about this treatment before getting started.

Scripting includes:

1. *"Before we get started on new material, do you have any questions?"*

4. Introduce the new material and answer questions

4.1. Chronic pain education

Scripting includes:

1. *"To get started, I want to talk a bit about what makes chronic pain different from acute pain, or pain that goes away after an injury heals."*

- Compare and contrast chronic pain with acute pain.
- Explain why these pains may feel the same but must be treated differently.

4.2. Effects of pain

- Use the **Factors that Impact Pain** handout to explain the 1) biopsychosocial model and 2) review the variety of factors that can negatively or positively impact chronic pain

Scripting includes:

1. *"Chronic pain impacts many areas of our lives. You can see in this diagram that the chronic pain you experience can be impacted by the interaction of biological or medical factors, psychological factors, or social factors."*
2. *"These factors can impact our chronic pain in either a negative way, a beneficial way, or both and vary from person to person. They can turn up the volume on pain or turn down the volume. What factors impact you the most?"*

Key Point: Asking patients about what factors impact them the most will help you to identify potential treatment targets (e.g., for SMART goal development).

Key Point: Emphasize that Brief CBT-CP is designed to help patients manage the impact of chronic pain across these three domains.

- Use **The Chronic Pain Cycle** handout to explain how chronic pain may negatively impact life over time.

Scripting includes:

1. *"Chronic pain can take a toll on our behaviors, thoughts, and feelings. It's shown here how pain may lead us to stop participating in activities that we enjoy which leads to negative thoughts and feelings. As our mood gets worse, we might withdraw from routine activities and even our relationships. The less engaged we are in life, the more distress we may feel. And without enough physical activity, we might become deconditioned or disabled, making our pain worse."*

Key Point: Review the costs of inactivity noted on the handout.

Note to provider: Be aware that some patients may not be avoiding or under-engaging in activities, but may be dealing with negative ramifications of pain nonetheless. Some individuals may also be overactive, which can exacerbate their pain. The primary goal, in this regard, is to achieve balance in activities. The module regarding Activities and Pacing will address this concern in greater detail.

Key Point: Brief CBT-CP can help break the chronic pain cycle.

4.3 Goal Identification

- Use the **Brief Cognitive Behavioral Therapy for Chronic Pain** handout to provide an overview of the objectives of Brief CBT-CP

***Scripting** includes:*

1. *"Brief CBT for chronic pain will provide you with several new strategies to help you manage your chronic pain. Overall, these tools are designed to help reduce the negative impact of pain on daily life, improve your physical and emotional functioning, and increase effective coping skills. This treatment may also reduce your pain over time."*

- Use the **SMART Goal Setting** handout to identify Veteran-specific goals for change. Identify <u>at least one</u> short-term goal and supporting rationale during this appointment (with additional goals completed as home practice.)

2. *"It's important that we make sure that Brief CBT for chronic pain is addressing the areas of your life that you find important. So, let's get you back to doing more of what is important to you. The first step will be to identify some short-term goals and then some long-term goals. We'll use the SMART goals format you see here."*

Key Point: Be certain that goals identified are relevant to chronic pain management.

Key Point: Goals should include as many of the SMART elements as possible.

Key Point: It is sometimes difficult for individuals to produce specific goals on their own, so it can be helpful to ask questions to guide the discussion, such as:

1. *"What is something specific that you would like to see change in your life in the weeks to come?"*
2. *"What would you like to be able to do (better, more of, etc.)?"*
3. *"If this treatment were successful, how would that look in your day-to-day life?"*
4. *"Are there relationships that you would like to improve?"*

5. Discuss new home practice opportunity

5.1. Clearly specified goals

Emphasize the value of identifying clearly specified goals (using SMART elements) for ensuring that Brief CBT-CP will address areas of concern for the patient.

5.2. Short and long-term goals

Any short- or long-term goals not identified during this appointment should be completed by the patient as home practice.

Scripting includes**:**

1. *"Today we've identified a few SMART goals that will guide our future appointments. Since we have already determined that you have a number of strengths, such as (X) and (Y), I am confident that you will be able to complete the remaining short-term (and/or long-term) goals at home. By completing this at home and bringing them with you to our next appointment, we will be able to review them together and move more quickly into learning new skills for chronic pain management."*

6. Module wrap-up

6.1. Summary of key points

This module includes considerable educational information about chronic pain and ends with identifying patient goals for treatment. The following scripting can provide a concise summary of key points and emphasizes again the value of goal setting and home practice.

Scripting includes**:**

1. *"Today we discussed the difference between acute and chronic pain, including why chronic pain is best treated from a biopsychosocial perspective. This approach emphasizes treating pain from several angles, including developing new coping skills. We identified some of the areas in your life that have been negatively impacted by pain and discussed how we must avoid getting caught in the chronic pain cycle. To help us become more active and break this cycle, we began to identify some short- and long-term goals that will guide the rest of our appointments together. Completing the SMART goals sheet before the next module will ensure that the remainder of our appointments are geared towards your top priorities."*

Brief CBT-CP Module 1 Outline: Education and Goal Identification

1. Introduce the module and confirm the agenda

2. Ask about mood, complete the PEG, and discuss findings

3. Review material from the previous module, including home practice

- Although this is the first module of Brief CBT-CP, it is a good time to check in with patients about any final questions or concerns they have about this treatment before getting started.

4. Introduce new material and answer questions

4.1. Chronic pain education

- Compare and contrast chronic pain with acute pain.
- Explain why these pains may <u>feel the same</u> but must be <u>treated differently.</u>

4.2. Effects of pain

- Use **Factors that Impact Pain** handout to explain the 1) biopsychosocial model and 2) factors that impact pain.
- Use **The Chronic Pain Cycle** handout to explain how chronic pain may negatively impact life over time.

4.3. Goal identification

- Use the **Brief Cognitive Behavioral Therapy for Chronic Pain** handout to provide an overview of the objective of Brief CBT-CP.
- Use the **SMART Goal Setting** handout to identify Veteran-specific goals for change. Identify at least one short-term goal and supporting rationale within this in-session (with additional goals completed as home practice.)

5. Discuss new home practice opportunity

- Emphasize the value of identifying clearly specified goals (using SMART elements) for ensuring that Brief CBT-CP will address areas of concern for the patient.
- Any short- or long-term goals not identified during this appointment should be completed by the patient as outside practice.

6. Session wrap-up

- Provide a concise summary of key points and emphasize the value of home practice.

2. BRIEF CBT-CP MODULE TWO: ACTIVITIES AND PACING

This module focuses on the importance of engaging in activities and how to safely do so through the use of time-based pacing. Unlike many other mental health interventions, behavioral activation and guidance on how to properly pace activities is particularly important with managing chronic pain so it is typically introduced early in the intervention.

2.1. Module Agenda

1. Introduce the module and confirm the agenda
2. Ask about mood, complete the PEG, and discuss findings
3. Review material from the previous module, including home practice
4. Introduce the new material and answer questions
5. Discuss new home practice opportunity
6. Module wrap-up

2.2. Module Materials

- PEG self-report measure
- Patient handouts (see appendix):
    - The Chronic Pain Cycle
    - Pleasant Activities List
    - Pleasant Activities Schedule
    - Pacing Activities

2.3 Module Content for the Provider

1. Hurt versus Harm

Often, one of the greatest challenges for those with chronic pain is the belief that they no longer can engage in life fully or do the things that they want to do. Veterans with chronic pain may believe that activity will lead to increased pain while also causing physical damage. This belief, while typically true in acute pain, is inaccurate in chronic pain and may lead to maladaptive responses such as avoidance. By avoiding activity, chronic pain worsens over time.

Inactivity leads to issues such as decreased flexibility and stamina, increased weakness and fatigue, and even spasms from tight muscles. The problems related to deconditioning often lead to increased risk of injury and weight gain (adding strain to the body) as well as feelings of sadness, frustration, or boredom, which only encourage more general withdrawal from people and places.

The avoidance response has been termed *kinesiophobia (*Miller, Kori, & Todd, 1991), or fear of movement, and may develop to varying degrees in those with chronic pain. Unfortunately, it creates a self-fulfilling cycle – not moving only makes patients' next attempts to engage in

activity more difficult and painful, reinforcing this fear. For Veterans who have lower levels of kinesiophobia and are more active, the manner in which they approach situations (e.g., overdoing) may also have detriments, such as new injuries. Flare-ups (relatively brief increases in pain intensity) are a central concern of those with chronic pain. They do not want to induce a flare-up with movement and are concerned with how to manage flare-ups when they occur. Lack of movement, avoidance, or approaching activities without thoughtful planning makes the occurrence of flare-ups more likely. Another common response is avoiding an area that hurts by favoring another area. If a patient has pain in the right knee, they may begin compensating by adding additional pressure to their left side when ambulating. In these cases, the initial area of pain become deconditioned, and the area that is now absorbing additional stress may begin to develop new pain.

Use **The Chronic Pain Cycle** handout, introduced in module one, to discuss the negative consequences that often result from responding in a maladaptive manner to pain.

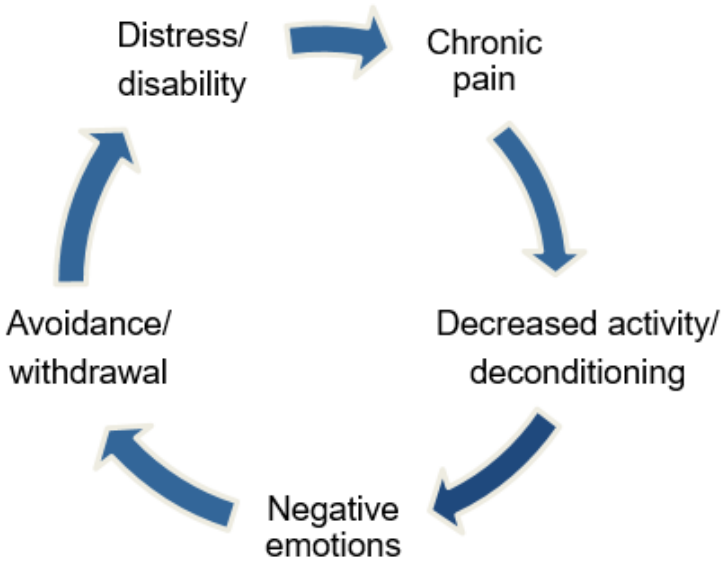

Figure 10. Chronic Pain Cycle

2. Pleasant Activities

For those with chronic pain, decreasing fear and engaging in activity is a key to improved functioning but can be challenging. One way to increase re-engagement and decrease kinesiophobia is to participate in pleasant activities. Many with pain may have stopped participating in hobbies, spending time with others, or engaging in physical outings. For those that do engage in activities more regularly, they may have given up some of their favorite hobbies or be less comfortable when around friends and family. Many may feel that they physically cannot do the things they want, are “no fun” to be with because of pain, or are

worried about experiencing a pain flare-up that might interfere with plans. The benefits of engaging in pleasant activities are included in Figure 11.

Figure 11. Pleasant Activities

Identifying pleasurable activities for those with chronic pain may be challenging for several reasons. Pain-related negative mood such as depression and irritability may lessen the ability to identify such activities or diminish the motivation to engage in them. Psychosocial challenges, such as limited resources, may be a barrier. Chronic pain and poor sleep may leave patients feeling too tired or fatigued to participate in activities. Primarily, however, Veterans may mention things that they would like to do but "can't" because of pain limitations. Use the **Pleasant Activities List** and **Pleasant Activities Schedule** to explore options. This discussion will likely generate a forum for examining creative alternatives for previously enjoyed hobbies. For example, if Veterans report that they used to enjoy bowling but are now unable to, inquire about their willingness to teach bowling to children or adolescents or to play an adapted version of bowling through a gaming system.

3. Time-Based Pacing

Some people are prone to "pushing through" pain in the name of accomplishing a task and will not stop until it is complete, while others may be preoccupied with fears about harming themselves and avoid activity altogether. Often, those with chronic pain use a "good pain day" when they are feeling better to try and complete one or more rigorous activities that have fallen by the wayside. For example, they clean the garage or mow the grass without excessive pain – but wake up the next day feeling like they cannot move and thus are "laid up" for several days in a row. This cycle of overactivity, increased pain, and increased rest seen in Figure 12 often happens on a recurring basis. This boom-bust pattern can lead to various negative consequences such as pain flare-ups, increased stress and anxiety, decreased efficiency, lowered self-esteem, and avoidance of any activity.

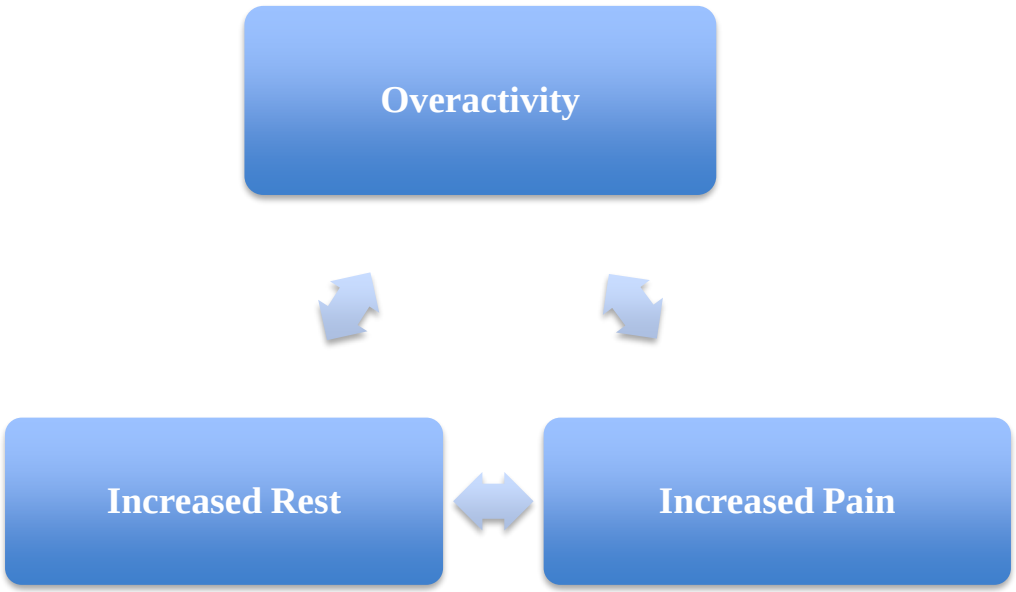

Figure 12. Overactivity Cycle

Overdoing or not planning activities carefully beforehand can lead to flare-ups lasting from minutes to weeks. Minimizing the occurrence of flare-ups as well as knowing how to manage them when they do occur is a critical component of successful Brief CBT-CP.

Engaging in a moderate, safe level of activity on a regular basis is how to avoid this maladaptive cycle. Using the skill of pacing, where time is the guide for activity engagement, can be a helpful strategy. It allows Veterans to consistently and thoughtfully engage in activities without causing detrimental consequences. Pacing is often about balancing activities and planning ahead, or working "smarter not harder." Breaking tasks into "chunks" such as painting a room for 45 minutes per day over four days instead of for three hours on a single day is one example of pacing. Alternating between standing to do dishes for ten minutes and sitting to fold laundry for five minutes may be a way to avoid standing longer than is comfortable, avoiding a flare-up, but also engaging in an "active rest" period where something is still being accomplished. Being more thoughtful about activity allows Veterans to get more done on a more consistent basis, which also encourages mood improvements brought about by accomplishment. Without pacing, the cycle of being sedentary or over-active with pain flare-ups can be very discouraging.

During this module, use the **Pacing Activities** worksheet to explore how to pace an activity with the Veteran. Use examples to illustrate how pacing can enable Veterans to consistently carry out activities while minimizing the likelihood of increased pain. It is the middle ground between doing nothing and overexertion that enables Veterans with chronic pain to engage in reasonable amounts of activity and improve quality of life. It is important to remember to take a break *before* an exacerbation occurs, and not wait until the pain is increasing. Asking a

Veteran how long they can engage in an activity before they begin to experience an increase in discomfort should be the guide.

Once the concept of pacing has been reviewed, it is important to discuss in this module how Veterans will apply it to their own lives. Ask the Veteran to choose an activity where they can use pacing over the next week, such as washing the dishes or doing yard work. With the worksheet and sample provided, use the steps to develop a plan for incorporating the activity into the week. Pacing is a primary means to avoid flare-ups which should be emphasized. While pacing may be a difficult concept to implement, highlight its critical role in effective pain management and the need for practice.

Brief CBT-CP Module 2 Therapist Guide: Activities and Pacing

Note to provider: Scripted statements are provided below as suggestions, rather than rules, of how to introduce topics to patients. Scripting can be especially helpful for those providers who are new to the content of Brief CB-CP. Feel free to modify the scripting as needed as you become more comfortable with core elements of each module.

1. Introduce the module and confirm the agenda

Scripting includes*:*

1. *"Today we will discuss how to safely engage in activities through pacing. This topic is important because it helps us to keep active but avoid "overdoing it." As you may have experienced, over activity can often lead to pain flare-ups that can last for days. It's also very important for individuals with pain to stick with enjoyable or pleasant activities, or find new ones, because this helps lower our level of distress and makes life more fulfilling."*

2. *"First, I will ask you to complete our usual measure about your pain and functioning so we can continue to track your progress. Next, I would like to do some follow-up from our last module, then move into our new topic about activity pacing. How does that sound to you? Are there other things relevant to our pain work that you want to be sure to cover today?"*

Note to provider: If the patient is inclined to add items to the agenda that are not related to pain management, the first effort on behalf of the therapist may be to link the topic back to pain. For example, a statement such as the following may be helpful to refocus the patient: "That sounds like it was stressful. Did you notice that your pain worsened during that time?"

2. Ask about mood, complete the PEG, and discuss findings

Scripting includes:

1. *"First off, how are you feeling today and how has your mood been?"*
2. *"I would like you to complete this brief measure, the PEG, again today to help with tracking your progress. After you complete it, we'll review the results."*

Note to provider: After the patient completes the measure, briefly review the score of the PEG with patient in comparison to prior scores to identify any areas of significant concern/distress.

3. Review material from the previous module

Note to provider: The key purpose of reviewing prior module's content is to 1) answer questions/concerns about the topics and skills addressed, and 2) follow-up on home practice for addressing skill acquisition and clarifying content.

Scripting includes:

1. *"Before we get started on new material, do you have any questions about what we covered last time?"*

2. *"Last time we discussed <previous topic> which included some home practice for you to complete. Do you have your practice work from last time?"*

Note to provider: It is not uncommon for patients to have not completed their home practice. It is therefore important to briefly explore barriers to completion and re-state the importance of home practice for developing and strengthening CBT skill development.

4. Introduce the new material and answer questions

4.1. Hurt versus harm

Use **The Chronic Pain Cycle** handout introduced in Module 1 to explain that acute and chronic pain may feel the same but must be addressed differently

Scripting includes:

1. *"It is important to remember that the pain we experience with our chronic pain condition does not indicate that we are harming ourselves. Rather, this pain is like an annoying alarm we can't trust: unpleasant but not an indication of damage. Similarly, like leaving bread in the toaster too long, smoke may set off the smoke detector. Even though the alarm is going off and some action on our part is required, it's not an emergency. There's no need to call the fire department."*

2. *"Individuals with chronic pain often stop participating in certain activities out of fear that they will experience a pain flare-up. Although we probably can't avoid all flare-ups, finding a balance between activity and rest is important when managing chronic pain."*

3. *"As you can see in the chronic pain cycle, when we experience pain, we often decrease our activity too much. This leads to lack of strength and flexibility, as well as an increase in distress. As we feel worse, we might withdraw from even more activities. This cycle can be broken by finding a balance in safe activities and rest."*

4. *"Chronic pain can take a toll on our behaviors, thoughts, and feelings. It's shown here in the chronic pain cycle how pain often leads us to stop participating in activities that we enjoy which leads to negative thoughts and feelings. As our mood gets worse, we might withdraw from routine activities and even our relationships. The less engaged we are in life, the more distress we may feel. And without enough physical activity, we might become deconditioned or disabled, making our pain worse."*

Key Point: Review the costs of inactivity noted on The Chronic Pain Cycle handout.

Key Point: Brief CBT-CP can help break the chronic pain cycle.

