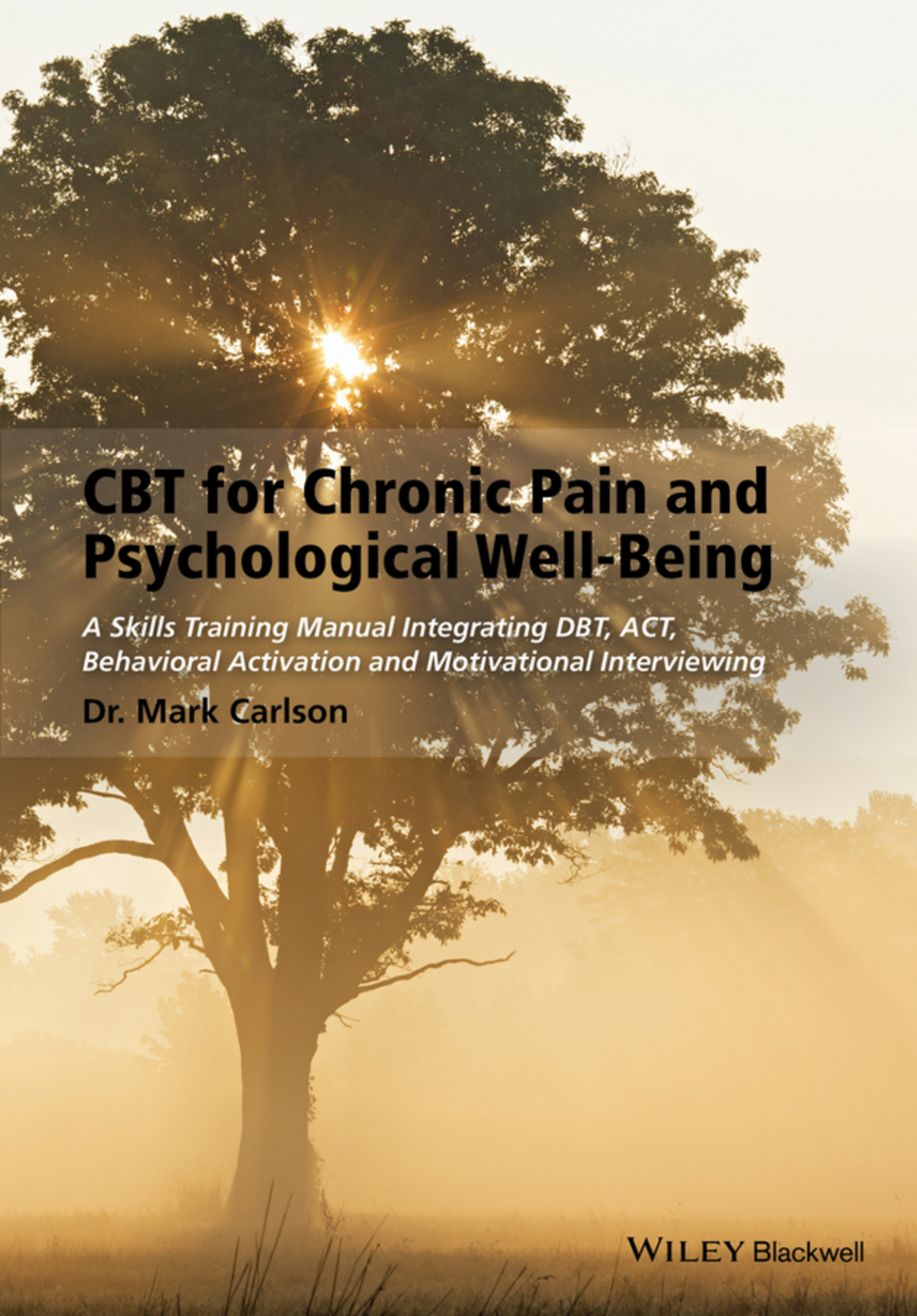
CBT for Chronic Pain and Psychological Well-Being
A Skills Training Manual Integrating DBT, ACT, Behavioral Activation and Motivational Interviewing
Dr. Mark Carlson
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To:

Jules and Spencer – I love you both with all of my heart

Mom and Dad – your love and support means the world to me

Grandma and Grandpa – I wish you would have been able to stay with us longer

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Chapter 1

Introduction to Comorbid Mental Health and Chronic Pain

The prevalence and cost of chronic pain is a growing concern in the United States. During the past decade, increasing research focus on exploring treatment for chronic pain has led to important implications for current coordination of medical and psychological management to treat individuals suffering with chronic pain. There are relatively few research articles that are not diagnosis- or syndrome-specific, with even fewer random clinical trials (RCTs) or meta-analytic studies. In their research, Elliott and colleagues (1999) have indicated that at least 45 percent of Americans will seek treatment or care for chronic pain at some point in their lives, making a total of over 50 million people in the United States. The Centers for Disease Control and Prevention reported that in 2005, 133 million Americans were experiencing chronic illness, equivalent to almost 1 out of every 2 adults. Nearly a quarter of people with chronic conditions also reported experiencing limitations to daily activity due to their illness, and also experienced clinical mental health concerns. Currently, children suffering from chronic illnesses that were considered fatal in the past now live well into adulthood, thanks to advances in medical care. While these advances are promising, they can result in prolonged lifespans and chronic pain (Martinez, 2009). In response to such findings, in 2010 the Joint Commission on Accreditation of Healthcare Organizations established a requirement for physicians to consider pain as a fifth vital sign, in addition to pulse, blood pressure, core temperature, and respiration (Gatchel, Peng, Peters, Fuchs, & Turk, 2007). Survival from chronic health conditions brings new challenges for individuals throughout their lifespan, including physical, psychological and social adjustment difficulties.

Health Care Costs

Chronic pain is associated with a wide range of illness, injury, disease, and mental health issues, and it is sometimes the primary concern in and of itself. With some

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conditions, pain and the associated symptoms arise from a discrete cause, such as postoperative pain or pain associated with a malignancy. In other situations pain constitutes the primary problem, such as neuropathic pains or headaches. Millions suffer from acute or chronic pain every year and the effects of pain take a tremendous toll on our country in terms of health care costs, rehabilitation, and lost worker productivity, as well as in terms of the emotional and financial burden placed on patients and their families. The costs of pain can result in longer hospital stays, higher rates of re-hospitalization, more emergency room visits, more unnecessary medical visits, and a reduced ability to function that leads to lost income and insurance coverage. As such, patients' unrelieved chronic pain often results in an inability to work and maintain health insurance.

According to a recent Institute of Medicine Report titled *Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education, and Research*, pain is a significant public health problem that costs society at least $560–$635 billion annually, an amount equal to about $2,000 for every person living in the United States. This includes the total incremental cost of health care due to pain ranging from $261 to $300 billion, and losses of productivity and associated issues ranging from $297–$336 billion.

Chronic Pain and Function

Pain is a complex sensational experience resulting from brain signals and damage or irritations to the nervous system, and is encompassed by cognitions, sensory-motor input, emotions, and hormone systems (Gatchel, 2004). Pain can be caused by chronic medical conditions, neuropathic trauma, injury, and accidents (American Society of Anesthesiologists, 2010). Acute pain is short term and temporary. Chronic pain is long term with symptoms exceeding three months (Lewandowski, 2006). The comorbidity of mental health and physical problems resulting from pain is well established in the research (Gatchel, 2004). Common comorbidity includes anxiety, depression, adjustment disorder, obsessive-compulsive disorder (OCD), histrionic personality disorder, and borderline personality disorder (BPD). The trigger is the pain and uncertain prognosis of the diagnosed condition, specifically around progression of the disease, recurrence, reduced lifespan, end-of-life issues, treatment and side-effects, cognitive, physical, and behavioral impairments, and functional limitations (Ownsworth, 2009). Pain often results from chronic illness, injury, degeneration, and many related triggers in a chronic population. People who experience chronic pain often experience a decrease in quality of life including: overall physical and emotional health; psychological and social well-being; fulfillment of personal expectations and goals; economic burden and financial stability; functional capacity to carry out daily routines; and activities of daily living. Additionally, destruction of family and social life, problems with treatment adherence and support systems, and decreased participation in sports or leisure activities have been found to increase the risk of clinical anxiety and depression, resulting in greater functional impairment and poor quality of life (Gatchel *et al.*, 2007). This functional impairment and reduction in quality of life often leads to a variety of mental health concerns including

demoralization and a reduction in effective participation in treatment as well as life in general.

Medical Interventions

There are a variety of medical interventions that are frequently implemented in the treatment of chronic pain. The American Society of Anesthesiologists Task Force (2010) conducted a literature review of treatment techniques for chronic pain and noted research support for the following nine interventions: ablative techniques, acupuncture, blocks (e.g., joint and nerve or nerve root), botulinum toxin injections, electrical nerve stimulation, epidural steroids with or without local anesthetics, intrathecal drug therapies, minimally invasive spinal procedures, and trigger point injections. The recommendations for use vary depending on the epidemiology of the chronic pain condition in question.

