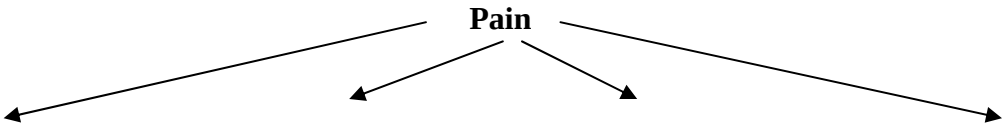

Daily Activities

Decreased self-care
Unable to perform daily activities
Household chores
Family
Social
Sports/recreation
Walking/Physical Activity
Sitting for a movie/show
Can't work
Can't carry kids/grandkids

Relationships

Less social interaction
Isolation
Strain
Helplessness
Uncertainty
Conflict
Miscommunication
Less intimacy

Thoughts/Beliefs/ Attitudes

"This pain is going to get worse and worse"
"I can't cope with this"
"There is nothing I can do about this"
"I am a failure"
"I can't accept this"
"I am useless"
"I feel sorry for myself"
"I am helpless"
"It's my fault"
"It's his/her fault"
"I'm letting them down"
"I have to show them I can still do it"
"If I take a break, I will look lazy"
"They don't believe me"
"They think it's all in my head"
"They just don't understand"
"Why me?"
"I am being punished"
"I'll never get better"
"This is never going to end"
"There must be some medical procedure that can fix this"

Feelings/Emotions

Frustration
Irritable
Anger
Guilt
Defensive
Sadness
Despair
Depression
Anxiety
Fear (of Injury)

Coping Strategies

Relaxation
Pacing
Rest
Ice/Heat
Distraction
Stretching
Exercise
Stress Management
Self-Talk
Changing Thoughts/Beliefs
Patience
Acceptance

Self-Help Books and Websites for Chronic Pain Self-Management

COPING WITH PAIN

Managing Pain Before It Manages You. (2009). Author: Margaret Caudill, Guilford Press, New York, NY

The Pain Survival Guide: How to Reclaim Your Life. (2006). Authors: Dennis Turk & Frits Winter, American Psychological Association, Washington, DC.

The Chronic Pain Control Workbook. (1996). Authors: Ellen Mohr Catalano & Kimeron Hardin, New Harbinger Publications, Oakland, CA

The Back Pain Helpbook. (1999). Authors: James Moore, Kate Lorig, Michael Von Korff, Virginia Gonzalez & Diana Laurent, Perseus Books, Reading, MA

Living Beyond Your Pain: Using Acceptance and Commitment Therapy to Ease Chronic Pain. (2006). Authors: Joanne Dahl & Tobias Lundgren, New Harbinger Publications, Oakland, CA

COPING WITH EMOTIONAL DISCOMFORT

Thoughts and Feelings: Taking Control of Your Moods and Your Life. (2011). Authors: Mathew McKay, Martha Davis, & Patrick Fanning, New Harbinger Publications, Oakland, CA

***The Mindful Way Through Depression: Freeing Yourself From Chronic Unhappiness*.** (2007). Authors: Mark Williams, John Teasdale, Zindel Segal & Jon Kabat-Zinn, Guilford Press, New York, NY

When Anger Hurts: Quieting the Storm Within. (2003). Authors: Mathew McKay, Peter Rogers & Judith McKay, New Harbinger Publications, Oakland, CA

STRESS REDUCTION AND MINDFULNESS MEDITATION

The Relaxation and Stress Reduction Workbook. (2008). Authors: Martha Davis, Elizabeth Robbins Eshelman & Mathew McKay, New Harbinger Publications, Oakland, CA

Wherever You Go, There You Are: Mindfulness Meditation in Everyday Life. (1995). Author: Jon Kabat-Zinn, Hyperion Books, New York, NY

USEFUL WEBSITES FOR CHRONIC PAIN SELF-MANAGEMENT

http://prc.canadianpaincoalition.ca

http://www.mindfulwaythroughanxietybook.com (downloadable meditation exercises)

http://www.dartmouth.edu/~healthed/relax/downloads.html (downloadable exercises and music)

The Gating Mechanism

At the heart of the gate-control theory is a neural "gate" that can be opened or closed in varying degrees, thereby modulating incoming pain signals before they reach the brain. The theory proposes that the *gating mechanism* is located in the spinal cord—more specifically, in the *substantia gelatinosa* of the *dorsal horns*, which are part of the *gray matter* that runs the lenth of the core of the spinal cord. Figure 11–1 depicts how the gate-control process works. You can see in both diagrams of the figure that signals of noxious stimulation enter the gating mechanism (substantia gelatinosa) of the spinal cord from *pain fibers* (A-delta and C fibers). After these signals pass through the gating mechanism, they activate *transmission cells*, which send impulses to the brain. When the output of signals from the transmission cells reaches a critical level, the person perceives pain; the greater the output beyond this level, the greater the pain intensity.