Key Point: Managing chronic requires balance between safe, appropriate activity and rest to avoid both inactivity that leads to deconditioning and overuse that typically results in pain flare-ups.

4.2. Pleasant activities

Use the **Pleasant Activities List** and **Pleasant Activities Schedule** to help identify enjoyable or meaningful activities, particularly if the patient has a difficult time generating ideas without assistance. Explain that pleasant activities take many shapes and forms, including those that require varying levels of physical activity, from walking to playing board games.

Start by asking the Veteran to identify activities on their own but use the **Pleasant Activities List** if they have a difficult time or need to expand their list of potential activities. When several activities are identified, record them on the **Pleasant Activities Schedule** as instructed in the handout.

Scripting includes:

1. *"One of the best ways to avoid inactivity is to get reconnected with your hobbies or social activities. Pleasant activities are very helpful because they can distract us from pain, improve our mood, give us a chance to socialize, and even help give us a sense of purpose."*

2. *"Often individuals stop certain activities because they no longer seem possible when living with chronic pain. While this is true in some cases, other times we can modify the activity itself, or how we participate. What pleasant activities or hobbies would you like to go back to?*

3. *"It's clear that chronic pain has had a negative impact on your activities lately. Sometimes it's nice to also explore some new options for the first time. Is there anything on this list of Pleasant Activities that we might talk about further?"*

Key Point: If the patient is highly committed to an activity that is no longer feasible, engage in a conversation about what they found enjoyable about the activity (e.g., did they enjoy running because of being outside, a running group, etc.) and go from there. The "essence" of that activity that they enjoyed might be found in other more feasible activities. Alternatively, help them find ways to remain active in a similar activity in a new capacity.

4. *"It sounds like one of the parts about your jogging group that you loved was the opportunity to meet with friends on a weekly basis. Even though you are no longer able to jog with them for the full time, how might you continue to see your friends?"*

5. "*It's clear that you really enjoyed the teamwork aspect of playing basketball. Is there a way to keep helping the team, even if you don't play as frequently?"*

Key Point: It is often helpful to identify a range of activities, including those that may require fewer resources (e.g., activities inside the home), can be completed alone (e.g., gardening), with friends (e.g., lunch at a favorite restaurant), those where physical activity is the main focus (e.g., playing sports), and those that are important because they are personally meaningful (e.g., volunteering for a charitable organization.)

4.3. Time-based pacing

Use the **Pacing Activities** worksheet to describe the goals of planning activities and to illustrate the process of planning activity and rest.

Scripting includes:

1. *"The goal of activity planning, or pacing, is to take a larger job and break it into smaller pieces to make it more manageable. For example, an individual might plan to paint a room in their house. Trying to paint the room in one day may be too strenuous whereas making progress each day for several days may help avoid overexertion that can cause a pain flare-up."*

2. *"Balance applies to everyday activities as well. For example, take a break from standing every 10 minutes while doing the dishes. During a 5-minute break, you can remain active with other tasks that don't require standing, like folding laundry or paying your bills on-line."*

3. *"Whatever the activity, the main goal of pacing is to engage in routine moderate activity. Using a bit of planning to guide our activities helps us avoid situations where we 'push through' the pain throughout the day, which often leads to several days of being 'laid up' due to a pain flare-up."*

4. *"This worksheet will help us break down a larger activity into pieces to ensure that we are finding a balance between activity and rest. It may seem unusual at first to make an*

activity longer than you are used to, but it will help to avoid unnecessary pain in the long run."

5. *"Pacing helps us stay balanced because it reminds us to start being active as well as to stop or take breaks. Relying on a pre-determined schedule means we do not need to rely only on our internal signals about the need for movement and rest."*

Key Point: To find the optimal balance of activity and rest, it's important to estimate the degree of active time and rest time ahead of time. The active v. rest time will vary depending on the task. These time estimates can be adjusted as needed.

Key Point: Be sure to identify at least one activity to illustrate pacing, with attention to including a pleasurable or personally meaningful activity (e.g., playing games with grandchildren) in addition to others (e.g., washing dishes).

6. *"Let's use the worksheet to sketch out how to apply principles of pacing using active and rest time. What activity should we focus on first?"*

5. Discuss new home practice opportunity

With at least one activity identified, patients should record their engagement in pacing cycles, noting both their active time and rest time. Additional activities can be identified by the patient as part of outside practice.

Scripting includes:

1. *"Today we've discussed the importance of pacing to keep active while reducing the likelihood or overexertion. We've identified (one, two, three, etc.) activities and estimated the amount of rest and active time for each. The next step will be for you to record the number of cycles you complete for each activity. By completing this at home and bringing them with you to our next appointment, we will be able to review the sheet together, identify any areas of concern, and move into learning the next skills."*

6. Module wrap-up

This module included information about a key chronic pain management skill: time-based activity pacing. The following scripting can provide a concise summary of key points and emphasizes again the value of pacing and at-home practice.

Scripting includes:

1. *"Today we discussed how chronic pain is like an unreliable alarm rather than an indication that we are doing harm. Our topic emphasized finding balance between*

activities that are pleasurable and helpful to us and avoiding overexertion that can bring on a pain flare-up. Planning ahead and pacing out our activities is an important approach to finding that balance and avoiding the risks of too little or too much activity. Try out the pacing schedule we identified for your activities we discussed and record your progress on the handout for discussion at our next module.

Brief CBT-CP Module 2 Outline: Activities and Pacing

1. Introduce the module and confirm the agenda

2. Ask about mood, complete the PEG, and discuss findings

3. Review material from the previous module, including home practice

- Reviewing the prior module's content to 1) answer questions/concerns about the topics and skills addressed, and 2) follow-up on outside practice or homework. Briefly explore barriers to completion of outside practice and possible solutions (as necessary).

4. Introduce new material and answer questions

4.1. Hurt versus harm

- Use the **Chronic Pain Cycle** handout to explain that acute and chronic pain may feel the same but must be addressed differently, and that chronic pain is like a "broken alarm".
- Use the **Chronic Pain Cycle** handout to explain how chronic pain negatively impacts life over time unless we find a balance between activity and rest.

4.2. Pleasant activities

- Use the **Pleasant Activities List** to help identify enjoyable or meaningful activities, particularly if the patient has a difficult time generating ideas without assistance.
- Explain that pleasant activities take many shapes and forms, including those that require varying levels of physical activity, from walking to playing board games.
- Schedule identified activities on the **Pleasant Activities Schedule** handout.

4.3. Time-based pacing

- Use the **Pacing Activities** worksheet to describe the goals of planning activities and to illustrate the process of planning activity and rest.

5. Discuss new home practice opportunity

- With at least one activity identified, patients should record their engagement in pacing cycles, noting both their active time and rest time. Additional activities can be identified by the patient as part of home practice.

6. Session wrap-up

- Provide a concise summary of key points and emphasize the value of home practice.

3. BRIEF CBT-CP MODULE THREE: RELAXATION TRAINING

This module introduces Veterans to the pain management benefits of relaxation and then reviews two specific techniques: diaphragmatic or deep breathing and progressive muscle relaxation. Since these interventions are used in the management of various mental health and medical conditions, many providers may already be familiar with them. Emphasize that practicing these techniques regularly between modules is critical to mastery and effective application.

3.1. Module Agenda

1. Introduce the module and confirm the agenda
2. Ask about mood, complete the PEG, and discuss findings
3. Review material from the previous module, including home practice
4. Introduce the new material and answer questions
5. Discuss new home practice opportunity
6. Module wrap-up

3.2. Module Materials

- PEG self-report measure
- Patient handouts (see appendix):
    - Relaxation Benefits and Tips Handout
    - Deep Breathing Training
    - Progressive Muscle Relaxation
    - Relaxation Practice Record

3.3. Module Content for the Provider

1. Relaxation Rationale

Relaxation techniques are fundamental skills for managing chronic pain. However, the notion of relaxation in the service of pain management is an unfamiliar concept to most individuals with chronic pain. The rationale behind the use of relaxation techniques for pain management can be explained most easily by focusing on chronic pain as a chronic stressor, both physically and psychologically.

When patients experience chronic pain, their bodies react with a “fight or flight” response. This *stress response*, controlled by the sympathetic nervous system, is critical to survival when individuals face a dangerous or threatening situation. While in acute pain the response is adaptive, with chronic pain the response is ‘stuck on’ and creates additional wear and tear on the body. Since the body is chronically stressed due to persistent pain, it does not have the chance to recuperate (Benson & Klipper, 1975).

Veterans may hold certain areas of their bodies rigidly to brace or protect against pain. They may tense their necks or shoulders in anticipation of or in response to pain. These types of reactions, while perfectly natural, only increase tension levels and pain intensity, but are often done unconsciously. In addition, coping with the chronicity of the pain condition, not feeling understood by others, reduced involvement in enjoyable activities, and negative thoughts may also increase the stress related to pain. Since stress and pain have a bidirectional relationship – pain influences stress and stress influences pain – gaining greater control over the response to stress can help to better manage pain.

The good news is that the opposite physiological process, known as the *relaxation response*, slows down and stops the fight or flight reaction. This parasympathetic nervous system has the effect of reversing physiological arousal and bringing the body back to a calm state. Human beings are capable of developing control over this relaxation response and engaging it as a means of managing physical and emotional stress. With practice, the skill of using relaxation techniques to return the body to a relaxed state can be developed, thereby closing the pain gate and reducing the intensity of pain. We are retraining the body and mind to respond in a more adaptive way to stress and tension.

2. Implementation

As with any new skill, practice of relaxation techniques should be performed daily to gain mastery. It can be helpful to offer an analogy such as learning to play the guitar. While at first it may be difficult and uncomfortable with little noticeable improvement, regular practice helps a person become a skilled musician over time. In fact, fingers may begin to play certain songs on "autopilot" as the body develops a memory for the movements. This is the case with practicing and learning relaxation as well. Over time, relaxation exercises become easier to implement, require less thought, result in greater benefit. Daily practice is required to develop these skills. Some hints that may be helpful are included in Figure 13.

- Pair relaxation with a daily activity such as having a meal or making coffee/tea.
- Use a relaxation "app" on a smart phone (See Appendix for examples).
- Select a phrase or mantra that serves as a cue such as "calm, peace, or positivity."

Figure 13. Hints for Adding Relaxation Strategies to Daily Routines

Use the handout on **Relaxation Benefits and Tips** in this module which further outlines the advantages to developing the skill of relaxation and ways to implement it successfully.

3. Techniques

While there are various relaxation techniques that are effective, all involve a unique mental state of passive attention to a stimulus that decreases the inner dialogue and the sympathetic nervous system arousal. They combine a focusing tool (e.g., breath, area of body, image) with a quiet and accepting disregard of everyday thoughts when they occur in order to return to the focus of attention. Steps to help achieve this mental state are illustrated in Figure 14.

Two relaxation techniques will be introduced and demonstrated in this module. A brief review of deep breathing, the foundation of all options, will be followed by an overview of brief progressive muscle relaxation. **Information regarding guided imagery, another common relaxation technique, is included in the appendix for those who would prefer this approach.** Guided imagery can be used as a substitute for brief progressive muscle relaxation or as an additional relaxation skill.

1. Sit in a comfortable chair or on a mat. (If you get in bed you may fall asleep so it is not recommended, unless you are using the technique to aid in sleep initiation).
2. Lower the lights.
3. Take off your shoes and loosen tight clothes.
4. Close your eyes. (If you want to keep your eyes open, then focus them on one spot).
5. Turn off your phone, TV, and radio.
6. Put pets in another room.
7. Let others in the house know you need some time alone to focus on your health.

Figure 14. Steps to Being Prepared for Relaxation Training and Practice

Deep Breathing

The first relaxation technique is diaphragmatic breathing, often called “deep breathing”, and it is the foundation for all other relaxation techniques. It uses deep breathing to contract the diaphragm by expanding the chest cavity and allowing more room for the lungs to fill with air. This serves the purposes of slowing breathing, increasing oxygen intake, and even increasing energy.

Diaphragmatic breathing is a brief and portable strategy that can be done anywhere, at any time, and usually without others becoming aware that it is being done. It involves normal breathing, but uses breaths that are intentionally smoother, slower, and deeper than the breaths usually taken throughout the day. It is one of the easiest, most effective ways to decrease tension in the body.

The steps for teaching this exercise are detailed here. The clinician can help model effective technique by engaging in the exercise along with the Veteran.

Steps for Deep Breathing

1. Establish good posture.

2. Explain chest/shallow versus belly/deep breathing.

3. Have Veteran place one hand on chest and one hand on abdomen.

4. Determine if the Veteran is “chest breathing” or “belly breathing.”

5. Close eyes completely or look downward and fix gaze on one spot.

6. Observe the hands and ensure they are free of tension.

7. Have the Veteran keep one hand on chest and one hand on abdomen and keep eyes closed or fixed on one spot.

8. Have the Veteran inhale slowly through the nose (if possible), causing the abdomen to expand, extending inhale to three to five seconds in duration.

9. Instruct the Veteran to exhale slowly and completely through mouth, extending exhale to three to five seconds in duration.

10. Continue this exercise for three to five minutes.

During the exercise, the clinician may wish to coach the Veteran with statements such as: “Feel your body become more and more relaxed with each exhalation,” or “Each time you exhale, think of the word *relax*,” or “Breathe in feelings of relaxation and breathe out any tension.” Refer to Figure 15 and to the **Deep Breathing Training** handout for a sample script of this exercise.

MINI BREATHING EXERCISE

One idea is to try and use mini-sessions of deep breathing during the day. Incorporating brief sessions of breathing will help with frequent practice. Because this exercise is so portable and easy, it can help any time you are “on the go.”

For example, when you are standing in a line at the store, you may find yourself becoming increasingly tense or impatient. Instead of focusing on that:

1. Take a deep breath in. As you breathe out, imagine the tension and negativity leaving your body.

2. On your next breath, imagine breathing in feelings of calm and relaxation.

3. Count to six taking a slow, deep breath. Breathe out slowly, again to a count of six.

Before you know it, you will feel less tense and more in control. What are some other situations where you might be able to do a mini-session during the day?

Figure 15. Mini-Breathing

Brief Progressive Muscle Relaxation

The second technique is progressive muscle relaxation (PMR). This exercise is focused on systematically tensing and relaxing specific muscle groups. The underlying explanation for the utility of this technique is that a muscle group cannot be both tense *and* relaxed at the same time. By deliberately tensing the muscles and then relaxing them, patients can learn to observe the difference between these two sensations; the body can then learn to notice tension in muscles and to automatically release that tension.

Gentle contraction (i.e., mild to moderate tension) of each muscle group is required, not severe tension. Tensing the muscle should not hurt, but it may feel unfamiliar and thus slightly uncomfortable on the first practice of PMR. Muscle groups that are particularly tense may be repeated, if desired.

For Veterans who fear that contracting a particular muscle will increase pain in that location, encourage them to approach that area gently. If there is a spasm or any undesirable effect, Veterans can visualize the muscle and imagine tensing that area when they get to that part of the body. Veterans should continue to contract the other muscles as the PMR exercise continues.

Given the time limitations of primary Care, it is recommended to provide an overview of the concept behind PMR and demonstrate this approach with one area/muscle group during the module, such as wrist and arm. Demonstrate other muscle groups if time allows.

Major Muscle Groups

Please also refer to the handout entitled **Progressive Muscle Relaxation** for a sample script of this exercise. The following are the muscle groups to be tensed and relaxed:

- Lower arms/upper arms
- Lower legs
- Upper legs/buttocks/lower back
- Abdomen
- Chest
- Neck/shoulders/upper back
- Mouth/jaw/throat
- Eyes/upper forehead/scalp

Steps for Brief Progressive Muscle Relaxation

1. Start with relaxed, deep breathing.

2. Systematically tense and relax each major muscle group.

3. Tension should last 5-10 seconds then relax for 10-20 seconds.

4. Spend additional time on muscles that are difficult to relax.

5. Mentally scan the body in systematic order of muscle groups, looking for remaining tension.

6. Allow Veteran to relax any residual tension.

4. Practice

Encourage Veterans to practice relaxation techniques at least once per day over the next week, more if possible. In addition, ask them to use the **Relaxation Practice Record** to track practice and progress. Ask the Veteran to write down a tension rating before starting the exercise and then return to the record afterward to self-assess and rate tension again – clarify that they are rating tension not pain intensity. Remind patients that as the skill develops, the techniques will become easier and benefits will increase.

Brief CBT-CP Module 3 Therapist Guide: Relaxation Training

Note to provider: Scripted statements are provided below as suggestions, rather than rules, of how to introduce topics to patients. Scripting can be especially helpful for those providers who are new to the content of Brief CBT-CP. Feel free to modify the scripting as needed as you become more comfortable with core elements of each module.

1. Introduce the module and confirm the agenda

Scripting includes*:*

1. *"As I mentioned last time, today we will review the benefits of relaxation training in managing chronic pain, and practice two specific relaxation techniques: deep (or diaphragmatic) breathing and progressive muscle relaxation. Going over these techniques during our appointment today is important because this will help you learn the basics. However, practicing these techniques on your own at home is critical to mastering the techniques, and promoting your ability to apply them in an effective manner.*

2. *"First, I will ask you to complete our usual measure about your pain and functioning so we can continue to track your progress. Next, I would like to do some follow-up from our last module, then move into our new topic about relaxation. How does that sound to you? Are there other things relevant to our pain work that you want to be sure to cover today?"*

Note to provider: If the patient is inclined to add items to the agenda that are not related to pain management, the first effort on behalf of the therapist may be to link the topic back to pain. For example, a statement such as the following may be helpful to refocus the patient: "That sounds like it was stressful. Did you notice that your pain worsened during that time?"

2. Ask about mood, complete the PEG, and discuss findings

Scripting includes:

1. *"First off, how are you feeling today and how has your mood been?"*
2. *"I would like you to complete this brief measure, the PEG, again today to help with tracking your progress. After you complete it, we'll review the results."*

Note to provider: After the patient completes the measure, briefly review the score of the PEG with patient in comparison to prior scores to identify any areas of significant concern/distress.

3. Review material from the previous module

Note to provider: The key purpose of reviewing prior module's content is to 1) answer questions/concerns about the topics and skills addressed, and 2) follow-up on home practice for addressing skill acquisition and clarifying content.

Scripting includes**:**

1. *"Before we get started on new material, do you have any questions about what we covered last time?"*

2. *"Last time we discussed <previous topic> which included some outside practice for you to complete. Do you have your practice work from last time?"*

Note to provider: It's not uncommon for patients to have not completed their home practice. It is therefore important to briefly explore barriers to completion and re-state the importance of home practice for developing and strengthening CBT skill development.

4. Introduce the new material and answer questions

4.1. Relaxation training education

Scripting includes**:**

1. *"I'd like to provide a little bit of background on why relaxation techniques are valuable tools to manage chronic pain."*

Discuss that chronic pain is a stressor for both the body *and* mind that triggers and subsequently maintains the fight or flight response.

Explain that relaxation skills are more than just resting or enjoying a hobby. Relaxation training is specifically designed to counteract the fight or flight response by reducing both bodily and psychological tension/stress.

1. *"These skills can be good for your health for a variety of reasons, including that relaxation can help improve your mood, energy level, sleep, blood pressure, as well as pain. Though there are many different types of relaxation skills, they each have common features, and importantly, all require practice."*

Use the **Relaxation: Benefits and Tips** handout to 1) explain the benefits of relaxation training, and 2) provide an overview of basic tips to enhance relaxation skill practice**.**

4.2. Provide a brief overview of two types of relaxation training:

4.2.1. Deep breathing:

Scripting includes:

1. *"Deep breathing is the foundation for all other relaxation techniques. Very deep breaths expand the chest cavity, contract the diaphragm, and make more room for your lungs to fill with air. This helps to slow your rate of breathing and increase oxygen intake, among other things. It is a brief, easy to learn, and portable strategy, but is also one of the most effective ways of quickly decreasing tension in your body."*

Use the **Deep Breathing Training** handout to guide the patient through in-vivo practice of the scripted exercise.

