GUIDING INDIVIDUALS LIVING WITH CHRONIC PAIN TOWARDS IMPROVED PSYCHOLOGICAL FLEXIBILITY

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COI

• I have no conflicts of interest to report
Learning Objectives

• Identify the prevalence of chronic pain and those factors that increase the risk of disability
• Explain how pain-related disability is significantly determined by a person’s psychological response to their pain and underlying condition
• Describe the multiple factors that can influence a person’s experience of pain
• Understand why coordination of care is essential as pain persists and its impact grows
• Identify the unique challenges in caring for individuals with high impact pain
• Describe the steps an individual must take to decrease the limitations associated with chronic pain
Be Still, Be Courageous, Be Open, Be Grateful!

The warriors challenge in living with chronic pain. There are two paths—one with heart, one with fear. The choice of paths is monumental.
How Big a Problem is Chronic Pain?

Child and Adolescents: 20-25%

Adults: 37-41%

Adults (50+): 50%

Elderly in Care Facilities: 75-85%

Pain is the most common reason for medical care

Bruns, D., 2019, APA Conference, Chronic Pain Treatment and the Opioid Crisis: A Science-Based Interdisciplinary Approach
Jacobs et al, (2016), British Journal of Pain, 10(1), 38-45
Jensen & Turk, (2014), American Psychologist, 62(2), 105-118
Molton & Terrill, (2014), American Psychologist, 69(2), 197-207
Perquin et al, (2000), Pain, 87(1), 51-58
Significant Healthcare Costs

Focus Article

The Economic Costs of Pain in the United States

Darrell J. Gaskin* and Patrick Richard

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Abstract: In 2008, according to the Medical Expenditure Panel Survey (MEPS), about 100 million adults in the United States were affected by chronic pain, including joint pain or arthritis. Pain is costly to the nation because it requires medical treatment and complicates treatment for other ailments. Also, pain lowers worker productivity. Using the 2008 MEPS, we estimated 1) the portion of total U.S. health care costs attributable to pain; and 2) the annual costs of pain associated with lower worker productivity. We found that the total costs ranged from $560 to $635 billion in 2010 dollars. The additional health care costs due to pain ranged from $261 to $300 billion. This represents an increase in annual per person health care costs by about $4,250 for persons without pain. The value of lost productivity due to pain ranged from $29 to $335 billion. We found that the annual cost of pain was greater than the annual costs of heart disease ($309 billion), cancer ($263 billion), and diabetes ($188 billion). Our estimates are conservative because they do not include costs associated with pain for nursing home residents, children, military personnel, and persons who are incarcerated.

Perspective: This study estimates that the national cost of pain ranges from $560 to $635 billion, larger than the cost of the nation's priority health conditions. Because of its economic toll on society, the nation should invest in research, education, and training to advocate the successful treatment, management, and prevention of pain.

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Keywords: Cost of illness, chronic pain, persistent pain.
United States National Pain Strategy for Population Research: Concepts, Definitions, and Pilot Data

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5Yale University School of Medicine, New Haven, Connecticut.
**University of Virginia Health System, Charlottesville, Virginia.
6University of Washington School of Dentistry, Seattle, Washington.
7National Institute of Neurological Disorders and Stroke, National Institutes of Health, Bethesda, Maryland.
8Department of Psychiatry, St. Louis University School of Medicine, St. Louis, Missouri.
9University of Washington School of Medicine, Seattle, Washington.
10Chronic Pain Research Alliance, Milwaukee, Wisconsin.
***Stanford University School of Medicine, Palo Alto, California.
Hot Research Topics in Pain Management

- Racial/Ethnic Patterns
- Pediatric Pain
- Resilience
- Diagnostic Uncertainty
- Psychosocial Risk
- Stigma and Perceived Injustice
- Fear

Other topics receiving attention:

- Couples and families
- Coping
- Opioids
- Pre-surgery risk
- System approaches
- PTSD/Pain
- High-impact chronic pain

Journal of Pain
Health Psychology
2016-2019
Pain Drivers

An aversive sensory and emotional experience, typically caused by, or resembling that caused by, actual or potential tissue injury (IASP, 2019)

Damage or dysfunction of peripheral nerves

Peripheral Nervous System

Nociceptive

Tissue damage or Inflammation

Excitatory and Inhibitory Pain Pathways

Neuropathic

Central Nervous System

Central or Nociplastic

Psychophysiological Pain

Diffuse hyperalgesia and allodynia

Psychological conflicts: intimacy or autonomy struggles, shameful secrets, perfectionism, fear of assertion, or social rejection.
Lumley & Schubiner, 2019, Psychosomatic Medicine, 81, 114-124
Adverse Childhood Events

Adverse childhood events (ACEs) are characterized as traumatic life events occurring before age eighteen.