The two diagrams in the figure outline how the gating mechanism controls the output of impulses by the transmission cells. When pain signals enter the spinal cord and the gate is open, the transmission cells send impulses freely; but to the extent that the gate is closed, the output of the transmission cells is inhibited. What controls the opening and closing of the gate? The gate-control theory proposes that three factors are involved:

1. *The amount of activity in the pain fibers.* Activity in these fibers tends to open the gate. The stronger the noxious stimulation, the more active the pain fibers.

2. *The amount of activity in other peripheral fibers.* Some peripheral fibers, called *A-beta fibers*, carry information about harmless stimuli or mild irritation, such as touching, rubbing, or lightly scratching the skin. Activity in A-beta fibers tends to close the gate, inhibiting the perception of pain when noxious stimulation exists. This would explain why gently massaging or applying heat to sore muscles decreases the pain.

3. *Messages that descend from the brain.* Neurons in the brainstem and cortex have efferent pathways to

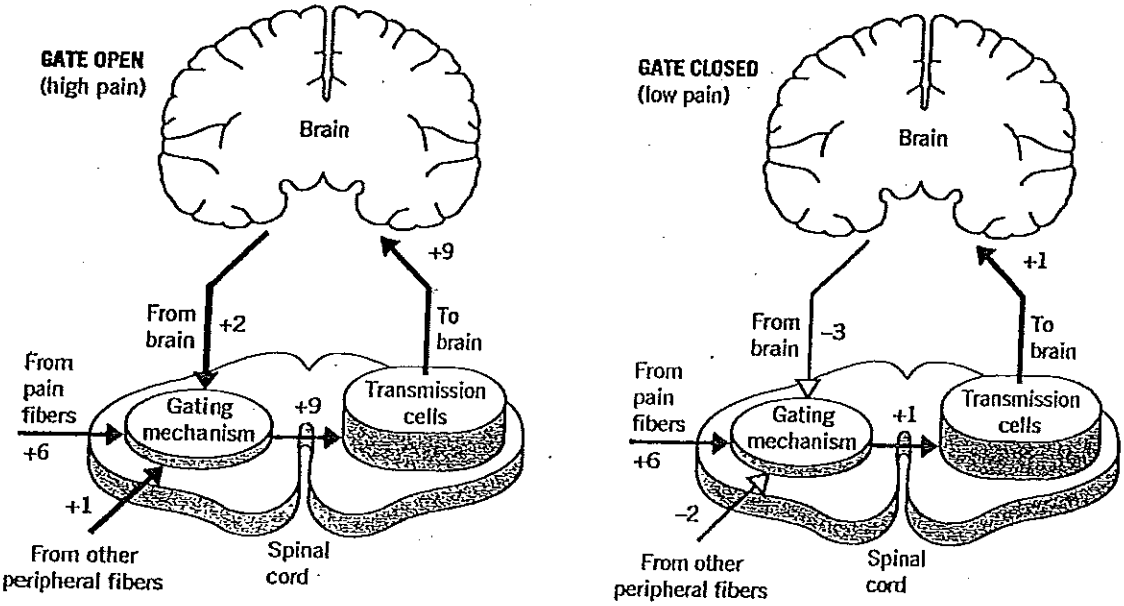

Figure 11–1 Two diagrams to illustrate gate-control theory predictions when strong pain signals arrive from *pain fibers* (A-delta and C) at the spinal cord, along with signals from other *peripheral fibers* (A-beta) and the *brain*. The diagram on the left depicts what conditions might exist when the gate is *open*, and the person feels strong pain; the one on the right shows a scenario when the gate is *closed*, and the person feels little pain. The thick arrows indicate "stimulation" conditions that tend to open the gate and send pain signals through, and the thin ones indicate the opposite, "inhibition," effect. The numbers that accompany each arrow represent hypothetical values for the degrees of pain *stimulation* (positive numbers) or *inhibition* (negative numbers). Pain signals enter the spinal cord and pass through a gating mechanism before activating transmission cells, which send impulses to the brain. (From information in Melzack & Wall, 1965, 1982.)