Pharmacotherapy

Pharmacologic management is often included in the treatment regimen of chronic pain conditions. Pharmacotherapy for the treatment of chronic pain includes the use of anticonvulsants, antidepressants, benzodiazepines, *N*-methyl-D-aspartate (NDMA) receptor antagonists, nonsteriodal antiiflammatory drugs (NSAIDs), opioid therapy (e.g., oral, transdermal, transmucosal, internasal, and sublingual), skeletal muscle relaxants, and topical agents (American Society of Anesthesiologists, 2010).

Physical therapy

The use of physical or restorative therapies for the treatment of chronic pain, particularly with back pain, has also been popular. A review of available research on the use of physical or restorative therapies for the treatment of chronic pain conducted by the American Society of Anesthesiologists (2010) indicated promising results. Randomized controlled trials that incorporated a variety of these therapies, such as with fitness classes, exercise therapy, and physiotherapy, were effective for treating low back pain. American Society of Anesthesiologists and American Society of Regional Anesthesia members recommended that physical or restorative therapies be implemented in the treatment strategy for patients with low back pain, as well as for other chronic pain conditions.

Cognitive Behavioral Therapy

Cognitive factors play an important role in the experience of chronic pain (Gatchel *et al.*, 2007). Cognitive Behavioral Therapy (CBT) interventions are based on the view that an individual's beliefs, evaluation, and interpretation about his or her health condition, in addition to pain, disability, and coping abilities, will impact the degree of both physical and emotional disability of the pain condition. CBT-based techniques currently vary widely in the literature, and can include distraction, imagery,

motivational self-talk, relaxation training, biofeedback, development of coping strategies, goal setting, and changing maladaptive beliefs about pain.

Morely, Eccleston, and Williams (1999) conducted a meta-analysis of randomized trials of Cognitive Behavioral Therapy (CBT) for treating clients with chronic pain. Their findings concluded that the use of CBT treatment to replace maladaptive patient cognitions and behaviors with more adaptive ones is effective for a variety of pain conditions. More recently, Linton and Nordin (2006) reported a 5-year follow-up of a randomized controlled trial of CBT intervention for clients suffering from chronic back pain. Their results indicated that CBT interventions (compared to the control group) resulted in significantly less pain, a more active life, higher perceived quality of life, and better overall health. In addition, significant economic benefits were associated with the clients who had completed CBT treatment.

Multimodal interventions

Multimodal interventions include the use of more than one type of therapy for the treatment of patients with chronic pain. Multidisciplinary interventions bring together multimodality approaches within the context of a treatment program that consists of more than one discipline. After a review of the literature on the treatment of chronic pain, the American Society of Anesthesiologists Task Force on Chronic Pain Management (2010) concluded that in comparison to conventional treatment programs, multidisciplinary treatment programs are more effective in reducing the intensity of pain reported by patients with chronic pain. Based on the research, the Task Force recommends that multimodal interventions should be part of the treatment plan for patients with chronic pain, and implemented within multidisciplinary teams if available.

Current psychological treatment modalities and levels of care

There currently appear to be three levels of care for clients suffering from chronic pain in the United States. The first level of care is primary medical treatment. This tends to be carried out in hospitals and interventions are based upon medical treatments for pain. This level involves assessment, surgery, acute-care, recovery, and is staffed primarily with medical teams and supplementary work with physical therapists and occupational therapists. Psychological interventions at this level typically operate in more of an ancillary fashion, and include assessment and interventions designed to assist the individual with planned medical procedures. The second level of care is more diverse in service options. At this level of care, hospitals, emergency rooms, outpatient medical programs, and specialty pain programs typically provide treatment. Psychological interventions at this level typically include time-limited individual therapy, biofeedback training, supportive group work, and psychoeducation to families and clients. Many pain programs incorporate psychological work at this level through ancillary treatment or manualized program options designed to support the work of the medical interventions. Research does not indicate any standard manualized approach that is either accepted or used across programs. Inpatient programs and specialty pain programs appear to have their own psychological treatment manuals

and standards of care for clients, but the content varies to a great degree. Some distinct commonalities are found, however: cognitive behavioral work with clients, relaxation training, biofeedback, and a growing emphasis on mindfulness. The third level of care is general outpatient work with clients. This level may include working with medical teams, rehabilitation and restorative therapies, work force training, and potentially worker's compensation claims. The client may have exhausted medical interventions and be faced with learning to accept their status and changes in functioning and quality of life. Psychological interventions at this level tend to include individual therapy, biofeedback training, supportive group work, and psychoeducation to clients and families.