 Increased risk of physical/MH dx

 Dose response risk

Pain Volume Control Switch or Pain Matrix

Nociplastic Pain Drivers

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Pain Patterns

Structural

Dermatomal Consistency

Persistent

Psychophysiological

Dermatomal Variation

Situation-Specific

Chronic Pain: Combined Conditions

Nociceptive: none, small, moderate, large

Neuropathic: none, small, moderate, large

Nociplastic: none, small, moderate, large

Subjective Pain

Imaging and physical exams are not effective predictors of the percent contributions or subjective pain.
Identifiable Tissue Damage and Persisting Pain

Injury
Inflammation
Cancer
Structural Disorder
Damage to Brain Cells

Acute Pain
Decreased nerve regeneration and healing; CNS reorganization

Persisting Structural Drivers
Central Sensitization and Conditioned Pain Responses

Persisting and Chronic Pain
Decreased pain tolerance and psychosocial risk

Distress reduces wound healing

Feizerfan (2015), Continuing Education in Anesthesia, Critical Care & Pain, 15(2), 98-102
Gouin & Kiecolt-Glaser (2011), Immuno, Allergy, Clin North, 31(1), 81-93
Psychophysiological/Central Pain

Affective/Motivational Processing: anterior cingulate cortex, amygdala, periaqueductal gray, anterior insula, and nucleus accumbens

Cognitive Modulation: frontal cortex and anterior cingulate cortex

Voluntary and Involuntary Muscles
Inflammation
Central Amplification

Continuum of conscious and unconscious central pain drivers!

Learned cognitive, behavioral and interpersonal factors—low trauma load, insightful and healthy attachments (Kinesiophobia)

Difficulty identifying, experiencing and expressing emotions—higher trauma load, more emotional conflicts, increase attachment problems, and poorer insight

Table 1

Incidence of CPSP, severe CPSP, and proportion of neuropathic pain in CPSP.

<table>
<thead>
<tr>
<th>Type of surgery</th>
<th>Incidence of all CPSP</th>
<th>Incidence of severe CPSP (&gt;5/10 of 10/10)</th>
<th>Proportion of neuropathic pain in CPSP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amputation</td>
<td>30%–85%</td>
<td>5%–10%</td>
<td>80%</td>
</tr>
<tr>
<td>Caesarean delivery</td>
<td>6%–55%</td>
<td>5%–10%</td>
<td>50%</td>
</tr>
<tr>
<td>Cholecystectomy</td>
<td>3%–50%</td>
<td>Not reported</td>
<td>Not reported</td>
</tr>
<tr>
<td>Coronary bypass</td>
<td>30%–50%</td>
<td>5%–10%</td>
<td>Not reported</td>
</tr>
<tr>
<td>Craniotomy</td>
<td>7%–30%</td>
<td>25%</td>
<td>Not reported</td>
</tr>
<tr>
<td>Dental surgery</td>
<td>5%–13%</td>
<td>Not reported</td>
<td>Not reported</td>
</tr>
<tr>
<td>Hip arthroplasty</td>
<td>27%</td>
<td>6%</td>
<td>Not reported</td>
</tr>
<tr>
<td>Inguinal herniotomy</td>
<td>5%–63%</td>
<td>2%–4%</td>
<td>80%</td>
</tr>
<tr>
<td>Knee arthroplasty</td>
<td>13%–44%</td>
<td>15%</td>
<td>6%</td>
</tr>
<tr>
<td>Melanoma resection</td>
<td>9%</td>
<td>Not reported</td>
<td>Not reported</td>
</tr>
<tr>
<td>Mastectomy</td>
<td>11%–57%</td>
<td>5%–10%</td>
<td>65%</td>
</tr>
<tr>
<td>Sternotomy</td>
<td>7%–17%</td>
<td>Not reported</td>
<td>Not reported</td>
</tr>
<tr>
<td>Thoracotomy</td>
<td>5%–65%</td>
<td>10%</td>
<td>45%</td>
</tr>
<tr>
<td>Vasectomy</td>
<td>0%–37%</td>
<td>Not reported</td>
<td>Not reported</td>
</tr>
</tbody>
</table>

Compiled from multiple sources including Refs. 9,14,22.