the spinal cord, and the impulses they send can open or close the gate. The effects of some brain processes, such as those in anxiety or excitement, probably have a general impact, opening or closing the gate for *all* inputs from *any* areas of the body. But the impact of other brain processes may be very specific, applying to only some inputs from certain parts of the body. The idea that brain impulses influence the gating mechanism helps to explain why people who are hypnotized or distracted by competing environmental stimuli may not notice the pain of an injury.

The theory proposes that the gating mechanism responds to the combined effects of these three factors. As Melzack and Wall have stated, "The degree to which the gate increases or decreases sensory transmission is determined by the relative activity in large-diameter (A-beta) and small-diameter (A-delta and C) fibers and by descending influences from the brain" (1982, p. 222). Table 11.1 presents a variety of conditions in people's lives that seem to open or close the gate. For instance, anxiety and boredom are conditions that tend to open the gate, and positive emotions and distraction tend to close it.

Table 11.1 *Conditions That Can Open or Close the Pain Gate*

Conditions That Open the Gate
- Physical conditions
  - Extent of the injury
  - Inappropriate activity level
- Emotional conditions
  - Anxiety or worry
  - Tension
  - Depression
- Mental conditions
  - Focusing on the pain
  - Boredom; little involvement in life activities

Conditions That Close the Gate
- Physical conditions
  - Medication
  - Counterstimulation (e.g., heat or massage)
- Emotional conditions
  - Positive emotions (e.g., happiness or optimism)
  - Relaxation
  - Rest
- Mental conditions
  - Intense concentration or distraction
  - Involvement and interest in life activities

Source: Based on material by Karol et al., cited in Turk, Meichenbaum, & Genest (1983).

Evidence on the Gate-Control Theory

The gate-control theory has stimulated a great deal of research and has received strong support from the findings of many, but not all, of these studies (Melzack & Wall, 1982; Winters, 1985). One study, for instance, confirmed the prediction from gate-control theory that impulses from the brain can inhibit the perception of pain. David Reynolds (1969) conducted this study with rats as subjects. He first implanted an electrode in the midbrain portion of each rat's brainstem, varying the exact location from one rat to the next. Then he made sure they could feel pain by applying a clamp to their tails—and all reacted. Several days later, he tested whether stimulation through the electrode would block pain. While providing continuous, mild electrical stimulation, he again applied the clamp. Although most of the subjects did show a pain reaction, those with electrodes in a particular region of the midbrain—the **periaqueductal gray** area—did not. The electrical stimulation had produced a state of not being able to feel pain, or *analgesia*, in these rats. Then Reynolds used these few rats for a dramatic demonstration: he performed abdominal surgery on them while they were awake and with only the analgesia produced through electrode stimulation. Subsequent studies by other researchers have confirmed that stimulation to the periaqueductal gray area can induce analgesia in animals and in humans. Moreover, they have determined that morphine works as a painkiller by activating the brainstem to send impulses down the spinal cord (Chapman, 1984; Melzack & Wall, 1982; Winters, 1985).

Other research findings have disconfirmed some details of the theory. But, as one reviewer has noted:

> Regardless of the specific wiring diagrams involved, the gate-control theory of pain has been the most influential and important current theory of pain perception. It ties together many of the puzzling aspects of pain perception and control.... It has generated new interest in pain perception, stimulating a multidisciplinary view of pain for research and treatment. It has been able to demonstrate the tremendous importance of psychological variables. (Weisenberg, 1977, p. 1012).

The gate-control theory clearly takes a biopsychosocial perspective in explaining how people perceive pain. You will see many features of this theory as you read the material in the next section.

