CHRONIC PAIN

BEHAVIORAL DEFINITIONS

1. Experiences pain beyond the normal healing process (six months or more) that significantly limits physical activities.
2. Complains of generalized pain in many joints, muscles, and bones that debilitates normal functioning.
3. Uses increased amounts of medications with little, if any, pain relief.
4. Experiences tension, migraine, cluster, or chronic daily headaches of unknown origin.
5. Experiences back or neck pain, interstitial cystitis, or diabetic neuropathy.
6. Experiences intermittent pain such as that related to rheumatoid arthritis or irritable bowel syndrome.
7. Has decreased or stopped activities such as work, household chores, socializing, exercise, sex, or other pleasurable activities because of pain.
8. Experiences an increase in general physical discomfort (e.g., fatigue, night sweats, insomnia, muscle tension, body aches).
9. Exhibits signs and symptoms of depression.
10. Makes many complaintive, depressive statements like "I can't do what I used to"; "No one understands me"; "Why me?"; "When will this go away?"; "I can't take this pain anymore"; and "I can't go on."

__. _____
_____

__. _____
_____

__. _____
_____

LONG-TERM GOALS

1. Acquire and utilize the necessary pain management skills.
2. Regulate pain in order to maximize daily functioning and return to productive employment.
3. Find relief from pain and build renewed contentment and joy in performing activities of everyday life.
4. Find an escape route from the pain.
5. Accept the chronic pain and move on with life as much as possible.
6. Lessen daily suffering from pain.

__. _____

_____

__. _____

_____

__. _____

_____

SHORT-TERM OBJECTIVES	THERAPEUTIC INTERVENTIONS
1. Describe the nature of, history of, impact of, and understood causes of chronic pain. (1, 2)	1. Assess the manifestation of chronic pain, its history, current status, triggers, and methods of coping (see *The Handbook of Pain Assessment* by Turk and Melzack). 2. Assess the impact of the pain on the patient's functioning in everyday life, including changes in the client's mood, attitude, social, vocational, and familial/marital roles.
2. Complete a thorough medical evaluation to rule out any alternative causes for the pain and reveal any new treatment possibilities. (3)	3. Refer the client to a physician or clinic to undergo a thorough medical evaluation to rule out any undiagnosed condition and to receive recommendations on any further treatment options.
3. Disclose any history of substance use that may contribute to and	4. Arrange for a substance abuse evaluation and refer the client

complicate the treatment of chronic pain. (4)

4. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (5, 6, 7, 8)

for treatment if the evaluation recommends it (see the Substance Use chapter in this *Planner*).

5. Assess the client's level of insight (syntonic versus dystonic) toward the "presenting problems" (e.g., demonstrates good insight into the problematic nature of the "described behavior," agrees with others' concern, and is motivated to work on change; demonstrates ambivalence regarding the "problem described" and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the "problem described," is not concerned, and has no motivation to change).
6. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with ADHD, depression secondary to an anxiety disorder) including vulnerability to suicide, if appropriate (e.g., increased suicide risk when comorbid depression is evident).
7. Assess for any issues of age, gender, or culture that could help explain the client's currently defined "problem behavior" and factors that could offer a better understanding of the client's behavior.
8. Assess for the severity of the level of impairment to the client's functioning to determine appropriate level of care (e.g., the behavior noted creates mild,

	moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment but the presenting problem now is causing mild or moderate impairment).
5. Follow through on a referral to a pain management or rehabilitation program. (9, 10, 11)	9. Give the client information on the options of pain management specialists or rehabilitation programs that are available and help him/her make a decision on which would be the best for him/her.
	10. Make a referral to a pain management specialist or clinic of the client's choice and have him/her sign appropriate releases for the therapist to have updates on progress from the program and to coordinate services.
	11. Elicit from the client a verbal commitment to cooperate with pain management specialists or rehabilitation program.
6. Complete a thorough medication review by a physician who is a specialist in dealing with chronic pain or headache conditions. (12)	12. Ask the client to complete a medication review with a specialist in chronic pain; confer with the physician afterward about his/her recommendations and process them with the client.
7. Participate in a cognitive-behavioral group therapy for pain management. (13)	13. Form a small, closed enrollment cognitive-behavioral treatment group (4–8 clients) pain management (see *Group Therapy for Patients with Chronic Pain* by Keefe et al.); supplement with *Managing*