CPSP, chronic postsurgical pain.
<table>
<thead>
<tr>
<th>Domain of risk factor</th>
<th>Preoperative period</th>
<th>Intraoperative period</th>
<th>Postoperative period</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Demographic</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Sex</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Others</td>
<td></td>
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<tr>
<td><strong>Genetic</strong></td>
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<td></td>
<td></td>
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<tr>
<td>Multiple mutations</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Psychological</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depression</td>
<td></td>
<td></td>
<td>Depression</td>
</tr>
<tr>
<td>Psychological vulnerability</td>
<td></td>
<td>N/A</td>
<td>Psychological vulnerability</td>
</tr>
<tr>
<td>Stress</td>
<td></td>
<td></td>
<td>Stress</td>
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<tr>
<td>Anxiety</td>
<td></td>
<td></td>
<td>Anxiety</td>
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<tr>
<td>Catastrophising</td>
<td></td>
<td></td>
<td>Catastrophising</td>
</tr>
<tr>
<td><strong>Pain</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preoperative chronic pain</td>
<td>N/A</td>
<td></td>
<td>Severe acute pain</td>
</tr>
<tr>
<td>Preoperative opioid use</td>
<td></td>
<td></td>
<td>Acute neuropathic pain</td>
</tr>
<tr>
<td>Increased sensitivity to experimental pain</td>
<td></td>
<td>N/A</td>
<td>Acute secondary hyperalgesia</td>
</tr>
<tr>
<td>Increased temporal summation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Decreased CPM</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Surgical</strong></td>
<td>N/A</td>
<td></td>
<td>Need for repeated revisions</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Nerve injury</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Longer duration of surgery</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Traumatic approaches</td>
</tr>
<tr>
<td><strong>Clinical</strong></td>
<td>Severity and numbers of comorbidities</td>
<td>N/A</td>
<td>Radiotherapy</td>
</tr>
<tr>
<td></td>
<td>Disability</td>
<td></td>
<td>Chemotherapy</td>
</tr>
</tbody>
</table>

Compiled from multiple sources including Refs. 13,22,26.
CPM, conditioned pain modulation; CPSP, chronic postsurgical pain.
Demographics of Pain

• Racial and/or ethnic minorities report more pain and have a higher prevalence of pain conditions compared with non-Hispanic white individuals.

• Hispanic Americans have the lowest level of medical insurance and more barriers to care than any other ethnic or racial group.

• Racial and ethnic minorities perceive significant discrimination in pain care.

• African Americans and individuals in the lowest wealth quartile report more pain-related disability.

• Relative to non-Hispanic whites, Hispanic Americans experience less pain interference (i.e., cultural emphasis on stoicism)

• A greater proportion of racial/ethnic minorities, specifically African Americans, have greater radiographic and symptoms of osteoarthritis.

Team-Based Pain Care

Common philosophy of functional restoration
Dynamic treatment informed by team input
Shared goals, education and messaging
Clearly defined clinical procedures
Early intervention with an engaged patient
Continuous communication

Resource and Structural Barriers

Fragmented Care

Multidisciplinary Care

Interdisciplinary Care

$ Disincentives

WORLD A

WORLD B
Stages of Grief and Chronic Pain

1. Shock and Disbelief
2. Protective Responses
3. Emotional Distress and Catastrophizing
4. Medical Treatment Focus
5. Stuck in a Loop
6. Search for a Solution/Cure
7. Acceptance, Emotional Integration, Efficacy and Resilience

↑ Psychological Flexibility
Pediatric Chronic Pain

- Functional: Abdominal, Musculoskeletal and Headache
- Structural: Post Cancer, Juvenile Idiopathic Arthritis & Sickle Cell Disease
- Adverse Childhood Events, Distress and Avoidant Coping
- Caregiver Distress, Pain Behaviors and Enabling
- Sleep Impairment
- Social-and-Emotional Regulation Skill Deficits
- Early Intervention: Triage Structural and Psychophysiological Drivers