4.2.2. Progressive muscle relaxation:

Scripting includes:

1. "Progressive muscle relaxation involves purposely tensing and relaxing specific muscle groups, one at a time. Naturally, a muscle cannot be both tensed and relaxed at the same time. By intentionally focusing on these alternating tensed and relaxed states, you can train yourself to notice when you are tense, and then help to alleviate it."

Using the Progressive Muscle Relaxation handout, provide a verbal overview of the exercise. Demonstrate tensing and relaxation of at least one muscle group (e.g., lower arms/wrists) and confirm that the patient understands the general technique. Demonstrate on additional muscle groups if time allows, but it is unlikely that you can complete the full in-vivo exercise in session due to time constraints.

Note to provider: If you or the patient believes that guided imagery should be used instead of Progressive Muscle Relaxation, this information is available in the appendices. Guided imagery may be considered a viable alternative to deep breathing in particular if there are risks or limitations associated with breathing retraining (e.g., patients with COPD or other pulmonary dysfunction).

Key Point: Emphasize that relaxation training is used to retrain the body and mind to respond differently to stressors so that it becomes automatic and more helpful.

Key Point: When using progressive muscle relaxation, Veterans may approach a currently painful area gently to avoid a flare-up. Alternatively, they may skip an area or use visualization to imagine tension and relaxation.

Key Point: Reinforce the importance of at-home practice, and practicality of mini-sessions brief of practice throughout the day (e.g., mini-breathing exercise).

5. Discuss new home practice opportunity

Scripting includes:

1. *"Earlier I mentioned that practicing these skills is important. But it is also important to track progress in using these skills. One way we can do that is by rating our overall level of tension before starting the exercise, and then again when we are through."*

Review **Relaxation Practice Record** handout and encourage patient to practice and track progress using the form provided.

6. Module wrap-up

Scripting includes:

1. *"Today we discussed the value of training our bodies and minds to relax. Relaxation skills can be used to directly address the stress of living with chronic pain. The techniques we reviewed are ones that you can use daily to help with feeling less tense and more in control of your pain. These skills work best when we apply them routinely, so I'd recommend practicing at least once per day over the next week (more if possible)."*

Brief CBT-CP Module 3 Outline: Relaxation Training

1. Introduce the module and confirm the agenda

2. Ask about mood, complete the PEG, and discuss findings

3. Review previous module

- Reviewing the prior module's content to 1) answer questions/concerns about the topics and skills addressed, and 2) follow-up on outside practice or homework. Briefly explore barriers to completion of outside practice and possible solutions (as necessary).

4. Introduce the new material and answer questions

4.1. Relaxation training education

- Discuss that chronic pain is a stressor for both the body *and* mind that triggers and subsequently maintains the fight or flight response.
- Explain that relaxation skills are more than just resting or enjoying a hobby, but are designed to counteract the fight or flight response
- Use the **Relaxation: Benefits and Tips** handout to 1) explain the benefits of relaxation training, and 2) provide an overview of basic tips to enhance relaxation skill practice**.**

4.2 Deep breathing

- Use the script in the **Deep Breathing Training** handout to guide the patient through an in-vivo exercise**.**

4.3 Progressive Muscle Relaxation

- **Use the Progressive Muscle Relaxation** handout to provide an overview of the technique and demonstrate tension and relaxation of one (or more) muscle groups.

5. Discuss new home practice opportunity

- Review the **Relaxation Practice Record** handout and encourage patient to practice and track progress using the form provided.

6. Session wrap-up

- Provide a concise summary of key points and emphasize the value of home practice.

4. BRIEF CBT-CP MODULE FOUR: COGNITIVE COPING 1

This is the first of two modules that target the cognitive component of the Brief CBT-CP model by helping Veterans to 1) recognize thoughts that are unhelpful, and 2) develop skills for coping with those thoughts. By understanding the dynamic interplay between thoughts and pain and recognizing common maladaptive cognitions, Veterans will be better equipped to manage their chronic pain and the difficult emotional reactions that often accompany it.

This module will focus on identifying unhelpful thoughts while the second coping module focuses on challenging those unhelpful thoughts. Cognitive Coping 1 should be addressed before moving to Cognitive Coping 2. Although these have been divided into two modules, if you find your patient masters this content quickly, it may be feasible to address both modules in a single appointment.

4.1. Module Agenda

1. Introduce the module and confirm the agenda
2. Ask about mood, complete the PEG, and discuss findings
3. Review material from the previous module, including home practice
4. Introduce the new material and answer questions
5. Discuss new home practice opportunity
6. Module wrap-up

4.2. Module Materials

- PEG self-report measure
- Patient handouts (see appendix):
    - Brief Cognitive Behavioral Therapy for Chronic Pain
    - Pain Thoughts
    - Catching ANTs

4.3. Module Content for the Provider

1. Relationship Between Thoughts and Pain

For those with chronic pain, the impact of their thoughts on how they experience pain can be powerful. If pain fails to disappear or improve significantly over time, Veterans' thoughts may become increasingly negative and exert a greater influence on pain. Research shows that negative thoughts are directly associated with pain perception (Lawrence, Hoeft, Sheau, & Mackey, 2011). Often, these thoughts are automatic and outside of a person's awareness but may still impact emotions and behaviors.

Return to the **Brief Cognitive Behavioral Therapy for Chronic Pain** handout to review the relationships between thoughts, pain, mood, and behaviors. Veterans will often recognize that with increased stress or negative emotions, they also notice an increase in pain intensity. Explain to Veterans that all human beings have automatic thoughts that may be helpful or unhelpful. The presence of pain, however, sets the stage for an increase in negative thinking since uncomfortable stimuli is always present. It may be important to tell Veterans that this is not suggesting that their thoughts have *caused* their pain; some patients may be sensitive to this notion as they may feel they have been accused of exaggerating pain in the past.

Assure them that while their pain is real, it is also accurate that unhelpful thoughts can negatively impact their *pain experience* in direct and indirect ways; conversely, having more adaptive thoughts can have a positive impact and turn down the volume of their pain experience.

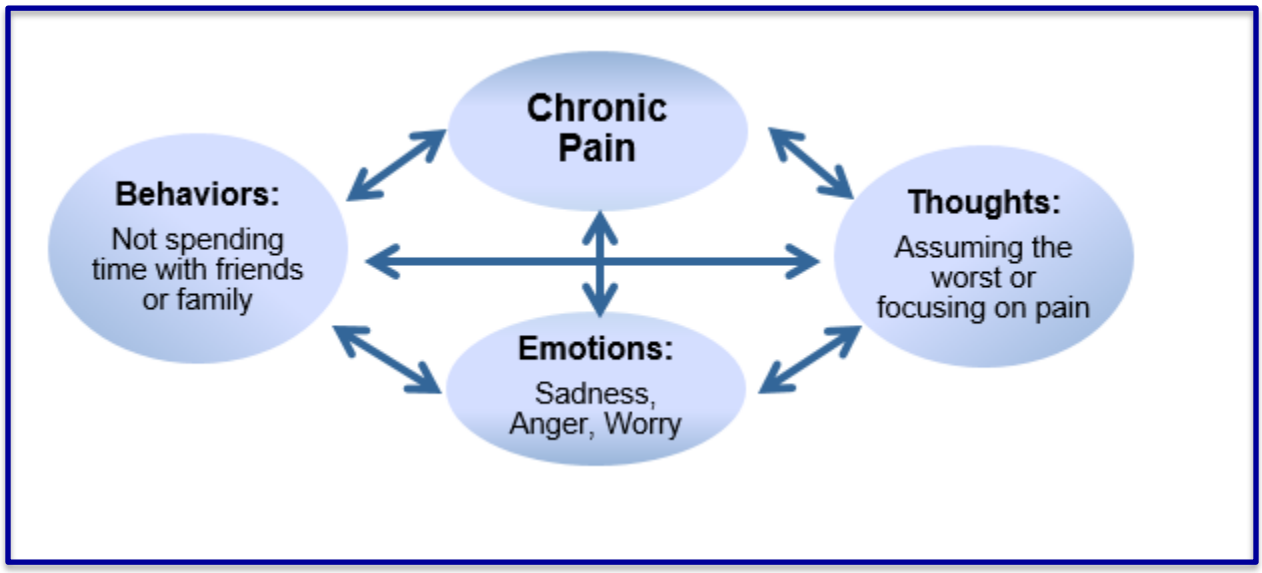

Figure 16. Interactions among Chronic Pain, Thoughts, Emotions, and Behaviors

2. Pain Thoughts

Another method for discussing unhelpful thinking patterns and their potentially automatic nature is through a discussion of common maladaptive cognitions, or *pain thoughts,* that many people have. In this module, these will be introduced to Veterans using the **Pain Thoughts** handout. While it is not necessary to review this entire list with Veterans, applying the appropriate labels to the examples on the handout as well as those provided by patients may be helpful.

It is important to make note of one cognitive distortion in particular: *catastrophizing*. Catastrophizing, or believing the worst, is particularly salient in the treatment of pain as it has consistently been associated with important pain-related outcomes. Catastrophizing is characterized by the tendency to magnify the threat value of pain and to feel helpless in the context of pain.

3. Recognizing Unhelpful Thoughts

Once Veterans have explored the role of unhelpful cognitions in the Brief CBT-CP model, they must now begin the process of increasing their awareness of the frequency of maladaptive thoughts associated with pain or negative mood. Use the **Catching Automatic Negative Thoughts (ANTs) Worksheet** to facilitate this process. Clarify to Veterans that since many of these thoughts happen without conscious awareness, this initial process requires some effort. Explain that the first step in improving thoughts is to increase recognition of those that are not helpful. Use time in this module to generate an example of a pain-related thought that the patient has had recently that did not serve them in a positive way. If the Veteran is unable to identify one, use an example that has arisen in previous modules. At this point in treatment, it is likely that the Veteran has expressed various pain thoughts, so it is recommended to take note of a few over the course of treatment. Identify how the thought impacted their mood as well as their experience of pain. The focus should not be on whether there is a grain of truth in the thought but rather on whether it is helpful – does it serve the Veteran? Does it make their experience better or worse? Turn up the volume or turn down the volume? Indicate whether the thought has been helpful or harmful to their pain experience on the **Catching ANTs Worksheet**.

Note that the next module, Cognitive Coping 2, will address finding alternative ways to respond to negative stimuli by challenging these thoughts and using coping statements.

4. Practice

Encourage Veterans to review the **Pain Thoughts** handout on their own to facilitate the understanding and identification of their own unhelpful thoughts, stressing the importance of completing as many examples as possible on the **Catching ANTs** worksheet. Circling whether the thought had a helpful/positive or unhelpful/negative effect on their pain and/or mood will help to connect the important role of thoughts in pain management.

Brief CBT-CP Module 4 Therapist Guide: Cognitive Coping 1

Note to provider: Scripted statements are provided below as suggestions, rather than rules, of how to introduce topics to patients. Scripting can be especially helpful for those providers who are new to the content of Brief CBT-CP. Feel free to modify the scripting as needed as you become more comfortable with core elements of each module.

1. Introduce the module and confirm the agenda

Scripting includes*:*

1. *"Today we will focus on the relationships between our thoughts and how we experience pain. We will discuss how some thoughts can be helpful, while others can make things worse. We will also start to apply strategies to identify negative thoughts so that we can learn to cope with them better."*

2. *"First, I will ask you to complete our usual measure about your pain and functioning so we can continue to track your progress. Next, I would like to do some follow-up from our last module, then move into our new topic about pain-related thoughts. How does that sound to you? Are there other things relevant to our pain work that you want to be sure to cover today?"*

Note to provider: If the patient is inclined to add items to the agenda that are not related to pain management, the first effort on behalf of the therapist may be to link the topic back to pain. For example, a statement such as the following may be helpful to refocus the patient: "That sounds like it was stressful. Did you notice that your pain worsened during that time?"

2. Ask about mood, complete the PEG, and discuss findings

Scripting includes:

1. *"First off, how are you feeling today and how has your mood been?"*
2. *"I would like you to complete this brief measure, the PEG, again today to help with tracking your progress. After you complete it, we'll review the results."*

Note to provider: After the patient completes the measure, briefly review the score of the PEG with patient in comparison to prior scores to identify any areas of significant concern/distress.

3. Review material from the previous module

Note to provider: The key purpose of reviewing prior module's content is to 1) answer questions/concerns about the topics and skills addressed, and 2) follow-up on home practice for addressing skill acquisition and clarifying content.

Scripting includes**:**

1. *"Before we get started on new material, do you have any questions about what we covered last time?"*

2. *"Last time we discussed <previous topic> which included some outside practice for you to complete. Do you have your practice work from last time?"*

Note to provider: It's not uncommon for patients to have not completed their home practice. It is therefore important to briefly explore barriers to completion and re-state the importance of home practice for developing and strengthening CBT skill development.

4. Introduce the new material and answer questions

4.1. Relationship between thoughts and pain

Use the **Brief Cognitive Behavioral Therapy for Chronic Pain** handout to discuss the relationships between thoughts and pain. (Some patients may also benefit from reviewing The Chronic Pain Cycle handout to discuss the role of unhelpful thoughts in perpetuating the chronic pain.)

Key Point: Explain that all people have automatic thoughts that may be helpful or unhelpful.

Scripting includes:

1. *"Everyone has thoughts that can be either helpful or unhelpful. Sometimes, we don't even realize that our thoughts are related to how we are feeling and acting. As you can see in this diagram, our thoughts, including negative beliefs, are linked to how we feel, our behaviors, and even how we experience pain. These thoughts are called automatic, meaning that they usually happen quickly and we often experience them as being out of our control. However, with practice we can identify these thoughts and replace them with alternative thoughts that can be more positive or helpful."*

Key Point: It may be important to tell Veterans that this is not suggesting that their thoughts have caused their pain or that "pain is in their head."

Key Point: Assure them that while their pain is real, it is also accurate that unhealthy thoughts can negatively impact their pain experience in direct and indirect ways; conversely, having more

adaptive thoughts can have a positive impact and turn down the volume of their pain experience.

Scripting includes:

1. "*Your thoughts have not caused your pain and your pain is very real. When we experience pain for a long time, we may be more likely to have negative pain-related thoughts. Although our thoughts do not cause the pain, they can influence how we cope with pain. The more skilled we are at creating helpful, balanced thoughts, the better we are at coping with pain. Then we have more control over whether our thoughts turn up or turn down the volume of our pain experience."*

4.2. Pain thoughts

Use the **Pain Thoughts** handout to review 1) common pain thoughts, 2) examples of unhelpful thoughts, and 3) examples of helpful alternative thoughts

Scripting includes:

1. *"There are some common types of thoughts that people with chronic pain report. This worksheet provides examples of some common pain thoughts that are unhelpful and others that are helpful. Although most people experience these pain thoughts as automatic, with practice you can become aware of them. Once you are aware of them, you can start to replace them with thoughts that are more helpful."*

Key Point: It is important to make note of one cognitive distortion in particular: catastrophizing. Catastrophizing, or believing the worst, is particularly relevant in the treatment of pain as it has consistently been associated with important pain-related outcomes.

Note to provider: Pick at least three examples to review with the Veteran, one of which should be catastrophizing, to review both the unhelpful and alternative helpful thought. Attempt to elicit from the Veteran if there are certain types of unhelpful thoughts that they experience more than others as these are likely targets for cognitive restructuring.

4.3. Recognizing unhelpful thoughts

Use the **Catching ANTs** handout to help the Veteran learn to 1) identify (catch) negative thoughts, 2) determine if the thought is helpful or harmful, and 3) challenge automatic negative thoughts

Key Point: Clarify to Veterans that since many of these thoughts happen without conscious awareness, this initial process requires some effort.

Scripting includes:

1. *"Now that we have explored the relationship between negative thoughts and pain, the next step is to learn how to identify some of the specific unhelpful thoughts you might have. At first, this can be difficult to do and takes some practice to do it well. Remember that these thoughts often occur quickly and outside of our awareness, making them hard to identify. The first step is learning to accurately recognize and identify your thoughts. Let's look at this example and then we'll create one that is specifically for you."*

Key Point: Review the example and use time in module to generate an example of a pain-related unhelpful thought that the patient has had recently. If the Veteran is unable to identify one, use an example that has arisen in previous modules.

Key Point: Using the Catching ANTS handout, identify how the thought impacted their mood as well as their experience of pain.

Scripting includes:

1. *"Can you think of a recent time when you had an unhelpful pain-related thought? What was happening? What was the thought? Was that thought helpful or harmful?"*

Key Point: Work with the patient to identify several unhelpful thoughts and clarify the impact on mood or behavior. This skill is essential before moving on to the next module (Cognitive Coping 2) which will introduce ways to challenge negative cognitions and to use coping self-statements.

5. Discuss new home practice opportunity

Encourage Veterans to review the **Pain Thoughts** handout on their own to facilitate the understanding and identification of their own unhelpful thoughts.

Scripting includes:

1. *"We have talked about a number of new concepts today. There are a few things that I am going to ask you to review on your own and practice before you come back. This is critical to mastering the skills and getting the most benefit from our time together. First, I would like you to take some time on your own to review the Pain Thoughts Handout. As you review, think about each type of thought and ask yourself if you have these types of thoughts or similar ones."*

Stress the importance of completing as many examples as possible on the **Catching ANTs** worksheet as possible, including circling whether the thought had a helpful/positive or unhelpful/negative influence.

Scripting includes:

1. *"Second, I would like you to work on part of the Catching ANTs Worksheet. It would be great if you could "catch" at least one unhelpful thought a day. The earlier we can catch those unhelpful thoughts, the less potentially negative impact they have on our life. Just like we did today, write down the situation, and the thought, and determine if it is helpful or harmful. You do not need to complete the final column 'Challenge it!' as we will review your examples at the next appointment.*

6. Module wrap-up

This appointment includes information about how thoughts influence the experience of pain. The goal of the appointment is for the patient to understand this relationship and be able to identify and challenge negative pain-related cognitions. The following scripting can provide a concise summary of key concepts.

Scripting includes:

1. *"Today we focused on how our thoughts influence our experience of pain. We identified how negative thoughts can make us feel worse while more balanced thoughts can be helpful. We worked to "catch" specific negative thoughts, rated if they were helpful or harmful, and started working to create more accurate and adaptive thoughts. This is the first step to learning to cope with these unhelpful thoughts."*

2. *"Next time, we will learn about how to modify these thoughts to make them more balanced and helpful in our everyday lives. Although these skills can be difficult at first to learn and apply, many people find them extremely helpful as they practice the skills. Practicing these skills before our next appointment will help to improve your ability to use positive thinking in your everyday life."*

Brief CBT-CP Module 4 Outline: Cognitive Coping 1

1. Introduce the module and confirm the agenda

2. Ask about mood, complete the PEG, and discuss findings

3. Review previous module

- Review the prior module's content to 1) answer questions/concerns about the topics and skills addressed, and 2) follow-up on outside practice or homework. Briefly explore barriers to completion of outside practice and possible solutions (as necessary).

4. Introduce the new material and answer questions

4.1. Relationship between thoughts and pain

- Use the Brief Cognitive Behavioral Therapy for Chronic Pain handout to discuss the relationships between thoughts and pain.

4.2. Pain thoughts

- Use the **Pain Thoughts** handout to review 1) common pain thoughts, 2) examples of unhelpful thoughts, and 3) examples of helpful thoughts.
- Pick at least three examples to review with the Veteran, one of which should be catastrophizing, to review both the unhelpful and alternative helpful thought.

4.3. Recognizing unhelpful thoughts

- Use the **Catching ANTs** handout to help the Veteran learn to 1) identify (catch) negative thoughts, 2) determine if the thought is helpful or harmful, and 3) challenge automatic negative thoughts.

5. Discuss new home practice opportunity

- Encourage Veterans to review the **Pain Thoughts** handout on their own to facilitate the understanding and identification of their own unhelpful thoughts.
- Stress the importance of completing as many examples as possible on the **Catching ANTs w**orksheet as possible, including circling whether the thought had a helpful/positive or unhelpful/negative influence.

6. Session wrap-up

- Provide a concise summary of key points and emphasize the value of home practice.