	Chronic Pain: A Cognitive-Behavioral Therapy Approach Workbook by Otis.
8. Verbalize an understanding of pain. (14)	14. Teach the client key concepts of rehabilitation versus biological healing, conservative versus aggressive medical interventions, acute versus chronic pain, benign versus nonbenign pain, cure versus management, appropriate use of medication, role of self-regulation techniques and other management techniques.
9. Verbalize an understanding of the rationale for treatment. (15, 16)	15. Teach the client a rationale for treatment that helps him/her understand that thoughts, feelings, and behavior can affect pain; that there are coping techniques and skills that can be used to help them to adapt and respond to pain and the resultant problems; emphasize the role that the client can play in managing his/her own pain.
	16. Assign the client to read sections from books or treatment manuals that describe pain conditions and their cognitive-behavioral treatment (e.g., *The Chronic Pain Control Workbook* by Catalano and Hardin).
10. Identify and monitor specific pain triggers. (17)	17. Teach the client self-monitoring of his/her symptoms; ask the client to keep a pain journal that records time of day, where and what he/she was doing, the severity of stress at the time, the severity of, and what was done to alleviate the pain (or assign "Pain and Stress Journal" in the *Adult Psychotherapy Homework Planner* by Jongsma); process the journal with the client to increase understanding of the nature of

	the pain, cognitive, affective, and behavioral triggers, and the positive or negative effects of the coping strategies he/she is currently using.
11. Learn and implement calming skills such as relaxation, biofeedback, or mindfulness meditation to ease pain. (18, 19, 20, 21, 22)	18. Teach the client relaxation skills (e.g., progressive muscle relaxation, guided imagery, slow diaphragmatic breathing) or mindfulness meditation, explaining the rationale and how to apply these skills to his/her daily life (see *New Directions in Progressive Muscle Relaxation* by Bernstein, Borkovec, and Hazlett-Stevens).
	19. Conduct or refer the client to biofeedback training (e.g., EMG for muscle tension-related pain); assign practice of the skill at home.
	20. Identify areas in the client's life where he/she can implement skills learned through relaxation or biofeedback.
	21. Assign a homework exercise in which the client implements somatic pain management skills and records the result; review and process during the treatment session.
	22. Assign the client to read about progressive muscle relaxation and other calming strategies in relevant books or treatment manuals (e.g., *The Relaxation and Stress Reduction Workbook* by Davis, Robbins-Eshelman, and McKay; *Living Beyond Your Pain* by Dahl and Lundgren).
12. Incorporate physical therapy into daily routine. (23)	23. Refer the client for physical therapy if pain is heterogeneous.

13. Learn mental coping skills and implement with somatic skills for managing acute pain. (24)

24. Teach the client distraction techniques (e.g., pleasant imagery, counting techniques, alternative focal point) and how to use them with relaxation skills for the management of acute episodes of pain (or assign "Controlling the Focus on Physical Problems" in the *Adult Psychotherapy Homework Planner* by Jongsma).

14. Participate in Acceptance and Commitment Therapy for chronic pain. (25)

25. Conduct Acceptance and Commitment Therapy including mindfulness strategies to help the client: decrease avoidance, disconnect thoughts from actions, accept one's experience rather than try to change or control symptoms, behave according to his/her broader life values, clarify his/her goals and values and commit to behaving accordingly (see *Acceptance and Commitment Therapy for Chronic Pain* by Dahl, Wilson, Luciano, and Hayes).

15. Increase the level and range of activity by identifying and engaging in values-consistent pleasurable activities. (26)

26. Ask the client to create a list of activities that are pleasurable to him/her and/or consistent with identified goals and values; process the list, developing a plan of increasing the frequency of engaging in the selected activities.

16. Incorporate physical exercise into daily routine. (27, 28)

27. Assist the client in recognizing the benefits of regular exercise, encouraging him/her to implement exercise in daily life and monitor results (see *Exercising Your Way to Better Mental Health* by Leith); offer ongoing encouragement to stay with the regimen.

17. Identify, challenge, and change maladaptive thoughts and beliefs about pain and pain management and replace them with more adaptive thoughts and beliefs. (29, 30, 31, 32, 33)

28. Refer the client to an athletic club to develop an individually tailored exercise or physical therapy program that is approved by his/her personal physician.
29. Explore the client's schema and self-talk that mediate his/her pain response, challenging the biases, assisting him/her in generating thoughts that correct for the biases, facilitate coping, and build confidence in managing pain.
30. Assign the client a homework exercise in which he/she identifies negative pain-related self-talk and positive alternatives (or assign "Journal and Replace Self-Defeating Thoughts" in the *Adult Psychotherapy Homework Planner* by Jongsma); review and reinforce success, providing corrective feedback toward improvement.
31. Use cognitive therapy techniques to help the client change his/her view of their pain and suffering from overwhelming to manageable.
32. Use cognitive therapy techniques to help the client change his/her self-concept and role in pain management from passive, reactive, and helpless to active, resourceful, and competent.
33. Assign the client to read about cognitive-behavioral approaches to pain management relevant books or treatment manuals (e.g., *Managing Chronic Pain: A Cognitive-behavioral Therapy Approach Workbook* by Otis;