Diagrams:
- Functional
- Structural
- Caregiver
- Sleep
- Social-emotional
- Early Intervention
- Adverse Childhood Events
Psychological Inflexibility: Pain Impact

Catastrophizing: Past or Future

Fixated on Medical Diagnosis and Treatment

Avoiding Anticipated Pain

Increased Emotional Integration

Decreased Emotional Integration

Increased Judgment: Self and Others

Disconnection from Values’

Loneliness

Perceived Injustice/Shame

Loss of meaning and purpose

Psychological Empty Spaces

Despair Active conflicts

“Stuck”

Lack of Presence/Mindfulness

Psychological and Physical Deconditioning

Fusion with Unhelpful Thoughts, Beliefs and Stories

Experiential Avoidance & Lack of Acceptance

Medication and Procedural Reliance

Increases nociplastic pain in pain conditions with various combinations of pain drivers
High-Impact Chronic Pain (HICP)

Original Reports

Prevalence and Profile of High-Impact Chronic Pain in the United States

Mark H. Pitcher, * Michael Von Korff, † M. Catherine Bushnell, * and Linda Porter †

*National Center for Complementary and Integrative Health, National Institutes of Health, Bethesda, Maryland, †Kaiser Permanente Washington Health Research Institute, Seattle, Washington, †Office of Pain Policy, National Institute of Neurological Disorders and Stroke, National Institutes of Health, Bethesda, Maryland

Available online at www.jpain.org and www.sciencedirect.com
High-Impact Chronic Pain

4.8% of the US population
10.6 million individuals


Moderate to severe pain – Increased prevalence of widespread pain

↑ Medication Risks
↑ Distress

Risk for Suicide

Younger adults
Men
HS or below education
Poverty
Hx of Anxiety/Depression

Daily impairment in one or more: work, school or training, leisure/social activity, time with friends/family, chores, transportation, important activities, and community gatherings (32% with 2-3 limitations and 22% have more than 4 limitations)

Low-Impact Chronic Pain

- Open to Mind/Body Strategies
- Willing to experience and express emotional pain

Broad Range of Reported Pain Severity

- Mild interference with enjoyment of life and activities

Effective self-management, emotional integration and meaning/purpose

↑ Committed Action
↑ Self-Efficacy
↑ + Social Support
### Key Components of Pain Evaluation

<table>
<thead>
<tr>
<th>Ethnic/Racial Factors</th>
<th>Structural versus Functional Disorders (e.g. peripheral versus central)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pain History</td>
<td>Screen for Suicidal Ideation and Risk</td>
</tr>
<tr>
<td></td>
<td>Purpose, Values and Goals</td>
</tr>
<tr>
<td>Emotional Dysregulation-Integration</td>
<td>Catastrophizing-Acceptance/Self-Efficacy</td>
</tr>
<tr>
<td></td>
<td>Behavioral Avoidance-Committed Action</td>
</tr>
<tr>
<td></td>
<td>Interpersonal Tension-Empathic Connection</td>
</tr>
<tr>
<td>Feasibility of Care Coordination</td>
<td>Medical, Mental Health and Substance Use Comorbidity</td>
</tr>
</tbody>
</table>
Psychological Flexibility and Pain Resilience

Psychological flexibility is “the ability to contact the present moment fully as a conscious human being, and to change or persist in behavior when doing so serves valued ends” (p.7).

Hayes et al, (2006), Behavior Research and Therapy, 44, 1-25
Lumley & Schubiner, 2019, Psychosomatic Medicine, 81, 114-124
MECHANISMS OF PSYCHOLOGICAL FLEXIBILITY

- Present-Moment Awareness
  - Acceptance: Nonjudgment and Emotional Integration
  - Cognitive Rerame-Defusion

- Values Insight
  - Committed Action
  - Self-as-Observer

- Empathy and Intimacy
  - Courage and Fearlessness
  - Non-Reactivity
  - Recognize, Experience & Express Grief & Emotions
  - Mindfulness
  - Wise Mind
  - Meeting Reality with Openness: Pain Acceptance
  - Self-Compassion