It is clear that the medical model is the primary intervention strategy for levels one and two. Psychological interventions are typically considered to be supportive and ancillary in nature. When faced with the reality of having pain be a part of their lives with little or no hope for positive change or a cure, demoralization is a common reaction for many clients. The field of psychology has few treatment manuals and integrated treatment options for clients as they move to the third level of care. It is also quite clear that a client with comorbid mental health, chronic pain, and chemical use problems has few if any integrated treatment options available to them. This manual aims to provide practitioners with one of the first comprehensive guides to treating clients at levels two and three – and which can be applied across modalities and multiple levels of care.

Chapter 2

Treatment Organization, Outline, and Structure of the Program

The TAG (Teach, Apply, and Generalize) program has its roots in the philosophy of contextualism. Leaders in the philosophy of contextualism include James, Dewey, Mead, K. Burke, and Bormann. The predominant character of behavior analysis or at least what is central and distinctive about behavior analysis, is contextualistic (Hayes 1988). The philosophy of contextualism corresponds well with Behavioral Analytic concepts of the operant, accomplishment of attainable goals, the active role of the therapist, and working with order and randomness. The TAG program incorporates these key concepts into its fundamental structure and operations. The TAG program is based on Cognitive Behavioral Therapy through practice, primary intervention strategies, and skills training. The TAG program incorporates skills and concepts from: Dialectical Behavior Therapy (DBT), Motivational Interviewing (MI), Acceptance and Commitment Therapy (ACT), and Behavioral Activation (BA). The TAG curriculum also includes grief and loss work, Existential approaches, relapse-prevention, Mindfulness, identity development, and an additional track of service for individuals with substance dependence through DBT-S (dialectical behavior therapy for substance use disorders).

There are many theories and approaches in the field of psychology. Empirically Supported Treatments (ESTs) were identified and relevant research was reviewed in order to create the TAG program. It was decided to continue the development through a contextual model that incorporates components shared by all approaches to psychotherapy, as well as six elements that are common to the rituals and procedures used by all psychotherapists (see below). As Arkowitz (1992) reports, dissatisfaction with individual theoretical approaches spawned three movements: (a) theoretical integration, (b) technical eclecticism, and (c) common factors. The contextual model is a derivative of the common factors view (Wampold 2001).

According to Wampold (2001):

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> A contextual model was proposed by Jerome Frank in his book, *Persuasion and Healing* (Frank & Frank 1991). According to Frank and Frank (1991), "the aim of psychotherapy is to help people feel and function better by encouraging appropriate modifications in their assumptive worlds, thereby transforming the meanings of experiences to more favorable ones" (p. 30). Persons who present for psychotherapy are demoralized and have a variety of problems, typically depression and anxiety. That is, people seek psychotherapy for the demoralization that results from their symptoms rather than from symptom relief. Frank has proposed that "psychotherapy achieves its effects largely and directly by treating demoralization and only indirectly treating overt symptoms of covert psychopathology" (Parloff, 1986, p. 522)

> Frank and Frank (1991) described the components shared by all approaches to psychotherapy. The first component is that psychotherapy involves an emotionally charged, confiding relationship with a helping person (i.e., the therapist). The second component is that the context of the relationship is a healing setting, in which the client presents to a professional whom the client believes can provide help and who is entrusted to work in his or her behalf. The third component is that there exists a rationale, conceptual scheme, or myth that provides a plausible explanation for the patient's symptoms and prescribes a ritual or procedure for resolving them. The final component is a ritual or procedure that requires the active participation of both client and therapist and is based on the rationale (i.e., the ritual or procedure is believed to be a viable means of helping the client).

> Frank and Frank (1991) discussed six elements that are common to the rituals and procedures used by all psychotherapists. First, the therapist combats the client's sense of alienation by developing a relationship that is maintained after the client divulges feelings of demoralization. Second, the therapist maintains the patient's expectation of being helped by linking hope for improvement to the process of therapy. Third, the therapist provides new learning experiences. Fourth, the client's emotions are aroused as a result of the therapy. Fifth, the therapist enhances the client's sense of mastery or self-efficacy. Sixth, the therapist provides opportunities for practice.

Wampold (2001) furthers this concept by adding that in the contextual model, specific ingredients are necessary to construct a coherent treatment that therapists have faith in and that provides a convincing rationale to clients.

The TAG program was created for individuals experiencing issues with comorbid mental health and chronic pain. The model that was adopted as a framework of understanding and organization is the biopsychosocial model of pain pioneered by G. L. Engel (1977).

According to Lewandowski (2006):

> We are beginning to live in the era of the biopsychosocial (BPS) view of pain, which takes into account the biological (physical) influences, but also looks at the psychological (emotional) influences and places them in a social (personal) context.