	The Pain Survival Guide by Turk and Winter; *The Chronic Pain Control Workbook* by Catalano and Hardin).
18. Learn and implement specific coping skills as well as when and how to use them to manage pain and its consequences. (34)	34. Teach the client specific coping skills based on an assessment of need (e.g., problem-solving, social/communication, conflict resolution, goal-setting).
19. Engage in positive self-talk as an alternative to the depressing, negative thoughts about self and the world. (35)	35. Assist the client in reframing thoughts about his/her life as one that has many positive elements outside of the pain; ask him/her to list positive aspects of himself/herself as well as his life circumstances (or assign "Positive Self-Talk" and/or "What's Good about Me and My Life?" in the *Adult Psychotherapy Homework Planner* by Jongsma).
20. Integrate and implement all new mental, somatic, and behavioral ways of managing pain. (36)	36. Assist the client in integrating his/her pain management skills learned in therapy (e.g., calming, cognitive coping, distraction, activity scheduling, problem-solving); transition use from therapy sessions to daily life as mastery becomes evident; review, reinforcing success and problem-solving obstacles toward the goal of integration (see *Psychological Approaches to Pain Management* by Turk and Gatchel).
21. Implement relapse prevention strategies for managing future challenges. (37, 38, 39)	37. Discuss with the client the distinction between a lapse and relapse, associating a lapse with an initial and reversible return of pain or old habits (e.g., a "bad day") and relapse with the persistent return of pain and previous cognitive and behavioral habits that exacerbate pain.

38. Identify and rehearse with the client the management of future situations or circumstances in which lapses could occur, using the strategies learned during therapy. 

39. Follow-up with the client periodically to problem-solve difficulties and reinforce successes. 

22. Make changes in diet that will promote health and fitness. (40)

40. Refer the client to a dietician for consultation around eating and nutritional patterns; process the results of the consultation, identifying changes he/she can make and how he/she might start implementing these changes.

23. Investigate the use of alternative therapies to pain management. (41)

41. Explore the client's openness to alternative therapies for pain management (e.g., acupuncture, hypnosis, therapeutic massage); refer for the services, if indicated.

24. Connect with social network sources who support the therapeutic changes. (42)

42. Assess the client's social support network and encourage him/her to connect with those who facilitate or support the client's positive change.

__. _____ __. _____

_____ _____

__. _____ __. _____

_____ _____

__. _____ __. _____

_____ _____

DIAGNOSTIC SUGGESTIONS

Using DSM-IV/ICD-9-CM:

Axis I:	307.89	Pain Disorder Associated With Both Psychological Factors and a General Medical Condition
	307.80	Pain Disorder Associated With Psychological Factors
	300.81	Somatization Disorder
	300.11	Conversion Disorder
	296.3x	Major Depressive Disorder, Recurrent
	300.3	Obsessive-Compulsive Disorder
	302.70	Sexual Dysfunction NOS
	304.10	Sedative, Hypnotic, or Anxiolytic Dependence
	304.80	Polysubstance Dependence
	_____	_____
	_____	_____

Using DSM-5/ICD-9-CM/ICD-10-CM:

ICD-9-CM	ICD-10-CM	*DSM-5* Disorder, Condition, or Problem
307.89	F54	Psychological Factors Affecting Other Medical Conditions
307.80	F45.1	Somatic Symptom Disorder, With Predominant Pain
300.81	F45.1	Somatic Symptom Disorder
300.11	F44.x	Conversion Disorder
296.3x	F33.x	Major Depressive Disorder, Recurrent Episode
300.3	F42	Obsessive-Compulsive Disorder
302.70	F52.9	Unspecified Sexual Dysfunction
304.10	F13.20	Sedative, Hypnotic, or Anxiolytic Use Disorder, Moderate or Severe

Note: The ICD-9-CM codes are to be used for coding purposes in the United States through September 30, 2014. ICD-10-CM codes are to be used starting October 1, 2014. Some ICD-9-CM codes are associated with more than one ICD-10-CM and *DSM-5* Disorder, Condition, or Problem. In addition, some ICD-9-CM disorders have been discontinued resulting in multiple ICD-9-CM codes being replaced by one ICD-10-CM code. Some discontinued ICD-9-CM codes are not listed in this table. See *Diagnostic and Statistical Manual of Mental Disorders* (2013) for details.