INSTRUCTIONS FOR RELAXED BREATHING (CENTERING)

1. Find a place where you will not be disturbed for at least 10 minutes.

2. Prepare yourself for the breathing exercise:

   Sit comfortably in a chair or on the ground with your back supported
   Relax your jaw and mouth and allow your lips to part slightly
   Allow your Shoulders to lower and remain even
   Take a minute to slow down your breathing
   Clear your mind of other thoughts - focus on your breathing

3. Rest one hand on your stomach, just above your navel. Place your other hand on your upper chest.

4. If you feel comfortable to do so, close your eyes.

5. Begin inhaling through your nose and exhaling through your mouth.

6. Focus on your breathing for a few moments, slowly breathing in and out. Notice which hand is moving when you breathe in and which hand is moving as you breathe out.

7. Focus on slowing your breathing down and begin inhaling a little more deeply through your nose. As you are breathing in a little more deeply, allow your stomach to fill with air about 1 inch as if it were an inflatable balloon.

8. As you are breathing in, slowly count to four and imagine warm air flowing into your lungs and to all parts of your body.

9. Then exhale to the count of five. While you are breathing out your stomach will slowly go down.

10. As you are breathing out, imagine that any tension in your body is also flowing out of your body.

11. Pause one second after breathing out.

12. Repeat the deep breathing in to the count of four, holding the air in for one second, and breathing out to the count of five.

13. As you breathe in, think to yourself "Breathe", and as you breathe out think "relax". In a complete inhalation/exhalation cycle you will think "Breathe --- relax".

14. Continue focusing on this relaxed manner of breathing for about five more minutes.

15. Try to practice this exercise 2 times per day for about 10 minutes each time.

16. When you are able to regularly experience the relaxation response under these conditions, gradually begin to use relaxed breathing whenever you begin to notice muscular tension or excessive worry.

ACTIVITY PACING

Excessive rest and avoidance of any activity that may increase your pain may seem helpful in the short term but can lead to a more sedentary lifestyle, muscle deconditioning, and more pain in the long term

- It becomes more and more difficult to do things the longer you avoid, or put off doing them
- Avoiding things, such as visiting friends, can make life increasingly negative and gradually reduces your self-confidence

Similarly, choosing to engage in too much activity without proper rest or too strenuous an activity can lead to increases in pain and lost time while recovering (ie., a Yo-Yo syndrome)

- Finding the right balance between excessive rest and overdoing it is the most helpful way to cope with pain
- Why?
  - Excessive rest and overdoing it can both lead to increases in pain

Important Points to Remember

- Decide what you do and how much you do based on a flexible plan – engage in activity each day but never exceed the recommended amounts
- Carry out activities at a steady and regular pace – in a way that suits you
- Take breaks to check on how you are doing before your pain level increases
- Set priorities and break activities into smaller steps
- Choose several activities that you value and enjoy rather than just chores or what other people think you should do

COGNITIVE-BEHAVIORAL STRESS MANAGEMENT
FOR CHRONIC PAIN

Why Is Stress Management Important for Chronic Pain?

There are at least two reasons. First, the symptoms of chronic pain are stressors in themselves. Having chronic pain reduces your ability to function, to cope, and to feel good. If your general ability to cope is reduced, then other daily stressors start to pile up. Second, in response to having chronic pain and experiencing a greater number of daily stressors, your muscles will typically tense up a lot of the time as a form of protection for what may be yet to come. This further decreases your ability to cope and you begin to feel even worse.

What Is the Stress Response?

Also known as the "Fight-or-Flight" response, the stress response is controlled by the sympathetic nervous system and had important evolutionary significance for human survival. We inherited this response from our earlier ancestors, who needed it to cope with extreme physical dangers. This response was adaptive when we were required to fight or run from predators. However, in today's society fighting or running away is seldom necessary or adaptive, yet we are still forced to deal with stress symptoms without having an appropriate outlet or release valve. The danger of prolonged stress is its wear and tear on your body. And when stress is coupled with chronic pain, the wear and tear you experience is multiplied possibly leading to additional problems such as headaches, chronic fatigue, or increased susceptibility to other illness. Under stress your body exhibits several reactions that can be noticed or measured:

Your heart rate increases	*You feel your heart pounding in your chest*
Your blood pressure increases	*(Not detectable unless measured)*
Your sweat level increases	*Your skin feels cold and clammy*
Your rate of breathing changes	*Your breathing becomes shallow or you breathe in gulps*
Adrenaline, and other stress hormones are released in the blood stream, causing vasoconstriction in the periphery and an increase in muscle tone. Blood flows away from the periphery (hands and feet) to the heart, lungs, and muscles	*Your muscles contract and your hands and feet become cold*
Certain acids are secreted in the gastrointestinal tract	*Your feel "butterflies", nausea, or discomfort in your stomach*
The general digestive activity of the gastrointestinal tract is altered	*You experience symptoms of diarrhea or constipation*

You can help yourself by learning to identify what daily situations contribute to your stress response and by learning to use adaptive coping strategies to deal with these situations, which often can't be escaped or fought.