5. BRIEF CBT-CP MODULE 5: COGNITIVE COPING 2

This is the second of two modules that target the cognitive component of Brief CBT-CP. This module focuses on modifying unhelpful thoughts identified in the previous module and during the patient's home practice. Cognitive Coping 2 is briefer in terms of its content to accommodate sufficient review from Cognitive Coping 1 as well as in-session practice regarding the key skill of challenging unhelpful thoughts. Taken together, the goal of these two modules is to prepare patients to identify, evaluate, and modify unhelpful thoughts related to chronic pain.

5.1 Module Agenda

1. Introduce the module and confirm the agenda
2. Ask about mood, complete the PEG, and discuss findings
3. Review material from the previous module, including home practice
4. Introduce the new material and answer questions
5. Discuss new home practice opportunity
6. Module wrap-up

5.2 Module Materials

- PEG self-report measure
- Patient handouts (see appendix):
    - Brief Cognitive Behavioral Therapy for Chronic Pain (as needed)
    - Pain Thoughts (as needed)
    - Catching ANTs
    - Coping Statements

5.3 Module Content for the Provider

1. Review of Progress - Pain Thoughts

Depending on the degree of skill or comfort the patient demonstrates with identifying unhelpful thoughts, it may be useful to briefly review the content from the prior module. One method for discussing unhelpful thinking patterns is by reviewing the **Catching ANTS** worksheet in comparison to the **Pain Thoughts** handout. This process can help patients to identify if they tend to experience certain types of negative thinking more often than others, such as a preponderance of "should statements" or emotional reasoning. Even if no specific pattern emerges, this is a good opportunity to link the patient's thoughts to the variety of unhelpful thoughts about pain that can occur. While it is not necessary to review their entire list, it can be helpful to discuss with Veterans which of the thoughts they found most frequent and/or distressing versus less so. This process can illustrate how thoughts can impact our mood and behavior in different ways (i.e., helpful, neutral, unhelpful).

2. Recognizing and Challenging Unhelpful Thoughts

Using the examples listed by the patient on **Catching ANTS** worksheet, introduce the concept of challenging unhelpful thoughts. Review one of the examples in detail, including how the thought impacted their mood as well as their experience of pain. Recall that the focus should not be on whether there is a grain of truth in the thought but rather on whether it is helpful – does it serve the Veteran? Does it make their experience better or worse? Turn up the volume or turn down the volume?

Once the Veteran understands and can identify unhelpful pain-related cognitions, work with them on alternative ways to respond to negative stimuli. The objective is not to create an unrealistic picture of situations but a more accurate and balanced perspective. If possible, propose a statement that reflects the role of the Veteran that increases self-efficacy. Review the full example on the **Catching ANTS** worksheet and determine if patients understand the process and rationale. It may be helpful to remind them that this is not suggesting that thoughts cause their pain, but rather that we may be able to decrease the negative impact of pain by making small changes to how we interpret situations.

3. Coping Statements

Another technique that can be helpful in managing pain flare-ups or negative mood is to use positive coping statements. The ideal coping statement helps patients remain calm during stressful situations. Coping statements provide "go-to" phrases that can replace unhealthy thoughts or help Veterans cope with specific difficult situations, especially ones that may be unanticipated. A key element to the success of coping statements involves finding phrases that strongly resonate with the individual Veteran. While these could be pain-specific, they might also be quotations, verses (e.g., song, scripture), or a phrase that a friend has delivered – the key is personal relevance and easy access.

The **Coping Statements** handout helps Veterans choose statements that may be effective for them. Patients may have their own phrases or statements that they have used in the past and have served them well. Encourage them to add such statements to the list provided. One advantage of formulating effective coping statements is that they can be portable and kept handy for use at any time. They can be written on a small piece of paper and kept in a wallet or placed into a smartphone that is carried routinely.

4. Practice

Encourage Veterans to complete the process of challenging unhelpful thoughts using the remaining examples on the **Catching ANTs** worksheet. Patients should make adaptations to unhealthy thoughts by creating a more balanced and accurate cognition. Finally, ask the Veteran to identify several statements that they find calming and reassuring which can be used before the next module.

Brief CBT-CP Module 5 Therapist Guide: Cognitive Coping 2

Note to provider: Scripted statements are provided below as suggestions, rather than rules, of how to introduce topics to patients. Scripting can be especially helpful for those providers who are new to the content of Brief CBT-CP. Feel free to modify the scripting as needed as you become more comfortable with core elements of each module.

1. Introduce the module and confirm the agenda

Scripting includes*:*

1. *"Today we will continue to focus on the relations between our thoughts and how we experience pain. Last time, we discussed how some thoughts can be helpful, while others can make things worse. Today, we will review strategies to identify unhelpful thoughts but also find ways to challenge and cope with these negative thoughts.*

2. *"First, I will ask you to complete our usual measure about your pain and functioning so we can continue to track your progress. Next, I would like to do some follow-up from our last module, then move into our topic about pain-related thoughts. How does that sound to you? Are there other things relevant to our pain work that you want to be sure to cover today?"*

Note to provider: If the patient is inclined to add items to the agenda that are not related to pain management, the first effort on behalf of the therapist may be to link the topic back to pain. For example, a statement such as the following may be helpful to refocus the patient: "That sounds like it was stressful. Did you notice that your pain worsened during that time?"

2. Ask about mood, complete the PEG, and discuss findings

Scripting includes:

1. *"First off, how are you feeling today and how has your mood been?"*
2. *"I would like you to complete this brief measure, the PEG, again today to help with tracking your progress. After you complete it, we'll review the results."*

Note to provider: After the patient completes the measure, briefly review the score of the PEG with patient in comparison to prior scores to identify any areas of significant concern/distress.

3. Review material from the previous module

Note to provider: The key purpose of reviewing prior module's content is to 1) answer questions/concerns about the topics and skills addressed, and 2) follow-up on home practice for addressing skill acquisition and clarifying content.

Scripting includes**:**

1. *"Before we get started on new material, do you have any questions about what we covered last time?"*

2. *"Last time we discussed <previous topic> which included some outside practice for you to complete. Do you have your practice work from last time?"*

Note to provider: It's not uncommon for patients to have not completed their home practice. It is therefore important to briefly explore barriers to completion and re-state the importance of home practice for developing and strengthening CBT skill development.

4. Introduce the new material and answer questions

4.1. Pain thoughts

It may be useful to first briefly review the concepts presented in the previous module with the help of the **Pain Thoughts** handout. Key areas to review (as needed) include 1) common pain thoughts, 2) examples of unhelpful thoughts, and 3) examples of helpful thoughts. This is also a good time to compare the patient's responses to the **Catching ANTS** worksheet to the prototypes in the **Pain Thoughts** handout.

Scripting includes:

1. *"As we discussed last time, there are some common types of thoughts that people with chronic pain report. This worksheet provides examples of some common pain thoughts that are unhelpful and others that are helpful. Let's compare your examples to those from the Pain Thoughts handout. Looking at your examples, which thoughts have impacted you the most?"*

Key point: The amount of review and discussion about the prior module's content will vary depending on the needs of the patient. When the patient can identify unhelpful thoughts, introduce the new content below about challenging these thoughts.

4.2. Recognizing and challenging unhelpful thoughts

Use the **Catching ANTs** handout to begin the process of challenging or modifying unhelpful thoughts.

Scripting includes:

1. *"The next step is to learn how to challenge some of the specific unhelpful thoughts you might have. At first, this can be difficult to do, and it takes some practice to do it well. Which of the examples you provided should we start with? Let's work to see if we can come up with a more positive or balanced thought. What might you have thought that would be more positive or helpful in that situation?"*

Key Point: Work with the patient to challenge the cognition. If possible, propose a statement that reflects the role of the Veteran and increases self-efficacy. Review the full thought record and determine if patients understand the process and rationale.

4.3. Coping statements

Use the **Coping Statements** handout to help the Veteran 1) become familiar with positive coping statements and 2) chose statements that may be effective for them.

Scripting includes:

1. *"Another technique that can be helpful in coping with pain or managing negative mood is to use positive coping statements. Coping statements help you remain calm during stressful situations. Coping statements are your "go-to" phrases that can replace unhealthy thoughts or help you cope with specific difficult situations. For example, telling yourself that, I'm going to focus on what I can do, not what I can't do, is an example of a powerful coping statement."*

Key Point: A key element to the success of coping statements involves finding phrases that strongly resonate with the individual Veteran. Patients may have their own phrases or statements that they have used in the past and have served them well. Encourage them to add such statements to the list provided.

Key Point: For patients who struggle after repeated trials of challenging unhelpful thoughts, developing coping statements can provide an alternative approach to coping with negative thoughts.

5. Discuss new home practice opportunity

Scripting includes:

1. *"We've covered some important material today. There are a few things that I am going to ask you to review on your own and practice before you come back. This is critical to mastering the skills and getting the most benefit from our time together. I would like you to continue to work on the Catching ANTs Worksheet. It would be great if you could "catch" at least one unhelpful thought a day. Just like we did today, write down the situation, and the thought, and determine if it is helpful or harmful. Then, take a few moments and challenge it. Work to identify a more positive and helpful thought that would turn down the volume on pain. We will review this at our next appointment."*

Stress the importance of completing as many examples as possible on the **Catching ANTs** worksheet as possible, including circling whether the thought had a helpful/positive or unhelpful/negative influence and creation of a more balanced and accurate cognition.

Finally, ask the Veteran to identify several statements that they find calming and reassuring which can be used before the next module.

Scripting includes:

1. "*Finally, I'd like to ask you to review the list of coping statements and identify any that you find calming or helpful. I would also like you to think about other statements that you may find beneficial. These could be parts of songs or poems, or even encouraging words from a close friend. Basically, these can be any statements that help to calm or soothe you, if you are feeling anxious or upset."*

6. Module wrap-up

Several cognitive strategies are reviewed in this module. The goal of the cognitive coping modules is for the patient to understand the relationship between thoughts and pain, be able to identify and challenge negative pain-related cognitions, create more helpful thoughts, and work to identify additional coping statements.

Scripting includes:

1. *"Our last two appointments have focused on how our thoughts influence our experience of pain. We identified how negative thoughts can make us feel worse while more balanced thoughts can be helpful. We worked to "catch" specific negative thoughts, rated if they were helpful or harmful, and started working to create more accurate and adaptive thoughts. We also reviewed common helpful coping statements and worked to*

identify some statements that are meaningful to you. Although these skills can be difficult at first to learn and apply, many people find them extremely helpful as they practice the skills. Practicing these skills before our next appointment will help to improve your ability to use positive thinking in your everyday life.

Brief CBT-CP Module 5 Outline: Cognitive Coping 2

1. Introduce the module and confirm the agenda

2. Ask about mood, complete the PEG, and discuss findings

3. Review Previous Module

- Review the prior module's content to 1) answer questions/concerns about the topics and skills addressed, and 2) follow-up on outside practice or homework. Briefly explore barriers to completion of outside practice and possible solutions (as necessary).

4. Introduce the new material and answer questions

4.1. Pain thoughts

- Briefly review the concepts presented in the previous module with the help of the **Pain Thoughts** handout.
- Key areas to review, as needed, include 1) common pain thoughts, 2) examples of unhelpful thoughts, and 3) examples of helpful thoughts.

4.2. Recognizing and challenging unhelpful thoughts

- Use the **Catching ANTs** handout to begin the process of challenging or modifying unhelpful thoughts.

4.3. Coping statements

- Use **Coping Statements** handout to help the Veteran 1) become familiar with positive coping statements, and 2) chose statements that may be effective for them.

5. Discuss new home practice opportunity

- Stress the importance of completing as many examples as possible on the **Catching ANTs** worksheet, including circling whether the thought had a helpful/positive or unhelpful/negative influence and creation of a more balanced and accurate cognition.
- Ask the Veteran to identify several coping statements that they find calming and reassuring which can be used before the next module.

6. Session wrap-up

- Provide a concise summary of key points and emphasize the value of home practice.

6. BRIEF CBT-CP MODULE 6: THE PAIN ACTION PLAN

This is the final module that focuses on relapse prevention. While functioning, mood, and pain intensity have likely improved, chronic pain remains a part of daily life and pain flare-ups are expected in the future. This module focuses on developing a plan for implementing the skills from prior modules. This appointment should also include making appropriate referrals as indicated should additional treatment be warranted.

6.1 Module Agenda

1. Introduce the module and confirm the agenda
2. Ask about mood, complete the PEG, and discuss findings
3. Review material from the previous module, including home practice
4. Review all progress/obstacles to date and develop a plan for future pain management
5. Discuss new home practice opportunity
6. Module wrap-up

6.2 Module Materials

- PEG self-report measure
- Patient handouts (see appendix):
  - Anticipating Obstacles: Plan for Coping
  - Weekly Activities Schedule
  - SMART Goal Setting

6.3 Module Content for the Provider

1. Review of Progress

Begin the module by reminding Veterans of where they were when they entered treatment and how much progress they have made. Be specific in the feedback provided, as patients may have lost sight of their gains. Obtain feedback from Veterans about areas where they feel they have made the most progress and what has worked best for them.

Asking questions, such as the following, may facilitate discussion and help Veterans identify their own progress:

- *Have you become more active?*
- *Has your mood improved?*
- *Do you feel like your life is more fulfilling, even though you still have pain?*
- *Have you noticed a difference in your pain intensity?*
- *What about how you react to your pain?*
- *Have others commented on positive changes they have seen in you?*

Before examining the things that may get in the way of pain management in the future, it is important to reflect on what the Veteran has already accomplished as a means of motivation.

2. Anticipating Obstacles

The best way to prevent a relapse to previous poor functioning is to be prepared for pain exacerbations and difficult days. Planning ahead will make it easier to cope during challenging times. Discuss anticipated obstacles that are likely to arise in the future as well as how those issues will be addressed.

Use the **Anticipating Obstacles: Plan for Coping** worksheet to identify Veterans' triggers for pain increases.

Common triggers are:

- Emotional stress
- Weather changes
- Lack of sleep
- Sitting or standing "too long"

When completing the handout, encourage Veterans to be as specific as possible. For example, instead of listing "stress", define it further by listing the source of stress such as, "kids fighting with each other." Similarly, if there is a particular kind of weather that increases pain, identify "weather under 50 degrees." Find out how many minutes of sitting or standing is "too long." If the patient is unable to think of potential barriers, suggest barriers identified in prior sessions related to coping with pain or even completing the home practice assignments. While identifying triggers may be challenging, increasing attention to any emotional and physical signs that may indicate an imminent flare-up can be beneficial.

Once personal triggers are identified, determine the best approaches for coping. This process is an opportunity to review all the ways to manage pain that have been explored over the last five modules. Engage in a discussion about all of the Brief CBT-CP techniques, from the role of pacing, to relaxation exercise, to monitoring and modifying pain-related thoughts. Reviewing options for managing each specific stressor can help make the exercise more realistic and facilitate implementation.

3. Action Planning

Now Veterans are ready to develop a specific daily plan. Having a clear schedule helps patients feel more prepared for several reasons. First, it can assist in mitigating difficult situations and minimizing the triggers previously discussed. Second, it shows Veterans how to incorporate various positive coping techniques into their everyday lives. Third, creating a plan promotes a structured and purposeful approach to daily life, something that is valuable for everyone.

Working through a plan will help reveal how all of the pieces fit together and increase confidence moving forward.

Using the **Weekly Activities Schedule** collaborate with Veterans to develop a schedule of activities for a typical week in their words. If they prefer to use their electronic device for the schedule, then defer to their preference. Ask about specific behaviors that they want to avoid and use these to develop items for the schedule that will combat maladaptive habits. For example, if someone wants to avoid isolating from others, perhaps "Meeting my friend John for coffee" can be scheduled for every Tuesday morning, and encourage Veteran to include where they will meet. Noting specific distractions to help keep the Veterans' minds occupied such as "garden (if nice weather)/puzzles (if bad weather)" or "play catch with my dog" will help create a concrete plan for the future. It is important that the schedule is realistic, since setting unreasonable plans will only make self-disappointment more likely if goals are not achieved. Rewarding oneself for engaging in all scheduled activities for one week may be another incentive to stay the course.

In all settings, but especially in primary care, it is critical to identify future needs and place referrals as indicated. For example, if the work thus far with Brief CBT-CP has been helpful but there is still significant progress to be made, perhaps a consult to pain psychology or a behavioral medicine specialist for continued services (such as group or individual treatment) may be in order. If the Veteran has increased activities and would be aided by participation in a rehabilitation modality, such as physical or aquatic therapy, these options should be discussed. Similarly, if in the course of treatment other more general mental health needs have emerged, consider connecting the patient to additional mental health services, such as psychiatry or a therapist in the mental health clinic.

4. Goals

The final task in session is to explore goals for the future. There may be accomplishments made in recent weeks that can be expanded or new ideas that the Veteran now feels comfortable considering. For example, if the patient has largely overcome a fear of movement, they may want to incorporate bicycling or another adapted sport into their routine. If negative cognitions have kept Veterans from considering dating, they may now feel confident enough to begin exploring ways to meet others. Discuss what the individual Veteran is motivated to accomplish in the future and tailor goals to meet specific interests and needs.

5. Practice

Provide positive feedback about all that has been accomplished so that Veterans leave feeling supported and confident. Assure them that even if obstacles or setbacks are encountered, they now have foundational tools necessary to manage their chronic pain.

Brief CBT-CP Module 6 Therapist Guide: The Pain Action Plan

Note to provider: Scripted statements are provided below as suggestions, rather than rules, of how to introduce topics to patients. Scripting can be especially helpful for those providers who are new to the content of Brief CBT-CP. Feel free to modify the scripting as needed as you become more comfortable with core elements of each module.

1. Introduce the module and confirm the agenda

Scripting includes*:*

1. *"Today is our final appointment for addressing chronic pain as part of Brief CBT for chronic pain. Today we will review the progress we've made over the last several modules and think about next steps. It's important that we take some time to look back on what we've learned to both consider the progress we've made as well as plan for how to continue to use the skills learned in the future.*

3. *"First, I will ask you to complete our usual measure about your pain and functioning so we can continue to track your progress. Next, I would like to do some follow-up from our last module, then move into our final topic about planning for the future. How does that sound to you? Are there other things relevant to our pain work that you want to be sure to cover today?"*

Note to provider: If the patient is inclined to add items to the agenda that are not related to pain management, the first effort on behalf of the therapist may be to link the topic back to pain. For example, a statement such as the following may be helpful to refocus the patient: "That sounds like it was stressful. Did you notice that your pain worsened during that time?"

2. Ask about mood, complete the PEG, and discuss findings

Scripting includes:

1. *"First off, how are you feeling today and how has your mood been?"*
2. *"I would like you to complete this brief measure, the PEG, again today to help with tracking your progress. After you complete it, we'll review the results."*

Note to provider: After the patient completes the measures, review the score of the PEG with patient in comparison to baseline to identify any areas of significant concern/distress. As this is the final module of this treatment protocol, it is also an excellent time to compare current

ratings to baseline ratings to draw some summary conclusions about progress made or areas to address in next steps.

3. Review material from the previous module

Note to provider: The key purpose of reviewing prior module's content is to 1) answer questions/concerns about the topics and skills addressed, and 2) follow-up on home practice for addressing skill acquisition and clarifying content.

Scripting includes**:**

3. *"Before we get started on new material, do you have any questions about what we covered last time?"*

4. *"Last time we discussed <previous topic> which included some outside practice for you to complete. Do you have your practice work from last time?"*

Note to provider: It's not uncommon for patients to have not completed their home practice. It is therefore important to briefly explore barriers to completion and re-state the importance of home practice for developing and strengthening CBT skill development.

4. Introduce the new material and answer questions

4.1. Review of progress

It is important to first emphasize substantive gains in functioning or mood that have occurred during the course of treatment. Identifying improvement (or stabilization) is accomplished in part by reviewing the change in patient measures, particularly from baseline to current status. If the patient is unable to spontaneously identify areas of improvement, asking open-ended questions may help guide them through likely areas that have improved.

Scripting includes:

1. *"I'd like to start by identifying either symptoms or larger areas of life that might have improved during the course of this treatment. Thinking back to when we first started Brief CBT for chronic pain, what changes have you seen in your life related to chronic pain?"*

2. *"One way to help identify areas of change is to take another look at the information you reported in the measures we completed at the beginning of each module. When we compare your score on the PEG, it looks like there's a trend for improved functioning in everyday activities over the course of this treatment. Have you noticed that you've been*

more active or better able to engage in routines? How has that impacted other areas of your life?"