- Behavioral Activation, Graded Exposure, Practice & Perseverance
- Body Strong and Open
- Connection and Caring
- Conscientiousness, Giving and Taking Care of, Open to Experience & Agreeableness
- Gratitude
- Meaning and Purpose
Neuropsychology of Psychological Flexibility

↑ Stability Regulation: PFC, Hippocampus, Insula, Striatum, PG, ACC, PCC
↓ Amygdala Activity

↑ Braking
↓ Acceleration

↑ Pain Tolerance
↓ Pain Volume

↓ Inflammation


Fig. 2. Based on Hammers ROIs. Coronal (A), Sagittal (B), Axial (C) and 3D (D) view of gray matter areas involved in MBSR. Prefrontal cortex (blue) and Hippocampus (yellow) show increased activation, the Amygdala (green) shows decreased activation. (For interpretation of the references to colour in this figure legend, the reader is referred to the web version of this article.)
Practice Makes Permanent, Not Perfect!

Monitor for Adverse Reactions (10%)

Key factor between responders and non-responders in research

Deliberate Practice (DP)
- Attention
- Rehearsal
- Repetition

Practice strengthens circuits helpful in mindful awareness and emotional regulation.

Baer et al, (2019), Clinical Psychology Review, in press
Critical Review

Effects of Yoga Interventions on Pain and Pain-Associated Disability: A Meta-Analysis

Arndt Büssing,,* Thomas Ostermann,* Rainer Lüdtke,† and Andreas Michelsen‡

*Center for Integrative Medicine, Faculty of Medicine, University of Witten/Herdecke, Herdecke, Germany.
†Karl und Veronica Carstens-Stiftung, Essen, Germany.
‡Department of Internal and Complementary Medicine, Charité-University Medical Centre, Immanuel Hospital Berlin-Wannsee, Berlin, Germany.

Abstract: We searched databases for controlled clinical studies, and performed a meta-analysis on the effectiveness of yoga interventions on pain and associated disability. Five randomized studies reported single-blinding and had a higher methodological quality; 7 studies were randomized but not blinded and had moderate quality; and 4 nonrandomized studies had low quality. In 6 studies, yoga was used to treat patients with back pain; in 2 studies to treat rheumatoid arthritis; in 2 studies to treat patients with headache/migraine; and 6 studies enrolled individuals for other indications. All studies reported positive effects in favor of the yoga interventions. With respect to pain, a random effect meta-analysis estimated the overall treatment effect at SMD = −0.74 (CI: −0.97; −0.52, P < .0001), and an overall treatment effect at SMD = −0.79 (CI: −1.02; −0.56, P < .0001) for pain-related disability. Despite some limitations, there is evidence that yoga may be useful for several pain-associated disorders. Moreover, there are hints that even short-term interventions might be effective. Nevertheless, large-scale further studies have to identify which patients may benefit from the respective interventions.

Perspective: This meta-analysis suggests that yoga is a useful supplementary approach with moderate effect sizes on pain and associated disability.

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Key words: Yoga, pain, disability, review, meta-analysis, mind body medicine, complementary medicine.
Yoga Therapy
Tai Chi for Chronic Pain Conditions: A Systematic Review and Meta-analysis of Randomized Controlled Trials

Ling Jun Kong¹, Romy Lauche², Petra Klose³, Jiang Hui Bu¹, Xiao Cun Yang¹, Chao Qing Guo¹, Gustav Dobos³,* & Ying Wu Cheng¹,*

Several studies reported that Tai Chi showed potential effects for chronic pain, but its role remains controversial. This review assessed the evidence regarding the effects of Tai Chi for chronic pain conditions. 18 randomized controlled trials were included in our review. The aggregated results have indicated that Tai Chi showed positive evidence on immediate relief of chronic pain from osteoarthritis (standardized mean difference [SMD], −0.54; 95% confidence intervals [CI], −0.77 to −0.30; P < 0.05). The valid duration of Tai Chi practice for osteoarthritis may be more than 5 weeks. And there were some beneficial evidences regarding the effects of Tai Chi on immediate relief of chronic pain from low back pain (SMD, −0.81; 95% CI, −1.11 to −0.52; P < 0.05) and osteoporosis (SMD, −0.83; 95% CI, −1.37 to −0.28; P = 0.003). Therefore, clinicians may consider Tai Chi as a viable complementary and alternative medicine for chronic pain conditions.
Pain Science Education