You can also manage your stress levels and chronic pain symptoms by attending to your thoughts and feelings. Negative thinking is thought to contribute to the stress response and feelings of anger or depression that some people with chronic pain experience.

What is the Association Between Thoughts, Feelings, and Chronic Pain?

Your brain takes in and processes all thoughts and emotions simultaneously. The part of the brain responsible for thinking is the cerebral cortex, the centre of higher learning and cognition. The part responsible for emotions is called the limbic system. It is now known that there is a great deal of communication between all parts of the brain. Between the cortex and the limbic system, messages flow freely back and forth through the hypothalamus, a gland at the base of the brain. The hypothalamus is responsible for sending and receiving messages from the brain to the body and back again. The hypothalamus regulates the pituitary gland, which in turn activates stress hormones such as adrenalin. Thus, the cortex represents thinking, the limbic system represents emotions, with the hypothalamus acting as mediator. Here is an example of a mind-body interaction: While attending a social occasion, a pain sensation travels up the spinal cord through the hypothalamus. You think, "I hate this pain! If this keeps up, I'll have to leave." Why did I even bother to come when I knew this would probably happen?" You feel angry, and maybe even depressed. Then you may think, "What if I never get well?" which causes you to feel afraid. The fear sends out a stress alarm via the hypothalamus, which in turn contracts your muscles in anticipation. The tight muscles fatigue and cramp, causing even more discomfort. You then decide that, to avoid a potentially embarrassing situation, you'd better leave. To avoid experiencing these negative feelings again, you become reluctant to attend similar social gatherings, which makes you feel more isolated, depressed, anxious, or angry in the long-term.

Because of this simultaneous processing in the brain, it is difficult to determine which comes first - your negative thoughts, your negative feelings, or the ever-increasing pain. But it is likely that whenever you think negative thoughts about your pain symptoms, you will probably have a resulting negative emotional and physical reaction. Conversely, whenever you experience pain symptoms, you will probably think negative thoughts about them, setting off a vicious cycle, unless you take steps to reverse or prevent this reaction.

Managing Your Stress Generating Thoughts

Once you have observed that your thinking can sometimes contribute to negative feelings, physical tension, and increased pain, what can you do? Well, simply being aware of this relationship is an important first step. Beyond awareness, there are several strategies that you can try. First, you can identify whether some underlying personal belief sets the stage for stress generating thinking. For example, if you have the tendency to set overly harsh standards for judging yourself or others, this can set you up for negative emotional reactions when you or others inevitably can not meet them. Similarly, if you have high needs for perfection, feeling in control of things, or social approval and acceptance from

others, these can often lead to disappointment and stress-provoking reactions. When we embrace these types of beliefs, we often tend to engage in several limited thinking styles including *all-or-nothing thinking*, *negative mental filtering* of anything positive that happens to us, *catastrophic thinking* involving the worst possible outcomes coming true, and *should statements* about how we and others should or should not behave without adequately considering outside circumstances impacting on behaviour.

In order to reverse these tendencies, several strategies can be helpful. We can challenge stress generating beliefs by *reversing positions* with someone else, that is, you can ask yourself what you would say to help another person experiencing your situation, or, try to think of how that person might respond to get some positive ideas. You could also try to *reframe* the situation, that is, ask yourself if there are alternative ways to view the situation. For example, can you see the glass is half-full, as opposed to half-empty, alternatives? Can you broaden your view to see the "big picture" about what this isolated situation means in the overall scheme of things? You could also employ a strategy of *reality testing*, in which you check things out with others to see if your view is most accurate before jumping to conclusions. Ask yourself, what are the odds of the worst-case scenario coming true? What if the worst did come to pass? How would you cope with that? Would it be as awful as you think or would you somehow get through it? These are some of the most helpful basic strategies for managing stress-generating thoughts and beliefs.