The Cartesian (biological) model of pain

The explanation for pain that has dominated much of medical history came from the sixteenth-century Western philosopher, physiologist, and mathematician René

Descartes. The Cartesian model – essentially a biological model – set forth that anything that could be doubted should be rejected. Under Cartesian thinking, the only useful factor in the pain experience was tissue injury. Tissue injury could be measured; it could be proven. The degree of pain was assumed to be determined by and directly proportional to the degree of injury. Only the physical aspects of pain mattered. Any person with a particular injury was expected to feel and respond in exactly the same way as any other person with that same injury. In the Cartesian model, tissue injury can be likened to a dial controlling volume; turn up the injury, the tissue damage, and you turn up the pain. But chronic pain has been shown to be much less mechanistic.

The gate-control model of pain

The Cartesian theory was the firmly accepted way of looking at pain until 1965, when Ronald Melzack, a Canadian psychologist, and Patrick Wall, a British physiologist, put forth the gate-control theory of pain. Melzack and Wall (1988) argued that pain signals do not travel simply from the injured tissue to the brain; rather, those signals must go through a gating mechanism in the spinal cord. When the gate is closed, pain is not registered in the brain. When the gate is opened, pain registers. And the gate can be opened or closed by more factors than the signals caused by tissue damage.

The gate-control theory goes beyond a simple focus on the body and takes into account the impact of the mind. Melzack and Wall said that the gate could be opened or closed by emotions, memories, mood, and thoughts. After the signals reach a certain threshold, the brain generates pain sensations. In fact, the brain can register pain even when there is no tissue damage whatsoever (as with phantom pain from amputated limbs). PET scans have shown that parts of the brain light up with pain even when there is no tissue damage.

Despite wide acceptance of the gate-control theory of pain, today's physicians still tend to see pain in Cartesian terms (as a physical process and a sign of tissue damage) because they are trained in Cartesian terms. They know how to look for ruptured disks, fractures, infection, and disease. But when it comes to pain, most physicians get only a few hours of training in pain management, if they get any at all.

The biopsychosocial model: The future of pain management

While there are people who still believe that pain must not be real if a physical cause can't be found, the tide is turning. Unfortunately, some of the people questioning the reality of pain are medical professionals. But the more comprehensive and inclusive biopsychosocial model, pioneered by G. L. Engel (1977), is gaining widespread acceptance as more and more success is reported in its use.

One major drawback to the biological model was that it expected every person with the same injury to experience the same pain. There is no question that the focus of medicine on biological factors improved the quality of our lives. Take medications, for example. Antibiotics give us a powerful weapon against bacterial infections, anti-inflammatory medications reduce swelling and pain, and anti-hypertensives lower

blood pressure. But the biological model did not consider external influences as relevant to disease in general and pain in particular.

Today, our understanding of pain has evolved and broadened. We are beginning to live in the era of the biopsychosocial (BPS) view of pain, which takes into account the biological (physical) influences but also looks at the psychological (emotional) influences and places them in a social (personal) context. The BPS model considers the entire person – body, mind, and environment.

The TAG Program for Chronic Pain and Psychological Well-Being – Structure, Purpose, and Rationale

The TAG program is designed to be 3–6+ months in duration and have flexibility in implementation across modalities of treatment. The concepts and skills training of the TAG program can be easily applied in individual therapy if that is the primary modality for intervention. The individual therapist will be able to modify the format and select concepts and skill sets to customize for the individual. This modification relies on the education, training, and expertise of the clinician since it deviates from the initial design and intensity of the program. The design that will initially be discussed is a group skills training model. Groups meet two times weekly for 3 hours with an optional third day for individuals also diagnosed with chemical dependency; this third day is based on a DBT-S curriculum. A clinician does not need to adhere to a specific order for the sessions. The structure of the program provides the clinician with a high degree of flexibility. This allows for individualization and customization of the skills to each individual in the group. Each session is formatted to provide goals for the individual and the group as a whole. There are multiple discussion topics designed to assess the individual's strengths, barriers to effective functioning, and to establish a baseline of understanding and coping. The discussion points can also provide a general orientation and segue to the coping skills. Each session has general coping concepts and specific skill sets for the individual to learn. The individual is taught a set of skills, encouraged to practice in the session, and then move to generalizing the skills to multiple aspects of their lives.