- Pain harm-alarm system
- Peripheral and central pain inputs
- All pain is real
- Plasticity of pain pathways and neurophysiological matrix
- Hurt versus harm
Results of Pain Science Education

• “I understand now that pain is a product of the brain”

• “I have learned that pain is not always a sign of damage”

• “I now realize that stress can trigger nerves that create pain”

• ”My fears decrease when I move my body—I just need the courage to continue”

• ”I have to find ways of lowering my inflammation”
Emotional Integration

Lumley & Schubiner, 2019, Psychosomatic Medicine, 81, 114-124
Results of Emotional Integration Strategies

• “I never realized how much my bottled-up anger was affecting my pain”

• “I have been asserting myself with my husband and I am experiencing a reduction in my headaches”

• “I now understand how much tension I was carrying in body because of my painful childhood”

• “When I feel insecure and afraid, my stomach hurts—now I see the connection”
Mindfulness Umbrella

- Openness
- Discovery
- Presence
- Observing
- Acceptance

Yoga and Tai Chi

Attention to Breath

Gratitude and Self-Compassion

Movement

Integration

Balance

Stability

Gratitude and Self-Compassion

Movement

Integration

Balance

Stability

Attention to Breath
Results of Mindfulness Practice, Yoga and/or Tai Chi

• “I use by breath to center myself when I start catastrophizing about pain”

• “I can move my body by breathing, paying attention, and accepting how my body is”

• “I am growing roots and I am learning to be flexible each day”

• “I have learned how to quiet my mind and stay connected to my body and life”

• ”I know that each breath is a new beginning”
Reduce Perceived Danger

- Catastrophizing
- Cognitive reappraisal and/or cognitive defusion
- Self-statements that reflect physical strength and flexibility, and safety
- Reframing pain as more benign
- Defuse pain stories
Cognitive Reappraisal

• Tracking fearful and depressive pain-related thoughts
• Identifying the triggers of these thoughts and their consequences on emotion and behavior
• Dismantling the unsupported beliefs holding these thoughts together
• Reframing the thoughts to align with evidence
• Tracking the behavior and emotional change that is the consequence of evidence-based thoughts and beliefs
• Promoting expansion in functioning and quality of life
Cognitive Defusion

• Mindful of unhelpful pain-related thoughts, beliefs and stories
• Mindful observation of their presence and understanding that we can see our thoughts, but do not have be our thoughts
• Letting these thoughts appear and disappear
• Creating breathing room
• 10-second rule
• Self-compassion for the way our minds are!
Expansion and Committed Action

Values

Goals

Connection, Caring and Contribution

Realistic and Graded

Experiential Engagement

Mindful Defusion of Fears

Graded Exposure

Small steps done consistently

Stories will be activated

Move towards rather than away

2/20/2020
Values

What really matters? What sort of person do you want to be?
What personal strengths or qualities do you want to develop?

How are values and meaning in life connected?

How does one live a meaningful life if pain persists?

Take A Stand!

Gratitude = improved wellness

Value-Driven Behavior and Self-Efficacy
Examples of Committed Action in Individuals with Chronic Pain

• “After so many years I am now playing with my grandchildren”

• “I have been working with my trainer for 2 months now—she understands me”

• “I am really glad I started the free one-on-one yoga therapy sessions”

• “I can now walk for 30 minutes—that is great progress”

• “I feel better about myself since I started volunteering and helping others”

• “I rejoined by friends for our weekly lunch and talk”
Adaptive Interpersonal Communication

- Assertiveness training
- Meet needs for connection
- Role playing communication challenges
- Changing roles that trigger emotional pain
- Communicating through courage
- Pruning toxic relationships that become pain amplifiers
Results of Adaptive Interpersonal Communication

• “I am standing up for myself and as a result I am carrying less tension in my body”

• “I really understand now how the anger I was sitting on was making my pain worse”

• “I have been practicing mindful listening and I feel less tense and pain when talking to my husband”

• ”I understand how negotiating for what I need is good for my body”
Questions?

drhillenberg@gmail.com

248.892-4364