STRESS MANAGEMENT FOR CHRONIC PAIN

Definition of Stress: Stress is our own physical reaction to anything exciting, upsetting, or unexpected.

Stress can be any physical reaction to a positive or negative event, the result of major or minor hassles that can add up over time.

Stress makes you more vulnerable to increases in pain.

By controlling stress, you can prevent or lessen the impact of increases in pain.

Our thoughts affect our emotions, physical responses, and behaviour.

Stress Generating Thoughts: negative, extreme thoughts that occur automatically, distort our view of reality, affect our physical responses (e.g., glass half-empty, worst case scenario thinking leads to avoidance of effective coping).

How do we recognize stress generating thoughts? We can use "thought scanning", a method of stopping to consider the nature and content of our automatic thoughts in certain situations.

Stress Generating Beliefs: The source of our stress generating thoughts, often involving the need to set overly harsh standards for judging one's self and others (e.g., needs for *perfection*, *approval*, *control*).

How do we identify our stress generating beliefs? We can ask ourselves the question, "what underlying belief may be driving my feelings and behaviour in this situation?"

What can we do about stress generating beliefs? We can challenge stress generating beliefs with several strategies: (1) *Reverse positions* with someone else (e.g, what would we say to them in this situation, or how would they approach this situation); (2) *Reframe* the situation (e.g., are there alternative ways to view the situation?, can we see the glass is half-full alternative?, what is the "big picture"?); (3) *Reality Testing* (e.g., can we check things out with others to see if our view is most accurate? Can we do an experiment to find out the truth?, What are the odds of the worst coming true?, What if the worst case scenario came true? How would I cope with that?); or (4) if you are still not convinced, ask yourself the question, W*hat are the costs* to me of maintaining my stress generating beliefs?

DAILY RECORD OF STRESS GENERATING THOUGHTS

Date	Situation	Stress Generating Thoughts	Physical Response	Emotional Response	Stress Generating Belief / Thinking Style	Reframed Thoughts

FIGURE 8.1 Cognitive Distortions (Errors in Thinking)

1. *All-or-nothing thinking.* You view your pain, yourself, people, or events as falling into extreme, opposing categories (e.g., good or bad, beautiful or ugly, perfect or defective, pain-free or pain-ridden) instead of seeing them as falling along a continuum.
   Examples: "I can't do *anything*. Having this chronic pain makes me feel like a *total* failure."
   "I am in pain *all* of the time. It *never* stops hurting. It *never* ends."
   "*Nothing* you say or do is going to help me cope with this pain."

2. *Overgeneralization.* You make sweeping negative conclusions based on little evidence. Or you view one negative event as a never-ending pattern of defeat.
   Examples: "If this doctor can't help me, no one can." (All physicians are the same.)
   "This first epidural injection didn't help my lower back pain. This just goes to show you that you cannot trust medicine to help you. What's the point of trying?" (If one medical intervention won't work, nothing will.)

3. *Negative mental filter (selective abstraction).* You tend to focus selectively on negative details taken out of context (tunnel vision) while ignoring the bigger picture of the situation, which may include positive experiences (disqualifying the positive). Mental filtering relates to your attention and focus on information in your environment (e.g., attending vs. not attending to your pain or your ability to cope with pain).
   Tunnel vision: You see only the negative aspects of a situation.
   Example: "All I can see is bad things happening to me."
   Disqualifying the positive (type of mental filter). You filter out positive experiences, so they do not enter your awareness. You don't give yourself credit for the good things you do or the positive aspects of life.
   Example: "Even if I did complete the project, it took me five times as long to finish it because of the pain."
   "If my doctor was being nice to me, it was because she had to. It was her job."

4. *Magnification (of the negative) and minimization (of the positive).* You magnify or exaggerate the significance of negative qualities in yourself (e.g., weaknesses), someone else, or an event; you minimize or shrink the significance of positive qualities in yourself (e.g., strengths), others, or an event.