3. *"Tell me about ways that you have become more active."*

4. *"Have you noticed any difference in your pain intensity or frequency? How has it changed? Do you respond to pain differently now?*

5. *"Have others commented on positive changes they've seen in you?"*

Key Point: Identify progress first (and before addressing barriers to progress) to bolster motivation and acknowledge the results of the patient's efforts to use CBT skills.

4.2. Anticipating obstacles

Having identified areas of growth or improvement, there are likely still areas that may need attention in the future should they arise again. Use the **Anticipating Obstacles** worksheet to identify triggers for pain and appropriate responses.

Explain that now is good time to plan for how skills learned in this treatment can be applied in the future when triggers for pain are present.

Scripting includes:

1. *"One of the best ways to help maintain our progress (or continue to move toward achieving our goals) is to take a moment to think about likely situations or other triggers that might bring on a difficult pain episode. By thinking of these triggers now, we might be able to avoid some difficult situations or match the coping skills that we've learned to the area of concern. Planning ahead may help us feel more confident in our ability to manage pain the future."*

2. *"Sometimes it's difficult to identify very specific triggers for pain. As a rule of thumb, consider times when your emotions, thoughts, or physical sensations may be hinting that a pain flare-up is close. Do you recall our last conversation when you found that _____ was a trigger for your pain? Of the skills that we've talk about in our modules, which was the most effective?"*

Key Point: As a chronic condition, pain will need to be managed well into the future. Planning ahead provides the opportunity for the patient to identify the most likely predictors of future pain episodes and matching the CBT skill to that situation that they have found to be most effective.

4.3. Action planning

Use the **Weekly Activities Schedule** to schedule important activities over a typical week. This process helps minimize the impact of triggers, ensures meaningful goals/activities are attended to, and adds structure and beneficial routines to otherwise unstructured time.

Scripting includes:

1. *"There are several benefits to developing this typical weekly schedule. For one, adding structure to our weeks can help with pacing, making sure we avoid inactivity or overactivity. By planning ahead, we are most likely to make sure that the activities or routines that are most important to us are really part of our day. This is also a great way to find time in the week to practice some prevention, such as using relaxation skills, to keep our stress and muscle tension levels down."*

2. *"Let's be sure to be as realistic as possible as we develop this plan. We can include obligations as well as pleasurable events. For example, we can include both your hours required at your part-time job, as well as the time you want to spend with your social club."*

In addition to completing the **Weekly Activities Schedule**, the final module is a time to make a determination if additional services are warranted. If the patient is requesting additional services, consider if these are best addressed by you or another provider. The options are potentially many depending on the needs of the patient and resources available in your clinic and health care system. Some patients may require additional psychosocial interventions for pain management in settings, such as pain clinics, that allow for longer treatment protocols. Other patients may benefit from additional services such as physical therapy, nutrition counseling, or specialty mental health.

Key Point: Weekly activity planning is an important final step of this treatment. Scheduling ensures that patient-identified goals and preferences are clearly included in future activities and routines.

Key Point: Concluding Brief CBT-CP is a highly personalized process in which additional referrals (e.g., more intensive pain management services, mental health, or other rehabilitation-focused services) should be considered based on patient need and local resources.

4.4. Future goals

Following weekly activity scheduling, it is valuable to briefly consider future long-term goals that are potentially feasible now that CBT skills have been introduced. Although the weekly scheduling will address a number of routine activities, discussing long-term goals once again can offer an opportunity to further enhance motivation for the patient to engage in additional realistic goals to achieve. Use the **SMART Goal Setting** handout to write down the short and long-term goals identified. The patient's short-term goals might have changed from the

beginning of treatment, which could indicate progress that can be emphasized. Provide encouragement for continuing long term goals after treatment ends.

Scripting includes*:*

1. *"Now that we've taken a look at what your typical weekly schedule will look like, it's also a good time to consider future goals. You've made progress in your pain management, so what other goals for the future should we discuss briefly? Let's write them down using the **SMART Goal Setting** handout. For example, early on in our modules we discussed that you had to quit the softball league because of your chronic pain. Now that you've made progress in addressing activity pacing and identifying triggers for flare-ups, maybe there's a way to return to playing softball or helping out with coaching."*

5. Discuss new home practice opportunity

Although it is very helpful to acknowledge the patient's progress throughout the course of treatment, it is especially important to provide positive feedback about small and large gains. This time is also good for reminding patients that they can continue to master their skills with additional practice, even when faced with setbacks.

The patient should complete (and continue to modify as needed) the **Anticipating Obstacles**: **Plan for Coping** and the **Weekly Activities Schedule** for application in the future.

Scripting includes:

1. *"Today we've discussed the importance of continued practice of the skills discussed over the course of our time together. We've identified the techniques that have worked best for you (or identified those in need of additional practice) as well as a plan for how to use those skills into the future. Be sure to keep the materials provided in these modules readily available as they can be an ongoing resource well into the future. I recommend that you come back to the worksheets we completed today to update and revise your goals as you move forward (or complete any unaddressed worksheet items at home). Returning to these worksheets from time-to-time can be a good 'tune-up' or reminder of how to practice these skills."*

6. Module wrap-up

This module emphasized progress made and the need for continued application of these skills into the future. It allowed time to arrange for any additional pain (or related) services that could not be addressed by Brief CBT-CP. This is also the perfect time to add any additional personal messages to the patient that acknowledges the value of their efforts, end of the focused therapeutic interaction, as well as options (pending how services are delivered at your site) for re-engaging with you as necessary.

Scripting includes:

1. *"As the final module of Brief CBT-CP, we review the progress you've made over the course of treatment. We started a few new worksheets that will be important for you to complete outside of this module because they will act as a guide for putting the skills into practice on daily basis. We also identified that it would be helpful to try a course of physical therapy to promote physical fitness. We've arranged for that service through your primary care provider. Finally, this is an opportunity for me to express my appreciation for the opportunity to work with you over this course of treatment as well as the service you have provided to our country."*

Brief CBT-CP Module 6 Outline: The Pain Action Plan

1. Introduce the module and confirm the agenda

2. Ask about mood, complete the PEG, and discuss findings

3. Review previous module

- Review the prior module's content to 1) answer questions/concerns about the topics and skills addressed, and 2) follow-up on outside practice or homework. Briefly explore barriers to completion of outside practice and possible solutions (as necessary).

4. Introduce the new material and answer questions

4.1. Review of progress

- First emphasize substantive gains in functioning or mood that have occurred during the course of treatment. Review the change in the PEG, particularly from baseline to current status.

4.2. Anticipating obstacles

- Use the **Anticipating Obstacles: Plan for Coping** to identify triggers for pain and appropriate responses.
- Explain that now is good time to plan for how skills learned in this treatment can be applied in the future when triggers for pain are present.

4.3. Action planning

- Use the **Weekly Activities** worksheet to schedule important activities over a typical week.
- This module is a time to make a determination if additional services (from you or another provider) are warranted.

4.4. Future goals

- Briefly consider future short and long-term goals using the **SMART Goal Setting** handout to write down the short and long-term goals identified.

5. Discuss new home practice opportunity

- The patient should complete (and continue to modify as needed) the **Anticipating Obstacles: Plan for Coping** and the **Weekly Activities w**orksheet.

6. Session wrap-up

- In addition to providing a general summary, add an additional personal message to the patient that acknowledges the value of their efforts, end of the focused therapeutic interaction, as well as options for re-engaging with you as necessary in the future (pending how services are delivered at your site).

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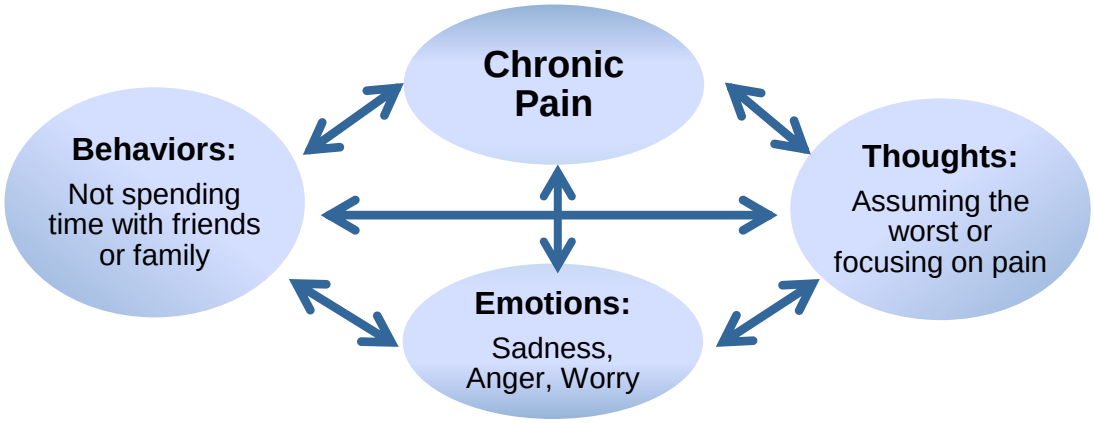
Appendix 1:
Patient Handouts

Module 1 Patient Handouts: Education and Goal Identification

Brief Cognitive Behavioral Therapy for Chronic Pain

This treatment focuses on how you think, feel, and behave in relation to your pain. As shown in the picture below, these things are all related:



For example, chronic pain could lead to:

- Thoughts like, "I'm never going to feel better"
- Avoiding activities, even ones that you enjoy
- Feeling sad, angry, or worried

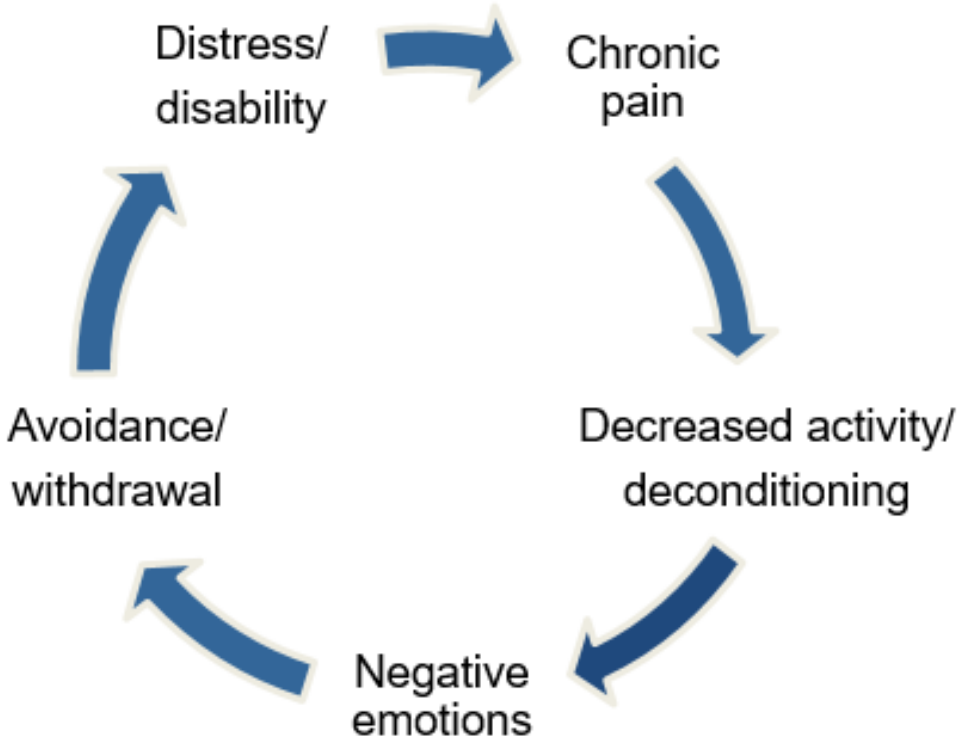
The goal of this treatment is to help you address these common reactions to chronic pain so that you feel more confident in your ability to do things you enjoy and live a full and meaningful life despite having pain.

Treatment Goals

- Learn new strategies to cope with pain
- Improve your physical and emotional functioning
- Decrease how often you experience flare-ups as well as how much they impact you
- Reduce the intensity of your pain

The Chronic Pain Cycle

Many people with chronic pain fear that movement will increase pain or cause physical damage/injury. This fear often leads a decrease in activities which then leads to physical deconditioning (e.g., less strength and stamina, weight gain). Dealing with constant pain may also lead to negative thoughts and emotions such as frustration and depression. **All of these factors contribute to increased avoidance of people and activities.**



THE COSTS OF INACTIVITY

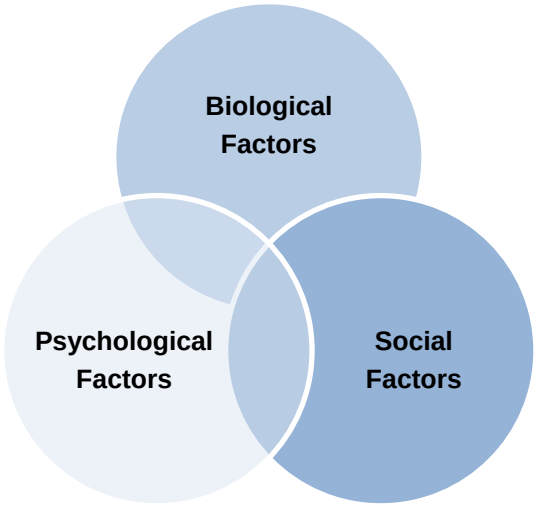
While this cycle is understandable for those with chronic pain, *it is not helpful!* In fact, getting stuck in this cycle actually makes things worse over time:

- More pain
- Poor physical fitness
- Less time with family and friends
- Depressed mood or increased irritability
- Lower self-esteem
- Increased strain on relationships
- Decreased quality of life

Factors That Impact Pain

Chronic pain is impacted by many factors. The interactions among these factors (shown below) influence how you feel overall:

1. **Biological factors**
   - Pain, medical issues
2. **Psychological factors**
   - Emotions, attention, thoughts
3. **Social factors**
   - Relationships, job, hobbies



The good news is that while some factors may increase your pain, others may decrease it. *You can decide how to manage many of these factors*.

Below are just a few examples of factors that may impact your pain:

Factors That May Increase Pain	Factors That May Decrease Pain
Physical Factors	
Illness or new injuries	Seeking medical treatments
Muscle tension	Using relaxation techniques
Thoughts	
Expecting the worst	Balancing positive and negative thinking
Focusing on pain	Distracting yourself
Emotions	
Depression or anger	Appropriate emotional expression, seeking social support, engaging in pleasant activities

Factors That May Increase Pain	Factors That May Decrease Pain
Stress/worry/anxiety	Exercising safely and using relaxation techniques
Behaviors	
Too much (*or too little*) activity	Pacing yourself
Lack of involvement in hobbies	Doing more of what you enjoy
Social Interactions	
Social isolation	Spending time with family and/or friends
Lack of (*or too much*) support from others	Volunteering/staying involved with community

What are some things that have helped make your experience with pain better?

1. _____

2. _____

3. _____

What are some things that have made your experience with pain worse?

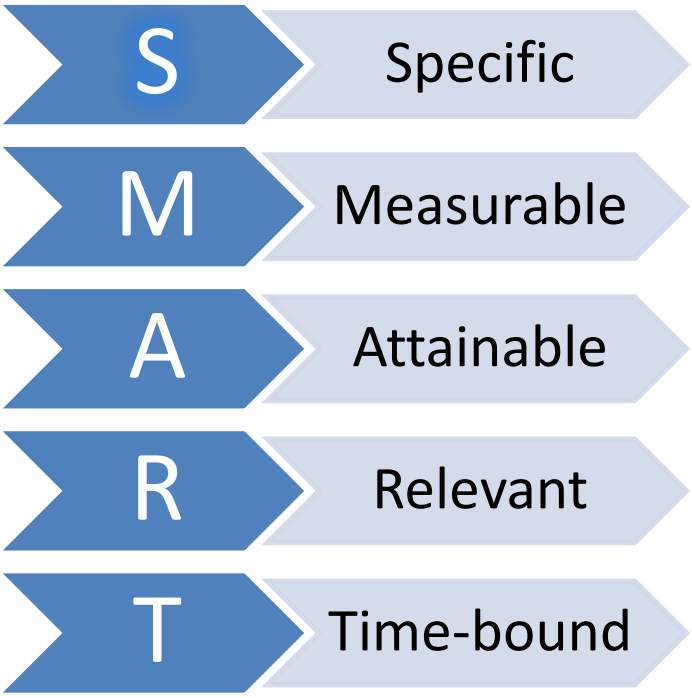
1. _____

2. _____

3. _____

SMART Goal Setting

A SMART goal uses the following guidelines:



Should identify a specific action or event that will take place. In other words, **"What specifically do I want to do?"**

Should be able to track progress. In other words, **"How will I know I have met my goal?"**

Should be attainable and realistic. In other words, **"Is this really something that I can do?"**

Should be personally meaningful and really matter. In other words, **"How important is this to me?"**

Should state the time period for accomplishing the goal. In other words, **"By when do I want to achieve this goal?"**

Adapted from Doran, 1981

SMART Goal Versus Non-SMART Goal

Non-SMART Goal: *I want to get into physical shape.*

SMART Goal: *I want to be more active by walking twice a week for 30 minutes for the next three months so that I can keep up with my grandchildren when I see them during the holidays.*

Non-SMART Goal: *I want to be more social.*

SMART Goal: *I want to go watch a movie and eat dinner with my friends once a week for the next three months so I spend less time alone while I manage my chronic pain.*

Short-term goals can be accomplished over the course of this treatment (about 3 months). For each goal, consider if it fits the SMART criteria listed above. These should be personally meaningful goals that motivate you to complete the program and improve your pain management skills. Once goals are identified, track them on a weekly basis to ensure that progress is occurring. If it is not, make adjustments as needed.

Short-Term Goals

In the space below, write down SMART goals you would like to achieve in the next three months.

1. _____

2. _____

3. _____

Accomplishing short-term goals keeps us motivated to achieve long-term goals. Long-term goals are those for the next 6–12 months (or even longer). They will not be accomplished fully during this program, but you can continue to work towards them using the skills you have developed.

Long-Term Goals

In the space below, write down SMART goals you would like to achieve in the next 6 –12 months.

1. _____

2. _____

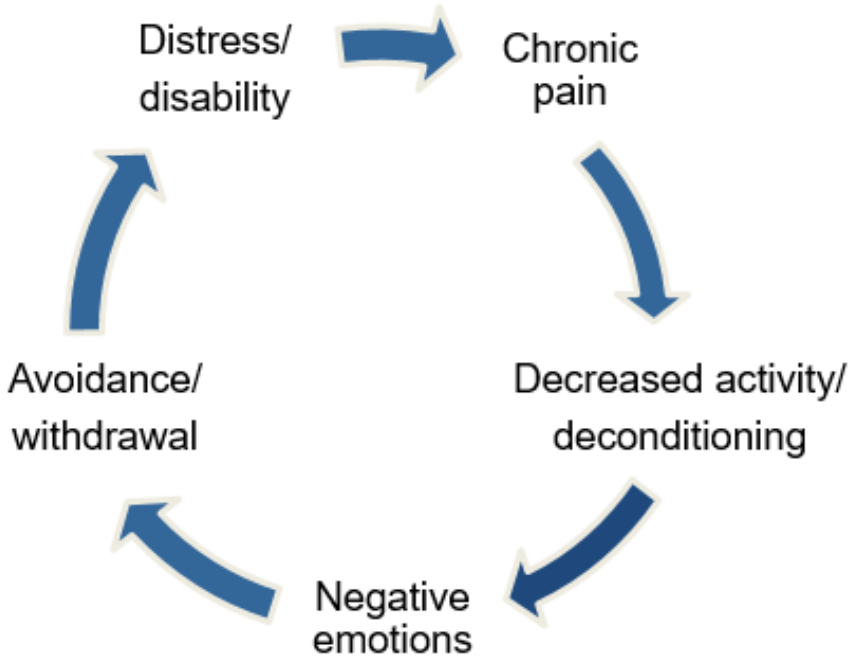
3. _____

Module 2 Patient Handouts:

Activities and Pacing

The Chronic Pain Cycle

Many people with chronic pain fear that movement will increase pain or cause physical damage/injury. This fear often leads a decrease in activities which then leads to physical deconditioning (e.g., less strength and stamina, weight gain). Dealing with constant pain may also lead to negative thoughts and emotions such as frustration and depression. **All of these factors contribute to increased avoidance of people and activities.**



THE COSTS OF INACTIVITY

While this cycle is understandable for those with chronic pain, *it is not helpful!* In fact, getting stuck in this cycle actually makes things worse over time:

- More pain
- Poor physical fitness
- Less time with family and friends
- Depressed mood or increased irritability
- Lower self-esteem
- Increased strain on relationships
- Decreased quality of life

Pleasant Activities List

Try different activities to distract yourself from pain and improve your mood. Which of the following are activities that have helped you feel better in the past or are some new things that you would like to try? Check off any that apply!