Group/session structure

Section 1: teaching

The group structure of the TAG program is designed to meet twice each week for three hours. Each hour is designed to have a specific focus for the individual and the group as a whole. The first section is the Teaching hour. The section is designed to be 45–50 minutes in length. The teaching section is prioritized as the first section of the day to provide grounding for each individual, establish expectations that all members will be focusing on leaning and applying skills, and to reinforce participation throughout the process. This section introduces the specific goals for the teaching. It starts with an introduction to the topic and why the topic is challenging for individuals. Each individual is engaged in the process to identify if this is a strength area for them or a barrier to more effective functioning. If the individual identifies

the topic as a strength area, they are encouraged to establish a goal of building consistency and a sense of mastery with the skills. If the individual identifies the topic area as a barrier to more effective functioning, they are encouraged to establish a goal of learning the core concepts of the skill sets and create an initial plan and commitment to practice the skills in session. Individuals who are working toward building consistency and mastery may then serve as mentors to those individuals who are newer to the skill sets.

Once the individuals and the group as a whole have set goals, the general topic is discussed from a variety of perspectives. This allows for engagement in the process, general orientation to the topic, and to establish baselines of functioning. Individuals are encouraged to provide examples from their lives as to why and how the topic is relevant. The clinician is encouraged to identify strengths, barriers to effective functioning, needs, and provide a segue to the specific skill sets to be taught. This section is designed to be highly interactive and organic in its process. This is where members discuss the topic's relevancy to their situation and see that they are not isolated in their experience as other members are encouraged to share. This provides a direct grounding experience for many individuals and "normalizes" their reality.

The next section is the skills training component. This is the core of the TAG program. Each session has multiple skill sets to teach. The curriculum is designed to have multiple skill sets that are directly designed to work with the current topic and have generalizability to global coping. This is designed to ground the individual into their current needs, strengths, coping strategies, and global functioning. The next step is to teach specific sets of cognitive and behavioral skills designed to increase the individual's functioning. The skill sets are focused on the current topic and how the individual can learn and apply the skills directly in the session. Each individual incorporates a set of skills into their identified goal work and commits to a plan to generalize the skills into their daily functioning. This plan is then reviewed in the third section where it is problem-solved to address the individual's strengths and barriers.

Section 2: application

The application section is designed to focus on pattern recognition and awareness (based on the principles of self-monitoring and adherence to treatment). The section is designed to be 45–50 minutes in length. A tracking card or diary card is the primary tool used in this section. Each individual completes their tracking card before the session. They review their card with the clinician and the entire group. The card includes areas of functioning, needs, strengths, skills that were used/attempted, and how effective their application of skills have been since the last session. Peers provide feedback in the form of support, challenges, and suggestions to increase effective application and generalizability of the skill sets. Treatment goals and objectives are also reviewed daily in this section.

Section 3: problem-solving

The problem-solving section is designed to assist the individual in applying their strengths to overcome barriers to effective coping. The section is designed to be

45–50 minutes in length. Each individual is expected to identify one of their goal areas that they want to focus on. They take problem-solving time to discuss their strengths, difficulties, their skill implementation plan, commitment to skill use, and receive feedback from the clinician and peers on their action plan. The goal of this section is to have the individual commit to applying their skills outside of the therapeutic setting, create a clear action plan designed to increase the efficacy of their coping strategies incorporating new skills that have been taught in the program, and have a review/completion time established before the next session. The completed action plan is then reviewed in the second section of the next group session. This increases the individual's accountability for follow-through and establishes continuity between sessions.

Curriculum overview

The curriculum is designed to be topic driven (arranged by topic) in an open group format. Therapy is multimodal incorporating group and individual therapy. The program is organized through the Biopsychosocial Model. There are 7 sessions designed to target coping with the biological aspects of mental health and chronic pain; 14 sessions designed to target coping with the psychological aspects of mental health and chronic pain; and 7 sessions designed to target coping with the social aspects of mental health and chronic pain. The term "individual" is used in place of "patient" or "client" to challenge stigma and labels – personalizing therapeutic approaches leads to adherence and personal responsibility.

Sources and recommended readings

It is recommended that the clinician review the original publications and material in the reference section of this manual for further conceptual depth and understanding. I strongly suggest reviewing the works of Steven Hayes on Acceptance and Committment Therapy, William Miller and Stephen Rollnick on Motivational Interviewing, and Marsha Linehan on Dialectical Behavior Therapy.