   Examples: "When I'm in pain, I tend to be absorbed in my sense of failure—in my insecurities." (magnifying)
   "My efforts to achieve don't count for much now that I am disabled with this pain." (minimizing)

5. *Catastrophizing (jumping to conclusions).* You tend to assume the worst and fail to consider more realistic possibilities. You may jump to conclusions and assume the worst in your relationships (by "mind reading") or in general (by "negative forecasting" or "fortune-telling").
   Mind reading: You assume people are reacting very negatively toward you without sufficient evidence. In assuming you can read other peoples' minds, you misread or misinterpret verbal and nonverbal cues in relationships as signs of rejection or failure.
   Example: "My partner doesn't care about me and my pain. I can tell even if he/she hasn't said it in so many words."
   Negative forecasting (fortune-telling error): You anticipate negative outcomes in the future without sufficient evidence.
   Examples: "I am doomed to be stuck with this pain forever."
   "Having this chronic pain is a catastrophe. There is nothing to look forward to."

6. *Emotional reasoning.* When you reason with your emotions, you assume they reflect the way things really are. If you feel emotions, you assume that they must be true, without considering other possible explanations or discounting them. When some people experience pain, they use their pain and their emotions to explain why they cannot engage with the world around them or take control of their lives.
   Examples: "Even though I'm taking steps to cope with my pain, I still feel like such a failure."
   "I feel like this pain has robbed me of my identity."
   "The pain reminds me of what I cannot do. Why even try?"
   "I feel as though people don't want to be around me when I'm in pain."

7. *"Should" statements.* You have precise, fixed ideas of how events occur in life and how you or other people should behave. When your expectations of yourself, others, or events are not met, you view this as horrible or bad. In expressing "shoulds," you may be attempting to motivate yourself or someone else. However, your "should" often ends up punishing, rather than motivating, yourself or others. "Shoulds" directed toward oneself typically result in guilt. "Shoulds" directed toward others or situations in general typically result in anger.

FIGURE 8.1 *(continued)*

Examples: "I should not have to deal with this chronic pain. No one should. It's unfair."
"My doctor should help me find a solution to my pain. It shouldn't take this long."
"Life just isn't fair. People shouldn't have to suffer with this chronic type of pain."
"I should be able to work again."

8. *Labeling.* You tend to use simplistic, fixed, global terms to describe yourself, others, or a specific situation without acknowledging the bigger picture or the complexity of the situation.
Examples: "I'm *stupid* for thinking I can trust others."
"My friend is a *jerk* for telling someone else about my chronic pain problem."
"I am a *cripple*."

9. *Personalization (self-blame).* You tend to assume responsibility for negative events or interactions, without considering other possible explanations or evidence to the contrary.
Examples: "My doctor was very short with me during my last office visit. I must have done something to make him/her mad."
"My friends haven't called me in weeks. It's my fault because all I ever talk about is my pain and suffering."

From J. Beck's *Cognitive Therapy: Basics and Beyond.* Copyright 1995 by Judith S. Beck, PhD. Adapted with permission by the Guilford Press: New York.

In Logan's case, he caught himself saying, "There I go again. How stupid can I be!" He and his therapist reviewed the list to identify the errors or distortions he might be making. Calling oneself "stupid" is an example of the "labeling" error. However, as the therapist and Logan explored how he came to the conclusion that he was "stupid," Logan said, "Well, that is how I was feeling then. I felt so embarrassed." The therapist could then point out how Logan used his feelings of embarrassment to reason that he was stupid. This is an example of the "emotional reasoning" error. In the Alternative Response column of the Automatic Thought Record, Logan wrote, "Cognitive errors—labeling and emotional reasoning."

The cognitive distortions can also be written down on a separate form, along with the answers to the other evaluation questions listed at the bottom of the ATR, to allow enough room to record information. See Figure 8.2.

FIGURE 8.2 Thought Evaluation Form

Automatic thought:

What is the evidence that the automatic thought is true?

What is the evidence that the automatic thought is not true?

Is there an alternative explanation?

What is the worst that could happen if the automatic thought were true? Could I live with it?

What's the best that could happen?

What is the most realistic outcome?

What's the effect of my believing the automatic thought? (advantages/disadvantages of believing it)

What could be the effect of changing my thinking? (advantages/disadvantages of letting go of it)

What should I do about it?

If _____(friend's name) was in this situation, what would I tell him/her?

From "Worksheet Packet," Bala Cynwyd, PA, Beck Institute for Cognitive Therapy and Research, Copyright 1996. Used with permission from Judith S. Beck, PhD.

52 Proven Stress Reducers

1. Get up fifteen minutes earlier in the morning. The inevitable morning mishaps will be less stressful.

2. Prepare for the morning the evening before. Set the breakfast table, make lunches, put out the clothes you plan to wear, etc.