- ☐ Go fishing
- ☐ Text, email, or call friends/family
- ☐ Get your hair cut or nails done
- ☐ Take a walk, exercise, or stretch
- ☐ Do yard work or gardening
- ☐ Read a book or magazine
- ☐ Watch or participate in sports
- ☐ Go to the park
- ☐ Organize
- ☐ Woodwork
- ☐ Surf the internet
- ☐ Look into classes you'd like to take
- ☐ Plan a trip
- ☐ Draw or paint
- ☐ Walk your dog/play with your pet
- ☐ Listen to music
- ☐ Watch a movie or your favorite show
- ☐ Take or edit pictures
- ☐ Repair or fix something
- ☐ Start or finish a project
- ☐ Go to the pool or beach
- ☐ Plan something nice for others
- ☐ Go for a drive
- ☐ Decorate or re-arrange your home
- ☐ Knit or sew
- ☐ Sing or play an instrument
- ☐ Do hobbies (e.g., building models)
- ☐ Visit with family or friends
- ☐ Enjoy a hot bath or shower
- ☐ Chat with your neighbor
- ☐ Write or journal
- ☐ Play games or do puzzles
- ☐ Go shopping
- ☐ Meditate or pray
- ☐ Other activities/ideas?

  _____

  _____

Adapted with permission from K.M. Phillips, Ph.D.

Pleasant Activities Schedule

List some activities that you enjoy doing:

1. _____

2. _____

3. _____

4. _____

Choose *at least two* pleasant activities that can be scheduled over the course of the week and write them on your personalized pleasant activity schedule on the next page.

Place an "X" to schedule your pleasant activity (example shown below).

Activity	Sun	Mon	Tues	Wed	Thu	Fri	Sat
Gardening		**X**		**X**		**X**	

Circle the "X" when completed (example shown below).

Activity	Sun	Mon	Tues	Wed	Thu	Fri	Sat
Gardening		**X**		**X**		**X**	

Pleasant Activities Schedule, continued

Now **schedule your own pleasant activities**. The example from above is shown in the shaded area.

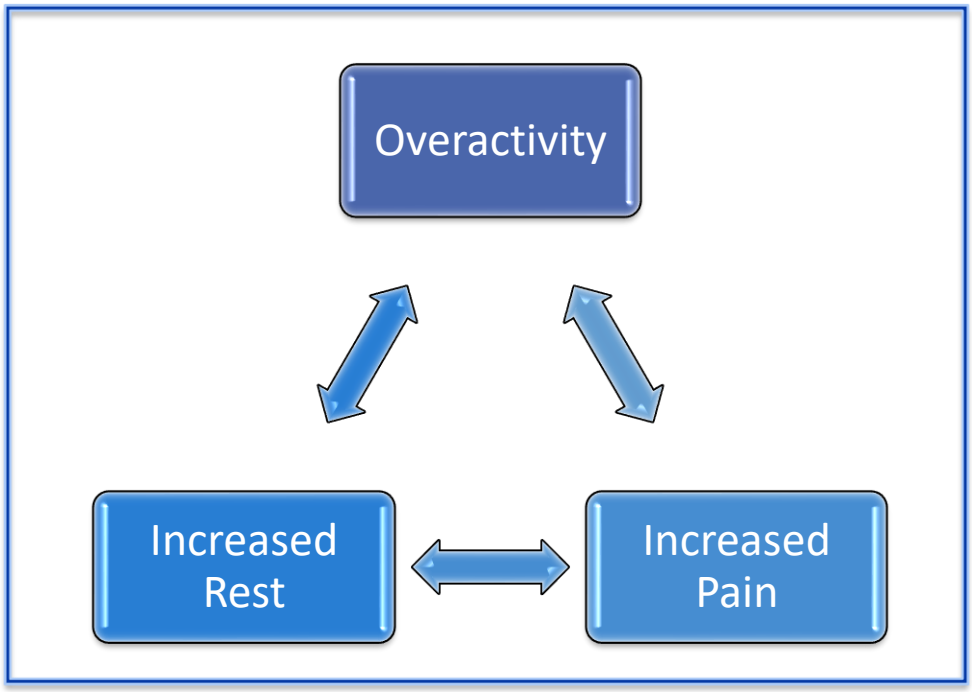
Activity	Sun	Mon	Tues	Wed	Thu	Fri	Sat
Gardening		**X**		**X**		**X**	

Remember to not overdo it when engaging in activities! This is an important concept that will be discussed in more detail later.

Pacing Activities

Some people with chronic pain may be fearful about harming themselves and avoid activity altogether. Others are prone to pushing through pain on a “good pain day” to accomplish a strenuous task and will not stop until it is complete. The next day, they wake up with a pain flare-up and must rest for a day or more to recover!

The example above describes the **Overactivity Cycle.** If the Overactivity Cycle happens on a recurring basis, it can lead to negative consequences such as increased stress and anxiety, decreased efficiency, lowered self-esteem, and avoidance of any activity.



Engaging in a moderate, safe level of activity on a regular basis helps you avoid this cycle of being underactive or overactive. Using the skill of pacing, where time is the guide for activity engagement, can be a helpful strategy. Pacing is about balancing activities, planning ahead, and working “smarter not harder.”

How to Pace

1. Estimate how long you can safely do one of your regular activities (e.g., yardwork, dishes) without causing a severe pain flare-up.
2. Set the length of time you’ve chosen minus one minute as your "active" goal time for the activity.
3. Approximate the amount of "resting" time you will need in order to safely resume activity or continue your day.

Pacing Activities, continued

Remember

You might discover that the amount of time you can stay active may need adjusting after you practice pacing for the first time. It is important to stick with the time-based pacing goals, even if you are having a "good" or "bad" pain day. Sticking to the pacing schedule prevents you from getting stuck in the overactivity or inactivity cycle.

Spread out activities during the week and be reasonable with the schedule so you can succeed.

Use the table on the next page to record how you pace activities this week. Use the sample below as your guide where each period of activity and rest equals one cycle.

Examples

In the first example, **one cycle of pacing** was completed on Day 1 (*working* for 10 minutes and *resting* for 15 minutes). **Two cycles of pacing** were completed on Day 2 (*working* for 10 minutes and *resting* for 15 minutes).

Activity 1: Gardening

	Active Goal (Minutes)	Rest Goal (Minutes)	Number of Cycles
Day 1	10	15	1
Day 2	10	15	2

Activity 2: Washing dishes

	Active Goal (Minutes)	Rest Goal (Minutes)	Number of Cycles
Day 1	15	10	1
Day 2	15	10	2

Pacing Activities, continued

Schedule Your Own Activity 1: _____

	Active Goal (Minutes)	Rest Goal (Minutes)	Number of Cycles
Day 1			
Day 2			
Day 3			
Day 4			
Day 5			
Day 6			
Day 7			

Schedule Your Own Activity 2: _____

	Active Goal (Minutes)	Rest Goal (Minutes)	Number of Cycles
Day 1			
Day 2			
Day 3			
Day 4			
Day 5			
Day 6			
Day 7			

Module 3 Patient Handouts:

Relaxation Training

Relaxation: Benefits & Tips

The goal of relaxation is to reduce the effects of stress on your health. Since chronic pain produces chronic stress on the body, it is important to regularly practice relaxation techniques that can help your mind and body recover. Relaxation is more than resting or enjoying a hobby – it involves using specific strategies to reduce tension.

Benefits of Relaxation

Relaxation is important for good health. When you are relaxed, your muscles are loose, your heart rate is normal, and your breathing is slow and deep. Learning how to relax can help especially when you feel pain. Relaxation prompts your body to release chemicals that reduce pain and produce a sense of well-being.

Relaxation won't cure pain or other chronic symptoms, but skills that relax the body and the mind may help decrease muscle tension, prevent muscle spasms, and relieve the stress that can aggravate pain and other symptoms.

Taking time to relax and refuel your energy provides benefits such as:

- Improved mood
- Increased energy and productivity
- Improved concentration and focus
- Improved sense of control over stress and daily demands
- Improved nighttime sleep
- Increased self-confidence
- Greater ability to handle problems
- Decreased anxiety and other negative emotions such as anger and frustration
- Increased blood flow to muscles and reduced muscle tension
- Lower blood pressure, breathing rate, and heart rate
- Decreased pain, such as headaches and back pain

Relaxation Practice Tips

Relaxation is a skill that requires practice. You may not feel the benefits immediately, so don't give up! Remain patient and motivated and you'll reduce the negative impacts of stress. And remember: If relaxation feels foreign or unnatural, that likely means you are a person who needs it most!

Establish a routine

1. Set aside time to practice relaxation at least once or twice a day. Pairing relaxation with a regular activity may help you remember to practice (for example, take ten relaxed breaths before bed or whenever you sit down to eat).

2. Practice at various times throughout the day until relaxation becomes natural and you can use it readily when you feel stressed. You may want to leave "reminders" for yourself to relax (for example, sticky notes on the bathroom mirror, kitchen cabinets, or car dashboard with the words "relax" or "breathe").

Be comfortable

1. Practice on a comfortable chair, sofa, mat, or bed. Dim the lights.

2. Loosen tight clothing and remove shoes, belt, glasses or contact lenses, if you like.

Concentrate

1. Eliminate disruptions. Turn off the TV, radio, or telephone.

2. Practice in a quiet, calm environment.

3. Close your eyes to reduce distractions and improve concentration. If you prefer, keep your eyes open and focus on one spot.

4. Move your body as little as possible, changing positions only for comfort. Don't worry if you have some distracting thoughts—it happens to everyone. Just notice that your thoughts have wandered and then gently, without judgment, return your attention to your breath.

Relax

1. Begin and end relaxation practices with relaxed breathing techniques.

2. Use a relaxation CD if it helps. Gradually, learn to relax without a CD so that you can use relaxation techniques anywhere.

3. Let relaxation proceed naturally and spread throughout your body. Do not try to resist.

Be patient

1. Give yourself time to learn relaxation skills. Practice is required for these techniques to become automatic.

2. Try not to become upset if you have trouble concentrating. A wandering mind is normal and expected. Keep bringing your attention back to your breath.

3. Don't worry about how well you are practicing.

4. After a few weeks, select a word, such as "calm," "relax," “peace," or “patience” that you can say during relaxation practices. Eventually, simply saying that word may help you relax.

Incorporate relaxation into daily life

1. Over time, move relaxation practices from planned, quiet settings to "real life." The goal is to be able to calm yourself when necessary, no matter where you are.

2. Use relaxation whenever you notice yourself feeling stressed or anxious, such as waiting in line, at a doctor’s appointment, or during a difficult meeting.

Deep Breathing Training

1. Start by becoming aware of your breathing. Place one hand on your abdomen at the waistline just over the bellybutton and the other hand on the center of your chest. Without trying to change anything, simply notice how you are breathing. Notice *where* you are breathing from, whether your shoulders are rising and falling, whether your chest is rising and falling, or perhaps whether your belly is rising and falling. Notice how your hands move as you breathe. Pay attention to whether one hand is moving more than the other. **(PAUSE 5 seconds)**

2. Now notice the rate of your breathing. Pay attention to whether you are breathing rapidly or slowly. Your breathing may be deep or shallow. **(PAUSE 5 seconds)**

3. Now as you slowly inhale, imagine the air flowing deeper into your belly. Feel your belly fill with air as your lower hand rises. Pause briefly at the top of your breath, and then follow your breath out as you completely exhale. Slowly take a breath in…two, three, four, and slowly exhale…two, three, four. Let any tension melt away as you relax more deeply with each breath. **(PAUSE 5 seconds)**

4. Notice the feeling of cool fresh air entering through your nose, through your nasal passage, to the back of your throat, and descends deep into your lungs. Notice what happens as you are inhaling… and then exhaling... Feel the temperature of each breath cool as you inhale, and warm as you exhale. Count your breaths as you breathe in and out. **(PAUSE 10 seconds)**

5. Notice your breath becoming smooth and slow. Feel your belly and ribcage expand outward with each breath. Feel yourself become more relaxed with each exhale. Allow your shoulders to become heavier with each exhale. **(PAUSE 15 seconds)**

6. Continue breathing slowly and gently. **(PAUSE 15 seconds)**

7. Again, slowly take a breath in…two, three, four, and slowly exhale…two, three, four. Feel yourself become more and more relaxed with each exhale. **(PAUSE 15 seconds)**

8. Continue breathing slowly and gently. **(PAUSE 15 seconds)**

9. Now, as I count from five to one, feel yourself become more alert. Five…bringing your attention to this room. Four…feeling calm and relaxed. Three…start to wiggle your fingers and toes. Two…slowly start to move and stretch your muscles. One…open your eyes, feeling refreshed.

Progressive Muscle Relaxation

Noticing the difference between tensed and relaxed muscles is important. This skill reduces anxiety by promoting relaxation and helps you to recognize when your body is tense. In order to master this skill, you will be asked to tense certain muscle groups as hard as you can without hurting yourself. After 5 seconds of holding the tension, you will be instructed to relax your muscles and release the tension.

1. Tense your **lower arms** by making fists with your hands and pulling your fists up by bending your wrists. Focus on the tension. **(PAUSE 5 seconds)**

2. Now release the tension. Let your hands and lower arms relax onto the chair or bed beside you. Feel the release from tension as you relax the muscles fully. **(PAUSE 10 seconds)**

3. Create tension in the **upper arms** by pulling the arms back and in toward your sides. Feel the tension in the back of the arms and radiating towards the shoulders and into the back. Focus on the tension and hold. **(PAUSE 5 seconds)**

4. Now, release the arms and let them relax – almost feeling heavy at your sides. Notice the difference between the previous tension and the new feelings of relaxation. Your arms might feel heavy, warm, and relaxed. **(PAUSE 10 seconds)**

5. Now bring your attention to your **lower legs**. Build tension by extending your legs in front of you and pointing your toes toward your upper body. Feel the tension as it spreads through your feet, ankles, shins, and calves. Hold this tension. **(PAUSE 5 seconds)**

6. Release all of the tension in your lower legs. Let your legs relax onto the chair or bed. Feel the difference in these muscles as they relax. Feel the release from tension, the sense of comfort, the heaviness of relaxation. **(PAUSE 10 seconds)**

Continue working through the various muscle groups, alternating between tension and release. Remember to feel the tightness when holding the tension, and to notice the difference between tension and relaxation upon release.

7. **Upper legs and buttocks**: Tense by pressing knees together and lifting legs slightly off the bed or chair. **(PAUSE 5 seconds).** Release tension by letting legs sink into chair or bed. **(PAUSE 10 seconds)**

8. **Abdomen**: Tense by pulling your abdomen in towards your spine. **(PAUSE 5 seconds).** Release tension by relaxing your abdomen to its normal position. **(PAUSE 10 seconds)**

9. **Chest**: Build tension in your chest by taking in a deep breath and holding it. **(PAUSE 3-5 seconds).** Release tension by slowly letting the air escape, and resume normal breathing, letting air flow in and out smoothly and easily. **(PAUSE 10 seconds)**

10. **Neck and shoulders**: Create tension by pulling your shoulder blades back and up towards your ears. **(PAUSE 5 seconds).** Release tension by letting your shoulders drop down, sinking further and further until they are completely relaxed. **(PAUSE 10 seconds)**

11. **Mouth, jaw, and throat**: Create tension by clenching your teeth and turning the corners of your mouth back into a forced smile. **(PAUSE 5 seconds).** Release the tension by letting your jaw drop down and relaxing the muscles around your throat and jaw. **(PAUSE 10 seconds)**

12. **Eyes and lower forehead:** Build tension by squeezing your eyes tightly shut and pulling your eyebrows down. **(PAUSE 5 seconds).** Now release all the tension in your eyes and lower forehead. **(PAUSE 10 seconds)**

13. Upper forehead and scalp: Build tension by raising your eyebrows as high as possible. Feel the wrinkling and pulling across the forehead and top of the head. **(PAUSE 5 seconds).** Now release all the tension in your forehead, letting the eyebrows gently rest down. **(PAUSE 10 seconds)**

Now, you will work towards a state of relaxation.

14. Your whole body is feeling relaxed and calm. Scan your body for any last bits of tension and if you notice any, let that tension go. Enjoy the feelings of relaxation. **(PAUSE 5 seconds)**

15. As I count from one to five, feel yourself become more and more relaxed. One…let all tension leave your body. Two…sink further and further into relaxation. Three…feel more and more relaxed. Four…feel very relaxed. Five…deeply relaxed. **(PAUSE 30 seconds)**

16. As you spend a few minutes in this relaxed state, think about your breathing. Feel the cool air as you breathe in and the warm air as you breathe out. Your breathing is smooth and regular. Every time you breathe out, think to yourself "relax, relax, relax." You are feeling comfortable and relaxed. **(PAUSE 1-3 seconds)**

17. Now, as I count from five to one, feel yourself become more alert. Five…bringing your attention to this room. Four…feeling calm and relaxed. Three…start to wiggle your fingers and toes. Two…slowly start to move and stretch your muscles. One…open your eyes, feeling refreshed and rejuvenated.

Relaxation Practice Record

Use the record below to chart your relaxation practice over time.

- **Before** you begin your practice, use the scale below to rate your level of tension.
- **After** you complete the practice, use the same scale again to rate your level of tension.
- Noting any differences will help you figure out if the exercises are helping you relax.

But remember, these exercises take practice and it might take several tries before you start to see results!

0	1	2	3	4	5	6	7	8	9	10
Extremely Tense		Slightly Tense		Slightly Relaxed			Very Relaxed		Totally Relaxed	

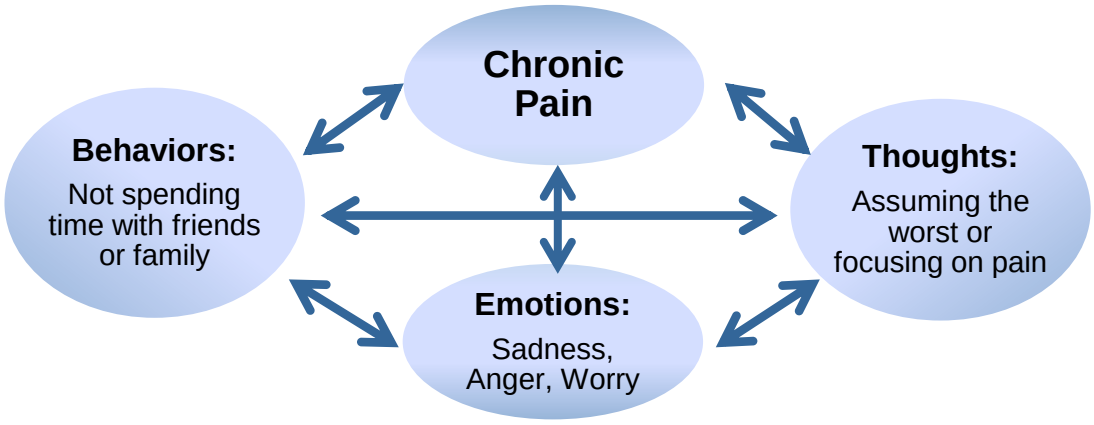
Date	How long did you practice? (minutes)	Level of tension before practice (0-10)	Level of tension after practice (0-10)	What did I notice?