Biologically based sessions

There are 7 sessions that comprise the focus of skills training designed to target issues related to the biological nature of the individual's mental illness and chronic pain. This section includes:

1. Goal Setting and Motivation
2. Functioning and Loss
3. Sleep
4. Emergence and Patterns
5. Adherence to Treatment Protocols
6. Complexity
7. Working with Your Team

Psychologically based sessions
There are 14 sessions that comprise the focus of skills training designed to target issues related to the psychological nature of the individual's mental illness and chronic pain. This section includes:

1. Orientation to Change
2. Readiness to Change
3. Depression
4. Anxiety
5. First Step toward Change
6. Anger Management
7. Attending to Distress
8. Meaning and Pain
9. Stress Management
10. Defense Mechanisms and Coping Styles
11. Stigma
12. Chemical Abuse
13. Lifespan Issues
14. Managing Flare-ups

Socially based sessions
There are 7 sessions that comprise the focus of skills training designed to target issues related to the social nature of the individual's mental illness and chronic pain. This section includes:

1. Managing Conflict
2. The 3 Is
3. Problem-Solving
4. Nurturing Support Systems
5. Social Roles in Relationships
6. Intimacy
7. Styles of Interacting

The goals of the program are to reduce hospitalizations, emergency room visits, decrease unnecessary doctor visits, improve individual functioning, improve quality of life, restore hope and activity, decrease demoralization, and reduce overall cost of care for the treatment of the targeted populations.

Suggested program/treatment outcome measures

Treatment Outcome Package (TOP)
The TOP is an outcome measure used to track changes in psychological symptoms and functional domains over the course of treatment. It was developed by Kraus, Seligman, and Jordan (2005) as a comprehensive outcome measurement tool for use in naturalistic settings that could gather information about the full spectrum of presenting problems and psychopathology. Additionally, the TOP collects data about

extraneous variables (e.g., changes in medications, medical illnesses, major life events, etc.) that serve as risk factors with the potential to significantly influence the course of treatment with behavioral health clients (Kraus and colleagues have named these variables *case-mix* variables). The TOP is designed to maximize the chances of measuring meaningful changes in psychological symptoms, functional domains, and case-mix variables over the course of treatment.

The TOP was normed on a large sample of adults with a variety of disorders seeking treatment in a variety of behavioral health services. The TOP generates reports using 12 clinically relevant scales that assist clinicians with (a) diagnosis, (b) treatment planning, (c) outcome assessment, and (d) improving the therapeutic relationship. The 12 clinical scales on the TOP are as follows: Depression, Quality of Life, Psychosis, Panic, Violence, Work Functioning, Mania, Sleep, Substance Abuse, Social Conflict, Sexual Functioning, and Suicidality.

SF-36

The SF-36 is a short form survey that was designed to evaluate health status as part of the Medical Outcomes Study. Initially formed and validated in 1988, it has since been cited in several thousand publications, and has been revised once, in 1996. It provides scores on a scale from 0 to 100 in 8 different domains. These domains are physical functioning, role-physical, bodily pain, general health, vitality, social functioning, role-emotional, and mental health. The reliability of these eight scales and subsequent summary measures have been evaluated in past studies using internal consistency along with test-retest methodology, with a minimum of .70 in the reliability coefficient being found in all but a few studies, and with .80 or higher being standard. The validity of this assessment is supported with various studies indicating that the measure has content, concurrent, criterion, construct, and predictive validity. The SF-36 v1.0 is available for free from the RAND Corporation, and the SF-36 v2.0 is currently controlled and licensed by Quality Metric.

BAP-2

The Behavioral Assessment of Pain Questionnaire (BAP-2) is a self-administered, multidimensional assessment tool for understanding factors that may be working to exacerbate and/or maintain sub-acute and chronic non-malignant pain. The BAP-2 was developed with a normative chronic pain sample of over 1,000 individuals suffering from sub-acute and chronic pain. As a pain assessment instrument, BAP-2 has been shown to have good reliability and validity data (Lewandowski, 2006).

The BAP-2 was developed using a biopsychosocial approach and examines various pain characteristics (e.g., pain intensity, pain behavior, and pain descriptions), past and current levels of physical activity, activity avoidance levels, fears of pain and reinjury, mood, attitudes and beliefs about pain, and behavioral responses to pain. There are over 32 scales that measure such variables as the impact that significant others, such as physicians and family members, may have on the individual's current pain behavior and make appropriate recommendations for successful treatment.

The BAP-2 generates a Clinical Profile report that helps the treating clinician develop a unique treatment plan tailored for that individual. An overall estimate of

dysfunction and impairment is estimated for each individual compared to the normative sample.

Quality of Life Questionnaire

The Quality of Life Questionnaire is an assessment tool designed by David Evans, Ph.D. and Wendy Cope, M.A. in 1985 (later published for public use in 1989). Its purpose is to measure "the relationship between a client's quality of life and other behaviors or afflictions, such as physical health, psychological health, and alcohol or other substance use." It contains a total of 192 true/false items, is self-administered, and reportedly takes about half an hour to complete. It can be scored by the administrator and results are provided through five domains (with a total of 15 subdomains). The major domains are General Well Being, Interpersonal Relationship, Organizational Activity, Occupational Activity, and Leisure/Recreational Activity. It has been used or referenced in approximately 600 studies and has been the subject of several psychometric evaluations to support its validity and reliability. It is available for purchase from Multi-Health Systems and has manual and web-based scoring options.