Module 4 Patient Handouts:

Cognitive Coping 1

Brief Cognitive Behavioral Therapy for Chronic Pain

This treatment focuses on how you think, feel, and behave in relation to your pain. As shown in the picture below, these things are all related:



For example, chronic pain could lead to:

- Thoughts like, "I'm never going to feel better"
- Avoiding activities, even ones that you enjoy
- Feeling sad, angry, or worried

The goal of this treatment is to help you address these common reactions to chronic pain so that you feel more confident in your ability to do things you enjoy and live a full and meaningful life despite having pain.

Treatment Goals

- Learn new strategies to cope with pain
- Improve your physical and emotional functioning
- Decrease how often you experience flare-ups as well as how much they impact you
- Reduce the intensity of your pain

PAIN THOUGHTS:

Identifying and Replacing Thoughts That Are Not Helpful

Thinking about how much pain you are in does not help you cope with the pain. As pain increases, thoughts may become more negative; as thoughts become more negative, pain often increases further. Negative thoughts can lead to:

- **Worsening mood**
- **Avoiding activities**
- **Isolating/avoiding others**

***Although pain thoughts can be automatic, with practice you can become more aware when you have them*.** Then you can replace unhelpful thoughts with ones that are helpful. Here are some examples of unhelpful pain thoughts and some coping statements that you can use to replace them:

Common Pain Thoughts

Types of Unhelpful Thoughts	Examples of Unhelpful Thoughts	Examples of Helpful Thoughts
Catastrophizing **Believing something is the worst it could possibly be.**	*When my pain is bad, I can't do anything.*	*Even when my pain is bad, there are still some things I can do.*
Should Statements **Thinking in terms of how things should, must, or ought to be.**	*My doctor should be able to cure my pain.*	*There is no cure for chronic pain, but I can use skills to cope with my pain.*
All or None Thinking **Seeing things as "either or" or "right or wrong" instead of in terms of degrees.**	*I can only be happy if I am pain free.*	*Even if I am in pain, I can still be happy. There is always something that I can do to have a better quality of life.*

Types of Unhelpful Thoughts	Examples of Unhelpful Thoughts	Examples of Helpful Thoughts
Overgeneralization **Viewing one or two bad events as an endless pattern of defeat.**	*I tried doing exercises for my back pain before and it didn't help. So, it isn't going to help now.*	*Although physical therapy didn't help much before, maybe this time it will help. I might as well try.*
Jumping to Conclusions **Drawing negative conclusions of events that are not based on fact.**	*When I move my back hurts, so it must be bad for me to move.*	*Hurt does not equal harm.*
Emotional Reasoning **Believing how you feel reflects how things really are.**	*I feel useless, so I am useless.*	*Even though I can't do all the things I used to do, it doesn't mean I can't do anything.*
Disqualifying the Positive **Focusing on only the bad and discounting the good.**	*So what if I am doing more, I am still in pain.*	*Doing more is important for me to live the life I want to live.*

Used with permission from KM. Phillips, Ph.D.

CATCHING ANTs: How to Catch, Check, & Challenge Automatic Negative Thoughts

When we feel upset or angry, most often we also have negative thoughts. These thoughts may happen automatically and increase your pain and negative mood. **You can feel better physically and emotionally by "catching" ANTs when they occur, noticing how they make you feel, and challenging them with more balanced thoughts. Using the chart below, record *at least one* ANT each day. Evaluate the thought and generate a new helpful one.**

Day/Situation	Catch It! Identify ANT	Check It! Effect on your pain/mood	Challenge It! Positive/balanced coping statement
Tuesday/Cleaning garage and pain flares	*This pain is killing me. I can't do anything anymore.*	Helpful or (Unhelpful)	*I am hurting right now because I overdid it, but I know that I will feel better soon. Then I will pace myself to get the job done.*
		Helpful or Unhelpful	
		Helpful or Unhelpful	
		Helpful or Unhelpful	
		Helpful or Unhelpful	
		Helpful or Unhelpful	
		Helpful or Unhelpful	

Adapted with permission from S. Palyo, Ph.D. & J. McQuaid, Ph.D.

Module 5 Patient Handouts:

Cognitive Coping 2

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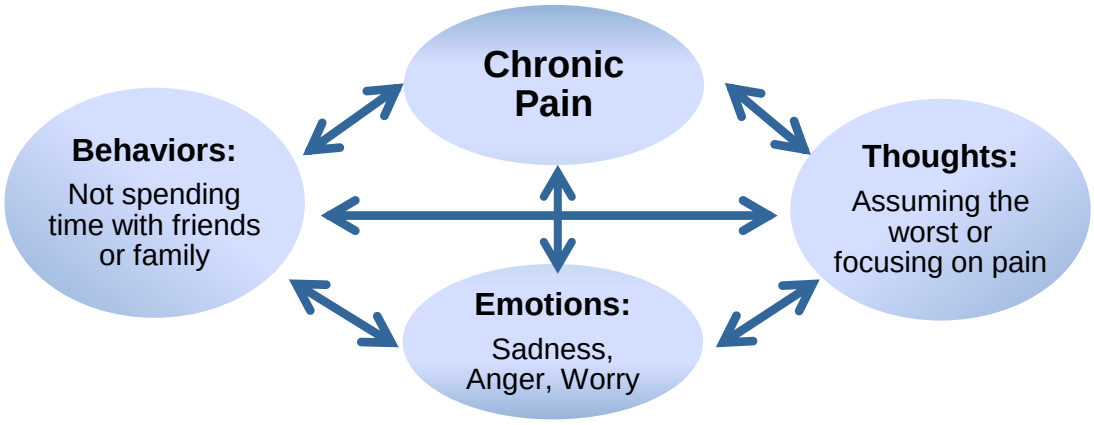
Brief Cognitive Behavioral Therapy for Chronic Pain

This treatment focuses on how you think, feel, and behave in relation to your pain. As shown in the picture below, these things are all related:



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- Avoiding activities, even ones that you enjoy
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Treatment Goals

- Learn new strategies to cope with pain
- Improve your physical and emotional functioning
- Decrease how often you experience flare-ups as well as how much they impact you
- Reduce the intensity of your pain

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		Helpful or Unhelpful	
		Helpful or Unhelpful	
		Helpful or Unhelpful	
		Helpful or Unhelpful	
		Helpful or Unhelpful	
		Helpful or Unhelpful	

Adapted with permission from S. Palyo, Ph.D. & J. McQuaid, Ph.D.

Coping Statements

Here are some statements that can be used to replace unhelpful thoughts. Put an "**X**" next to the ones that you think may be helpful for you. What things have you told yourself in the past to get through a pain flare or difficult situation? Add your helpful statements to the list.

X	Coping Statement Checklist
	The pain flare passes in a while.
	I can handle this. I just have to make it through this moment.
	I've gotten through it before and I can get through it again.
	I don't have to suffer. I have skills I can use to cope.
	What would I tell a friend who was in pain?
	How can I set a good example for my kids about coping with life's challenges?
	How would someone I admire cope with this?
	I just have to focus on something else.
	There may be no cure, but I can still live my life.
	I'm going to focus on what I *can* do, not what I can't do.

Adapted with permission from K.M. Phillips, Ph.D.

Remember: It's easy to think of positive statements when you're feeling okay. But, if you are in a bad mood or having a pain flare, it's more difficult. Keep a list of these or other helpful statements in a place where you can easily find them when you need them most (e.g., in your wallet, on your refrigerator, in your phone).

Module 6 Patient Handouts:

The Pain Action Plan

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Anticipating Obstacles: Plan for Coping

People have many challenging situations in their lives and it is expected that certain obstacles will arise. A difficult day may involve life stressors and increased pain symptoms. **The best time to plan for how you will cope with and manage your pain during one of these days is *now*.**

Below, identify the *specific* things in your life that may be triggers for pain flare-ups, as well as how you may cope with challenges using the skills that you have learned.

Potential Obstacles/Triggers/Stressors: *(Example: Kids fighting, Cold weather)*

1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

Ways to Cope: *(Example: Walking, Deep breathing, Pleasant activity)*

1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

Remember:

BE PREPARED! **Consider all the tools you have learned and do not undersell yourself or let automatic negative thoughts (ANTs) sabotage you**. Contact friends, family, and VA providers who are there to provide support as needed.

Weekly Activities Schedule

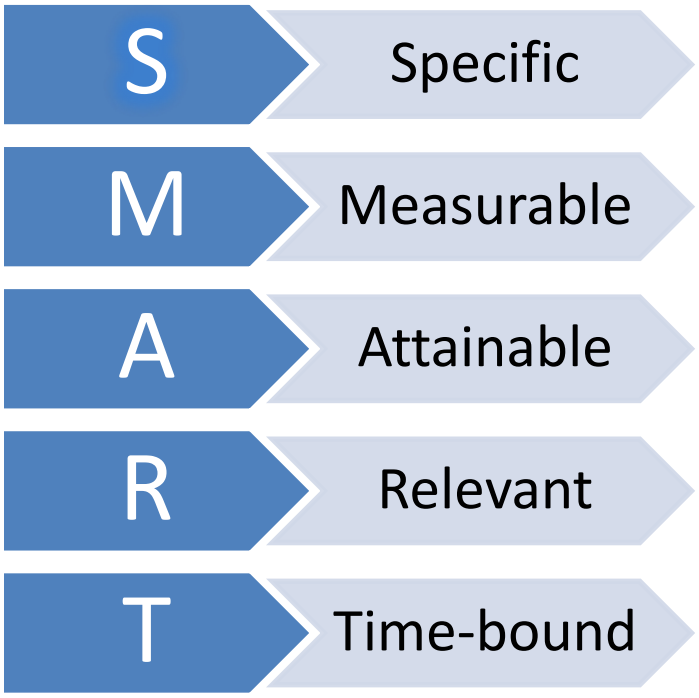
Use the schedule provided to plan your activities for the upcoming week. Be as specific as possible and include items such as doing the dishes as well as the pain management strategies you will employ regularly such as using relaxation techniques.

***Be realistic* in your planning so that you are able to follow the schedule.**

Time	Sun	Mon	Tues	Wed	Thurs	Fri	Sat
7:00 a.m.							
8:00							
9:00							
10:00							
11:00							
12:00 p.m.							
1:00							
2:00							
3:00							
4:00							
5:00							
Evening							

SMART Goal Setting

A SMART goal uses the following guidelines:



Should identify a specific action or event that will take place. In other words, **"What specifically do I want to do?"**

Should be able to track progress. In other words, **"How will I know I have met my goal?"**

Should be attainable and realistic given resources. In other words, **"Is this really something that I can do?"**

Should be personally meaningful and really matter. In other words, **"How important is this to me?"**

Should state the time period for accomplishing the goal. In other words, **"By when do I want to achieve this goal?"**

Adapted from Doran, 1981

SMART Goal Versus Non-SMART Goal

Non-SMART Goal: *I want to get into physical shape.*

SMART Goal: *I want to be more active by walking twice a week for 30 minutes for the next three months so that I can keep up with my grandchildren when I see them during the holidays.*

Non-SMART Goal: *I want to be more social.*

SMART Goal: *I want to go watch a movie and eat dinner with my friends once a week for the next three months so I spend less time alone while I manage my chronic pain.*

Short-term goals can be accomplished over the near future, or about 3 months from now. For each goal, consider if it fits the SMART criteria listed above. These should be personally meaningful goals that motivate you to complete the program and improve your pain management skills. Once goals are identified, track them on a weekly basis to ensure that progress is occurring. If it is not, make adjustments as needed.

Short-Term Goals

In the space below, write down SMART goals you would like to achieve in the next three months.

1. _____
2. _____
3. _____

Accomplishing short-term goals keeps us motivated to achieve long-term goals. Long-term goals are those for the next 6–12 months (or even longer). They will not be accomplished fully during this program, but you can continue to work towards them using the skills you have developed.

Long-Term Goals

In the space below, write down SMART goals you would like to achieve in the next 6–12 months.

1. _____
2. _____
3. _____

Appendix 2:
Pain Conditions

PAIN CONDITIONS

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

Low Back Pain. Low back pain (LBP or lumbago) is the most common form of pain and the most fiscally costly worldwide in terms of medical visits and loss of work productivity (Deyo & Weinstein, 2001). Most people with acute LBP recover in a matter of weeks, but for about 10% the pain will become chronic (Costa et al., 2012). Many individuals who experience chronic LBP report high levels of fear of movement and consequently are prone to deconditioning of the muscles leading to greater disability. LBP may be due to factors such as herniated discs, degenerative disc disease, spinal stenosis, or arthritis, but the vast majority of back pain is due to muscle strain (Deyo & Weinstein, 2001).

Middle and Upper Back Pain. Middle and upper back pain is less common than LBP because the bones in these areas do not move as often. As in the lower area of the back, pain is most often related to muscle sprain or overuse, herniated discs, or arthritic processes.

Neck Pain. Neck pain (i.e., cervicalgia) is a common issue with about 65% of the population experiencing it at some point in their lives. It is generally caused by activities that strain the neck such as poor posture or sleeping, muscle tightness, or whiplash from a motor vehicle accident. Neck pain may also be associated with headache pain.

Osteoarthritis. Osteoarthritis (OA) is the most common form of arthritis (Prieto-Alhambra & Judge, 2013) and occurs when cartilage that cushions the ends of bones and joints deteriorates. Because of this, OA is often referred to as the "wear and tear" disease and is common among Veterans given engagement in military and non-military occupations that often involve physical labor (Morgenroth, Gellhorn, & Suri, 2012). The most common areas of the body affected include hands, feet, neck, low back, knees, and hips.

Rheumatoid Arthritis. Rheumatoid arthritis (RA) is a chronic, systemic inflammatory disorder that primarily affects the joints. White blood cells accumulate in the joints causing swelling and pain. Progression of the disease can lead to destruction of cartilage, ligaments, and tendons. RA typically impacts functional status to a greater degree than OA and is twice as prevalent in women than men.

Tendonitis/Bursitis. Tendonitis and bursitis involve inflammation of one of the tendons and bursae, respectively. Tendons are thick cords that join muscles to bones and inflammation causes pain and tenderness in the joints. Tendonitis is commonly associated with sports involving repetitive motion, such as swimming or throwing a ball, but can result from any

repetitive movement involving the joints. Bursae are fluid-filled sacs found in joints that surround areas where tendons, skin, and muscle tissues meet. Bursae provide essential lubrication to the hips, knees, elbows, and heels. Damage can cause pain, swelling, and redness.

Pelvic Floor Disorders. Pelvic floor disorders occur when the area that supports the pelvic organs becomes weak or damaged. These may result in urinary or fecal incontinence, as well as persistent pain in the pelvic walls. Some of the common causes are endometriosis, pelvic floor tension myalgia, pelvic inflammatory disease, fibroids, surgeries, and irritable bowel syndrome. Pelvic pain is much more common among women, with one in seven experiencing some form of this chronic condition.

Gout. Gout is a type of arthritis that is characterized by inflammation, tenderness, and stiffness in joints. The disorder is more common in men than women and often affects the big toe. Symptoms are episodic and flare-ups are typically associated with increased levels of uric acid. Uric acid levels are influenced by genetic factors but also by diet and lifestyle (Gheita, El-Fishwawy, Nasrallah, & Hussein, 2012).

Peripheral Neuropathic Pain. Peripheral neuropathy typically affects the hands and feet. It involves microvascular lesions in small blood vessels and its development is often associated with high blood sugar secondary to diabetes. Pain is commonly, but not universally, associated with peripheral neuropathy. Pain quality is often described as numb and tingling, pins and needles, electric, or burning, as opposed to being characterized as "pain."

Radicular Pain. Radicular pain is most commonly associated with LBP or neck pain, referred to as lumbar radiculopathy and cervical radiculopathy, respectively. It radiates along a nerve due to inflammation or irritation of the nerve root and extends from the spinal cord to areas such as the buttocks and down the legs in the case of back pain, or down the arms in the case of neck pain. The sudden appearance of radicular pain, new muscular weakness, or the identification of radicular pain that is not noted by medical providers is cause for immediate medical evaluation (Gilron, Watson, Cahill, & Moulin, 2006). Radicular pain is typically described as burning, shooting, or shock-like (Atlas et al., 1996).

Phantom Limb Pain. A phantom limb is the sensation that an amputated or missing limb is still attached to the body. Between 60 and 80% of individuals with an amputation experience phantom limb sensations and the majority of these sensations are painful (Sherman, Sherman, & Parker, 1984). In addition, pain at the site of the amputation, or stump, caused by nerve damage in the stump region is also common. Pain is variable from a dull ache to shooting and severe.

Fibromyalgia. Fibromyalgia (FM) is a disorder of unknown etiology associated with widespread pain, sleep disturbance, fatigue, and psychological distress among other symptoms. FM pain typically includes tender "trigger" points found in soft tissue of the back of the neck, shoulders, low back, hips, shins, and knees, and the pain is often described as a deep aching or burning. FM is about 7 times more common in women than men (Haviland, Banta, & Prezekop, 2011) and individuals with FM are 3 times more likely to have a comorbid diagnosis of major depression than individuals without FM.

Complex Regional Pain Syndrome. Complex regional pain syndrome (CRPS), previously known as reflex sympathetic dystrophy syndrome, or RSD, is a poorly understood pain condition that often starts after a minor injury or complication, usually to a hand, arm, foot, or leg, and often spreads. Type 1, the form most commonly seen, has no demonstrable nerve lesions, while there is nerve damage in Type 2. Pain is described as severe and changes in the appearance and texture of the skin are often noticeable.

Types of Headaches

The most common types of headaches are listed below. It is important to remember, however, that patients may have more than one kind of headache (e.g., tension-type headaches a few times per week and migraines a few times per month). In addition, in the same way that other pain locations may be difficult to classify, Veterans may present with mixed symptoms that do not fall neatly into one category.

Tension-type. Tension-type headaches (TTH) are by far the most common type, accounting for over half of all headaches (ICHD, 2nd edition, 2004). The primary sensation associated with TTH is the feeling of a tight band wrapped around one's head. These range in intensity from mild to moderate and also range in frequency from episodic to chronic. Criterion for chronic TTH is met when an individual experiences headaches for 15 days a month for at least 6 months (ICHD, 2nd edition, 2004).

Migraine. Migraine headaches occur in about 10% of the population at some point in their lifetime (Rasmussen, Jensen, Schroll, & Olesen, 1991). They are classified as either with or without aura, defined by symptoms such as sensory or motor disturbance that precede or accompany the headache. Migraine headaches tend to be recurrent and are associated with a number of autonomic nervous system symptoms. The typical migraine headache is unilateral and pulsing in nature, lasts from 2 to 72 hours, may be associated with nausea, vomiting, sensitivity to light and sound, and aggravated by physical activity. Migraines are 2 to 3 times more common in women than men (ICHD, 2nd edition, 2004).

Cluster. Cluster headaches involve severe unilateral pain that is orbital, supraorbital, or temporal, lasting 15 to 180 minutes, and occurring in frequency from every other day to up to 8 times per day (ICHD, 2nd edition, 2004). Painful episodes may be accompanied by tearing, nasal congestion, sweating, a drooping eyelid, or a contracted pupil. These all occur on the affected side of the face. The intense pain of cluster headaches is due to

dilation of blood vessels creating pressure on the trigeminal nerve. However, the underlying cause of the dilation is not understood. This type of headache is much less common, affecting .1% of the population, and is 3 to 4 times more common in men than women (ICHD, 2nd edition, 2004).

Post-traumatic. Headaches associated with head trauma (e.g., mild to severe traumatic brain injury) is common immediately following an injury, with a prevalence up to 90%. Up to 44% of patients report continued headaches 6 months following an injury (Nicholson & Martelli, 2004). The three most common presentation patterns are tension-type, migraine type, or cervicogenic (Gironda et al., 2009). Exposure to blasts and concussions while deployed make this type of headache more common among Veterans and military Service members.

Medication Overuse. Medication overuse headaches, previously known as rebound headaches, are a secondary cause of chronic daily headaches due to the overuse of acute headache analgesics. Overuse is defined by treatment days per month and depends on the drug. Overuse is often motivated by the desire to treat headaches or a fear of future headaches, but regardless can make headaches refractory to preventative medications (Silberstein, Lipton, & Saper, 2007).