The Outcome and Session Rating Scales (ORS and SRS)

The ORS and SRS are brief measures for tracking client functioning and the quality of the therapeutic alliance. Each instrument takes less than a minute for consumers to complete and for clinicians to score and interpret. Both scales were developed in clinical settings where longer, research-oriented measures had been in use and deemed impractical for routine use. Versions of the ORS and SRS are available for adults, children, adolescents, and groups in 18 different languages, including French. Individual clinicians may download the scales free-of-charge after registering online at: http://www.scottdmiller.com/?q=node/6. A significant and growing body of research shows the scales to be valid, reliable, and feasible for assessing progress and the alliance across a wide range of consumers and presenting concerns.

Chapter 3

Clinical Manual for TAG Program

Biological Curriculum

Session focus: Goal setting and motivation

TAG
Teach – Apply – Generalize

- The goal of this session is to
  - Create one goal on each of the three areas: Biological/Psychological/Social
  - Provide feedback from assessment tools/measures and incorporate into the feedback and treatment planning process
  - Personalize client tracking tool for in-session use
  - Learn coping skills to improve the individual's functioning in the areas of goal setting and motivation to cope in a more effective manner
- What to discuss:
  - Setting realistic goals
  - Balancing wants with needs
  - Maintaining commitment to change
  - Introduce relevant forms
- Skills to teach
  - Observe, Describe, Participate
  - Non-judgmental Stance, One-Mindfully, Effectively
  - Radical Acceptance, Practical Acceptance, Practical Change, Radical Change
- Generalize
  - Create an action plan to complete **Goal Setting**
  - Problem-solve barriers
  - Commit to their plan
  - Review in next session
- Review goal sheet

CBT for Chronic Pain and Psychological Well-Being: A Skills Training Manual Integrating DBT, ACT, Behavioral Activation and Motivational Interviewing, First Edition. Mark Carlson.

Goal setting and motivation

Introduction of the topic

Many individuals want to make changes in their lives. Change is a natural state which allows individuals to be able to adapt, cope, and find enjoyment in life. Individuals are seldom taught how to be advocates for their own change. They may see something that they want and try to get it. When barriers and difficulties arise, individuals often try to continue on their current path until they get what they want, or quit trying because they lose hope. There are fundamental aspects to goal setting that are not formally taught. Education programs do not typically teach steps to goal setting. Life experiences tend to be the primary teacher. Individuals learn in a few basic ways and they can become quite rigid when they are forced to change. It may be easier to do nothing and just accept what is happening. They may feel that what is happening is unjust and respond by fighting against everything. All individuals feel like giving up or fighting everything at times, but extreme reactions tend to be very ineffective. They need to find balance, flexibility, and perseverance to be effective in a consistent manner. Most individuals struggle in three main areas: setting realistic goals, balancing wants with needs, and maintaining their commitment to change.

Setting realistic goals

There are a few key points to review about the process of goal setting. Goals need to be based in reality and they need to be attainable. Many individuals want a cure from their pain or illness. This is not realistic for most people. Hoping for a cure can often create barriers to coping and eventually decrease an individual's ability and desire to cope with their current situation. They need to strike a balance between hope for improvement and the work needed to increase functioning. Chronic health and pain issues can often lead to decreased hope and feelings of disempowerment and inability to necessitate change. Consistent work with goals and objectives can provide the core tools to increase hope and lead to more effective functioning. There are three main steps to setting realistic goals: identifying the Vision of Recovery (VOR), setting the goal, and establishing stepwise and sequential steps to reach the goal (objectives).

Balancing wants with needs

Many individuals struggle with prioritizing their work in treatment. It is natural in the course of treatment to want to focus on the most recent crisis, change in health, or change in functioning. This may be perfectly appropriate for many individuals, but may lead to loss of focus for treatment priorities. The clinician and the individual must agree upon the needs of the individual and prioritize treatment targets as a first step. Once that is done, a Skills Implementation Plan (SIP) form can be completed to target crises that may arise, without losing focus on the treatment priorities. This allows for crisis work in addition to maintaining focus on the agreed-upon treatment targets as changes occur.

Needs in treatment can be defined as something that is necessary for the individual to live a healthy life. Needs are distinguished from wants because with needs a