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Appendix 3: Treatment Options for Chronic Pain

TREATMENT OPTIONS FOR CHRONIC PAIN

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

The intent of this section is to familiarize non-medical providers with common treatment modalities by providing basic information that does not include data on efficacy.

Analgesic Medications

The following section is an introduction to analgesic, or pain relieving, medications. It is not meant to guide prescription of medications but instead to help providers understand the likely uses of medications taken by Veterans with chronic pain. A table of medications including both generic and brand names is also included below.

Non-Opioid Analgesics. Aspirin and other related compounds constitute a class of drugs known as nonsteroidal anti-inflammatory drugs (NSAIDS). This class of medication produces three desirable effects including anti-inflammatory, analgesic, and antipyretic (fever reducing). Commonly used medications in this category include aspirin, ibuprofen, naproxen, etodolac, meloxicam, and piroxicam. The most common adverse effects of NSAIDs are gastrointestinal and renal (kidney). Acetaminophen is also a non-opioid analgesic but is not an NSAID because, though possessing pain relieving and antipyretic properties, it lacks an anti-inflammatory component.

Opioid Analgesics. Opioid analgesics (or narcotics) refer to compounds that act by binding to opioid receptors in the brain. Though often used interchangeably, the term opiate refers only to the naturally occurring resin found in opium poppy while opioids also include synthetically produced substances and thus is the preferred general term.

This class of medications can either be short- or long-acting. Commonly used opioids include morphine, hydrocodone, oxycodone, codeine, methadone, and hydromorphone. The analgesic effects of opioids are due to decreased perception of pain, decreased reaction to pain, and increased pain tolerance. The most commonly cited side effects of opioids (in order of frequency reported) include nausea, constipation, drowsiness, dizziness, and vomiting (Eisenberg, McNicol, & Carr, 2006). Opioids may be associated with risk of misuse (Comptom & Volkow, 2006) and physiological dependence.

Measuring the risk to benefit ratio of opioid therapy for patients with chronic pain is complicated and prescribing providers are encouraged to follow the 2010 VA/Department of Defense (DoD) Clinical Practice Guideline for the Management of Opioid Therapy for Chronic Pain Of note, concurrently prescribing opioids and sedatives/hypnotics (e.g., benzodiazepines) should be done with extreme caution based on increasing evidence of risk of accidental overdose-related deaths (Jones, Mack, & Paulozzi, 2013).

Tramadol. Tramadol does not fit neatly into a single category because it is dual acting. It interferes with the transmission of pain signals like an opioid, but it also releases norepinephrine and serotonin like an antidepressant. It is used for moderate to severe chronic pain and the most common side effects are dizziness, sedation, constipation, nausea, and headaches. Because it is not a pure opioid, risk of physiological dependence is lower but is still present.

Topical Analgesics. Topical analgesics are applied to the skin for delivery of medication to targeted pain areas. They block the generation and transmission of nerve signals to the brain through a local numbing effect. Topical products are available in various creams, gels, lotions, patches, and plasters. Since they are applied to a localized area externally, topical agents afford a lower risk for systemic adverse events and side effects. They are frequently used in the VA and the most commonly prescribed topicals are capsaicin, lidocaine, diclofenac, and menthol-methylsalycylate.

Muscle Relaxants. Muscle relaxants (or spasmolytics, antispasmodics) are most commonly prescribed for LBP, neck pain, fibromyalgia, and tension headaches in situations where muscular contractions appear to be a prominent component of pain.

Muscle relaxants used most commonly in VA include cyclobenzaprine, tizanidine, baclofen, and methocarbamol. Muscle relaxants work by inhibiting the central nervous system, which contributes to the commonly reported side effect of sedation and the recommendation against driving or operating heavy machinery. Other common side effects include dizziness, headache, nausea, irritability, and nervousness. Muscle relaxants also pose a risk of physiological dependence.

Adjuvant Analgesics. Adjuvant analgesics, or co-analgesics, are medications that were originally developed and marketed for uses other than analgesia and are also used in pain management. The two most common classes of medications that fall into this category are certain types of antidepressants and anticonvulsants. Antidepressants commonly used for analgesic purposes include duloxetine, venlafaxine, and nortriptyline. Common side effects of antidepressants include nausea, vomiting, insomnia, decreased sex drive, and constipation. Anticonvulsants, primarily used to relieve neuropathic pain, include gabapentin, pregabalin, topiramate, and lamotrigine. Common side effects of anticonvulsant medications include dizziness, fatigue, weight gain, and drowsiness.

Headache Analgesics. Analgesics used to treat headaches vary widely and do not fall into a single class. Migraine medications are generally categorized by nature of their action into those that are preventative (e.g., propranolol, topiramate or Topamax), abortive (e.g., sumatriptan or Maxalt), and rescue (butalbital/acetaminophen/caffeine or Fioricet). Of note, medication overuse headaches, or rebound headaches, may occur when excessive analgesics are taken for headache relief, leading to chronic daily headaches of a different type.

Examples of Common Analgesics, By Class		
Opioid Analgesics	oxycodone	**Oxycontin**
	oxycodone + acetaminophen	**Percocet**
	oxymorphone	**Opana**
Opioid and Antidepressant	tramadol	**Ultram**
Muscle Relaxants	baclofen	
	cyclobenzaprine	**Flexeril**
	methocarbamol	**Robaxin**
	tizanidine	**Zanaflex**
Topical Analgesics	capsaicin cream/patch	
	diclofenac gel	**Voltaren**
	lidocaine gel/cream/ointment/ patch	**Lidoderm**
	menthol-methylsalicylate cream	
Adjuvant Analgesics: Anticonvulsants	carbamazepine	**Tegretol**
	gabapentin	**Neurontin**
	pregablin	**Lyrica**
	topiramate	**Topamax**
	lamotrigine	**Lamictal**
Adjuvant Analgesics: Antidepressants	amitriptyline	**Elavil**
	duloxetine	**Cymbalta**
	nortriptyline	**Pamelor**
	venlafaxine	**Effexor**
Headache Analgesics	butalbital + acetaminophen + caffeine	**Fioricet**
	rizatriptan	**Maxalt**
	sumatriptan	**Imitrex**
	zolmitriptan	**Zomig**

INVASIVE MEDICAL TREATMENT OPTIONS FOR CHRONIC PAIN

Epidural Steroid Injections. Epidural Steroid Injections (ESIs) are used for back pain complaints associated with conditions such as spinal stenosis or spinal disc herniation. ESIs include a combination of corticosteroids and local anesthesia that is injected into the epidural space around

the spinal cord and nerves. The injection may be guided by fluoroscopy or x-ray. The effects of the injection last from one week to six months.

Nerve Blocks. Nerve blocks (aka, regional nerve blockade) are used for pain in the neck, back, feet or even the head. Nerve blocks may include local anesthetic and epinephrine, with corticosteroids, and/or opioids that are injected directly into the nerve group associated with reported pain. Nerve blocks can be used to treat painful conditions, to determine sources of pain, or to judge the benefits of more permanent treatments such as surgery.

Trigger Point Injections. Trigger point injections (TPI) are used to relieve muscles where knots form when muscles do not relax. TPI is used in many muscle groups ranging from arms, legs, low back, and neck and is most often associated with treatment of fibromyalgia and tension headache. The injection contains a local anesthetic that may include a corticosteroid.

Facet Injections. Facet injections are used for those with chronic neck or back pain caused by inflamed facet joints, which are located between each set of vertebrae in the spine from the neck to the tailbone. A mixture of local anesthetic and corticosteroid medication is injected into the facet joint to reduce swelling and inflammation around the facet joint space.

Radiofrequency Ablation. Radiofrequency ablation (RFA) is used to treat severe chronic low back pain. Radiofrequency waves produce high heat on specifically identified nerves surrounding the facet joints in the lumbar spine, ablating the nerves and destroying their ability to transmit pain signals. RFA is an outpatient procedure using local anesthesia. While the procedure may provide pain relief, in most patients the nerves regenerate.

OnabotulinnumtoxinA (Brand name: Botox). Botox injections are typically used for relief of frequent migraine headaches. Botox received approval from the FDA as a treatment for chronic migraines in 2010.

Spinal Cord Stimulator. The most common use of spinal cord stimulators (SCS) is with patients diagnosed with failed back syndrome (see definition under **Surgery** below). A SCS includes electrodes implanted in the epidural space, an electrical pulse generator implanted in the lower abdominal area of gluteal region, connecting wires to the generator, and a generator remote control.

Intrathecal Pump. An intrathecal pump is an implantable device that delivers pain medication directly to the spinal fluid. Common medications used in pumps include baclofen or morphine. The pumps deliver medications at higher dosages than possible with oral medications.

Surgery. Surgery may be offered for various pain locations such as back, neck, knee, shoulder, or ankle. Surgery for chronic pain is usually considered only after conservative treatments have failed or if seen as medically necessary. Individuals who have undergone one or more unsuccessful back surgeries may receive the diagnosis or label of “failed back syndrome” or “failed back surgery

syndrome." Causes for failure of surgery vary, but the results can lead to frustration and distrust of medical providers, increased depression, and increased perceptions of disability (Onesti, 2004).

NON-INVASIVE TREATMENT OPTIONS FOR CHRONIC PAIN

Physical Therapy. Reduction in bodily movement that can be related to fear of pain or re-injury is common in chronic pain and often leads to physical deconditioning and, subsequently, increased pain. Physical therapy is an integral part of chronic pain interventions as it helps restore physical functioning and re-engagement in rewarding life activities. Physical therapy involves a range of activities including stretching exercises, strengthening exercises, and use of graded exercise techniques such as therapeutic pools or stationary bikes, in addition to a range of palliative therapies such as spinal manipulation and ultrasound, among others.

Cold/Heat. Application of cold and heat are often used for the management of chronic pain. Cold and heat may decrease sensitivity to pain and provide competing sensory central nervous system input that can reduce pain sensations.

Transcutaneous Electrical Nerve Stimulation (TENS). TENS units stimulate nerves by introducing a mild electrical current. The electric current is not strong enough to cause muscle contraction, but instead is thought to interfere with the transmission of pain signals to the brain. Electrodes are placed on the skin and a battery-powered unit is carried or worn on the person. No surgical procedures are involved in the use of a TENS unit.

Chiropractic. These interventions primarily focus on spinal adjustment or adjustment to other joint areas. Spinal or other joint manipulations involve a dynamic thrust that causes an audible release and attempts to increase range of motion.

Chiropractic care may also involve soft tissue therapy, strength training, dry needling, functional electrical stimulation, traction, or nutritional recommendations.

Acupuncture. Acupuncture involves the insertion of needles into acupuncture points in the skin in an effort to relieve pain. Acupuncture produces physiologic effects that are relevant to analgesia; however, the mechanism for how acupuncture affects chronic pain remains unclear (Vickers, et al., 2012).

Yoga/Tai Chi. Yoga and Tai Chi may provide a source of graded physical exercise combined with relaxation to improve chronic pain.

Biofeedback. Biofeedback involves increasing awareness of physiological functions or processes such as muscle tone, skin conduction, heart rate, or brainwaves. Awareness of different physiological processes is gained through use of a variety of types of monitoring devices specific to the process being monitored, such as an electromyography (EMG) to measure muscle activity or electrodermograph to register skin conductance or resistance.

Information on a specific process is gathered, amplified, and displayed (fed back) to the patient who then uses the visual or auditory feedback to gain control over the targeted behavior. Biofeedback has been used to treat a variety of chronic pain disorders but is most often used in the management of headaches.

Relaxation Training. Relaxation training, which may be done in the context of biofeedback, focuses on identifying tension within the body and applying systematic techniques for decreasing that tension. The most common techniques include diaphragmatic (or deep) breathing, progressive muscle relaxation, and visualization.

SELECTED PSYCHOLOGICAL APPROACHES

Operant Behavioral Therapy. The operant-behavioral formulation of chronic pain by Fordyce (1976) marked a significant development in the understanding and treatment of chronic pain by introducing the concept of pain behaviors. These refer to forms of communication that are observable expressions of pain and suffering such as moaning, clenching, grimacing, sighing, or limping. The model suggests that reinforcement of such behaviors, often by those in one's social environment, could lead to maintenance of subjective reports of pain and increased self-perceptions of disability.

Cognitive Behavioral Therapy (CBT). CBT helps individuals resolve their problems concerning maladaptive emotions, behaviors, and cognitions through a goal-oriented, systematic process. While it was originally used for treatment of those with depression and anxiety disorders, it has been implemented with a variety of other conditions from insomnia to substance abuse.

Acceptance and Commitment Therapy (ACT). Acceptance and Commitment Therapy, (ACT: Hayes et al., 1999) is an acceptance- and mindfulness-based intervention that teaches patients to observe and accept thoughts and feelings without judgment and without trying to change them. It focuses on identifying core values and behaving in accordance with those values. As applied to chronic pain, ACT emphasizes that while the physical sensation may be painful, the patient's struggle with pain is what causes suffering and emotional distress (Dahl & Lundgren, 2006). The aim of therapy, therefore, is to develop greater psychological flexibility in the presence of thoughts, feelings, and behaviors associated with pain.

Hypnotherapy. Hypnotherapy utilizes suggestive statements made by a therapist to alter the patient's attention and focus away from pain. Deep breathing is often used as a behavioral cue in an effort to alter the subjective experience of pain. However, there is significant variation in specific techniques.

Mindfulness. Mindfulness meditation is another approach combining elements of relaxation and hypnotherapy, which seeks to increase focused attention and facilitate relaxation. Based in Theravada Buddhism, it seeks to increase intentional self-regulation to what is occurring in the

present without attaching negative associations. As applied to pain management, a primary goal is to separate the pain sensation from unhelpful thoughts.

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Appendix 4:
Mobile Apps for Pain and Related Health Concerns

MOBILE APPS FOR PAIN AND RELATED CONCERNS

Below you will find several examples of mobile apps that can assist you with management of important health topics, including chronic pain. They can be used with (or without) Brief Cognitive Behavioral Therapy for Chronic Pain to help address wellness goals. All of the apps below are available at the VA AppStore (**https://mobile.va.gov/appstore)** where there is a full listing of additional free mobile apps:

Topic	App Image	Description
Pain Management		**Pain Coach** is a mobile application for Veterans that offers helpful tools to track and manage pain. You can reference educational information about pain; track your pain using a daily pain diary and a monthly check-in; monitor your progress managing your pain and see tables and graph of changes in your pain level over time and; and use techniques and tools to manage pain.
Self-care (Annie App for Veterans)		**Annie** is a VA service that sends automated text messages to Veterans to help them stay focused on their self-care. This might include health related notifications, reminders, or motivational messages. Annie also empowers Veterans to play an active role in their care, by prompting them to provide health data such as weight or blood pressure. Anyone with a phone that can send and received text messages can use Annie.
Insomnia/Sleep		**CBT-i Coach** is for people who are engaged in Cognitive Behavioral Therapy for Insomnia with a health provider, or who have experienced symptoms of insomnia and would like to improve their sleep habits.
Smoking/Tobacco Cessation		**Stay Quit Coach** is intended to serve as a source of readily available support and information for adults who are already in treatment to quit smoking and to help them stay quit after treatment ends.

Topic	App Image	Description
Weight Management		**MOVE! Coach** provides self-managed weight management allowing Veterans to monitor, track, and receive tailored feedback regarding their progress with weight and exercise goals while controlling relapse triggers and forming coping plans.
PTSD		**PTSD Coach** is designed for Veterans and military Service Members who have, or may have, Post-traumatic Stress Disorder (PTSD). This app provides users with education about PTSD, information about professional care, a self-assessment for PTSD, opportunities to find support, and tools that can help users manage the stressors of daily life.
PTSD		**CPT Coach** is for Veterans, Service members, and others with PTSD who are participating in Cognitive Processing Therapy (CPT) with a professional mental healthcare provider. This app contains support materials for a complete course.
PTSD		**ACT Coach** is designed for Veterans and military Service Members in Acceptance and Commitment Therapy (ACT) with a professional mental healthcare provider and provides additional assistance with unpleasant thoughts, feelings, and impulses without avoiding them or being controlled by them.
Emotional Distress		**Mindfulness Coach** is for people who may be experiencing emotional distress, and for those wanting to maintain healthy coping practices. The app can be used on its own by those who would like mindfulness tools, or to enhance face-to-face care with a healthcare professional. It is not recommended for PTSD. Available for iOS only.
TBI		**Concussion Coach** is designed for Veterans, Service Members, and other individuals who experience physical, cognitive, and emotional symptoms that may be related to mild to moderate traumatic brain injury. App provides a self-assessment and information on managing TBI. Available for iOS only.

Appendix 5:
Guided Imagery Script

GUIDED IMAGERY SCRIPT

This technique is designed to train the Veteran to create mental images that foster a relaxed state. The Veteran should choose a location to mentally visit during the exercise; the only "rule" is that the Veteran must pick a place that is peaceful and calm, with positive associations. Encourage a focus on detailed images that take the Veteran away from stressful thoughts and bodily tension.

The key to developing a deeply immersive experience where the Veteran completely engages in the imagery exercise is to give full attention to all the specific details of the scene. It is crucial to involve all five senses; to consider specifically what would be seen, heard, smelled, felt, and tasted in this location. Provide examples such as smelling fresh-baked cookies in the air, feeling warm sand in the hand, or hearing the crush of leaves underfoot.

Once the mental scene and the details of the patient's relaxing place are gathered, guide Veterans through the steps below. A sample for the therapist is presented below. Please refer to the **Guided Imagery Handout** for a sample script of this exercise.

OVERVIEW OF STEPS FOR ANY GUIDED IMAGERY

1. Begin with comfortable posture and relaxed breath with eyes closed or gaze fixed.
2. Imagine the "entryway" into the location (e.g., path, door, staircase, lake dock).
3. Enter the relaxing place (focus on five senses).
4. Spend 5-10 minutes in the relaxing scene.
5. Have the Veteran "leave" the location through the same "entryway."

SCRIPTING FOR INTRODUCING GUIDED IMAGERY TO THE PATIENT

"Guided imagery is designed to help us create mental images that promote a state of relaxation. Essentially, guided imagery involves creating a detailed, imaginal location to mentally visit and attune your thoughts and senses to. For some people, this might involve things like smelling fresh-baked cookies, listening to birdsongs, or imagining the sensation of walking through warm sand. But no two people will create the same mental scene. The image or images that you select are up to you; the only rule is that you must create a calm and peaceful scene."

GUIDED IMAGERY EXERCISE

1. Imagine yourself walking slowly down a path toward your special place. This path can be inside or outside. The path is comforting and peaceful. As you walk down this path, imagine all of your stresses, worries, and tension are leaving you. Enjoy this journey to your special place.

2. As you walk down this path, notice the ground beneath you…how it feels as you walk. Notice the sounds…the comfortable temperature of the air. Take a breath in, feeling all your tension leave you as you exhale. Notice any fragrance that may be here. Notice the view around you. Reach out and touch something around you. Feel its textures.

3. You feel calm and safe. All your worries and anxieties being left behind as you move toward your special place… (PAUSE 30 sec).

4. Walk down this path until you arrive at your own special place…and when you have reached this special place, go ahead and enter… (PAUSE 10 sec).

5. You have arrived at this relaxing and peaceful place. Notice the ground underneath you… whether it is hard or soft. Notice how the ground feels below your feet. Listen to the sounds in this place, both close and distant. Smell the air, the fragrances. Notice the temperature of the air around you.

6. Look above you… Notice the colors and sights above you. Look out into the distance… as far as you can see… Take in all of the sights, fragrances, and sounds around you.

7. Reach out and touch something in this place… Notice its texture and how it feels against your skin. Notice the different objects around you… their shapes, textures, and colors. Notice the light and shade of this place and how it reflects off of these objects.

8. There is a comfortable place for you to sit or lie here as you take in all the smells, sounds, sights, and textures… As you sit or lie in this place, away from it all, you feel calm and secure, refreshed and renewed, strong and at peace. As you enjoy this place for a few minutes, you know that you can come here whenever you please, and that this place will always be waiting for you… (PAUSE 3-5 min).

9. Now it's time to come back… leave by the same way you came, enjoying the path… and as you return on this path, you start to also notice the room in which you are sitting… start to wiggle your fingers and toes… and when you are ready, slowly open your eyes and stretch your muscles.