3. Don't rely on your memory. Write down appointment times, when to pick up the laundry, when library books are due, etc. ("The palest ink is better than the most retentive memory." - Old Chinese Proverb)

4. Do nothing which, after being done, leads you to tell a lie.

5. Make duplicates of all keys. Bury a house key in a secret spot in the garden and carry a duplicate car key in your wallet, apart from your key ring.

6. Practice preventive maintenance. Your car, appliances, home, and relationships will be less likely to break down/fall apart "at the worst possible moment."

7. Be prepared to wait. A paperback can make a wait in a post office line almost pleasant.

8 Procrastination is stressful. Whatever you want to do tomorrow, do today; whatever you want to do today, do it now.

9. Plan ahead. Don't let the gas tank get below one-quarter full; keep a well-stocked "emergency shelf" of home staples; don't wait until you're down to your last bus token or postage stamp to buy more; etc.

10. Don't put up with something that doesn't work right. If your alarm clock, wallet, shoe laces, windshield wipers — whatever — are a constant aggravation, get them fixed or get new ones.

11. Allow 15 minutes of extra time to get to appointments. Plan to arrive at an airport one hour before domestic departures.

12. Eliminate (or restrict) the amount of caffeine in your diet.

13. Always set up contingency plans, "just in case." ("If for some reason either of us is delayed, here's what we'll do…" kind of thing. Or, "If we get split up in the shopping center, here's where we'll meet.")

14. Relax your standards. The world will not end if the grass doesn't get mowed this weekend.

15. Pollyanna-Power! For every one thing that goes wrong, there are probably 10 or 50 or 100 blessings. Count 'em!

16. Ask questions. Taking a few moments to repeat back directions, what someone expects of you, etc., can save hours. (The old "the hurrieder I go, the behinder I get, " idea.)

17. Say "No!" Saying "no" to extra projects, social activities, and invitations you know you don't have the time or energy for takes practice, self-respect, and a belief that everyone, everyday, needs quiet time to relax and be alone.

18. Unplug your phone. Want to take a long bath, meditate, sleep, or read without interruption? Drum up the courage to temporarily disconnect. (The possibility of there being a terrible emergency in the next hour or so is almost nil.) Or use an answering machine.

19. Turn "needs" into preferences. Our basic physical needs translate into food, water, and keeping warm. Everything else is a preference. Don't get attached to preferences.

20. Simplify, simplify, simplify…

21. Make friends with nonworriers. Nothing can get you into the habit of worrying faster than associating with chronic worrywarts.

22. Get up and stretch periodically if your job requires that you sit for extended periods.

23. Wear earplugs. If you need to find quiet at home, pop in some earplugs.

24. Get enough sleep. If necessary, use an alarm clock to remind you to go to bed.

25. Create order out of chaos. Organize your home and workspace so that you always know exactly where things are. Put things away where they belong and you won't have to go through the stress of losing things.

26. When feeling stressed, most people tend to breathe in short, shallow breaths. When you breathe like this, stale air is not expelled, oxidation of the tissues is incomplete, and muscle tension frequently results. Check your breathing throughout the day, and before, during, and after high-pressure situations. If you find your stomach muscles are knotted and your breathing is shallow, relax all your muscles and take several deep, slow breaths. Note how, when you're relaxed, both your abdomen and chest expand when you breathe.

27. Writing your thoughts and feelings down (in a journal, or on paper to be thrown away) can help you clarify things and can give you a renewed perspective.

28. Try the following yoga technique whenever you feel the need to relax. Inhale deeply through you nose to the count of eight. Then, with lips puckered, exhale very slowly through your mouth to the count of 16, or for as long as you can. Concentrate on the long sighing sound and feel the tension dissolve. Repeat 10 times.

29. Inoculate yourself against a feared event. Example: before speaking in public, take time to go over every part of the experience in your mind. Imagine what you'll wear, what the audience will look like, how you will present your talk, what the questions will be and how you will answer them, etc. Visualize the experience the way you would have it be. You'll likely find that when the time comes to make the actual presentation, it will be "old hat" and much of your anxiety will have fled.

30. When the stress of having to get a job done gets in the way of getting the job done, diversion — a voluntary change in activity and/or environment — may be just what you need.

31. Talk it out. Discussing your problems with a trusted friend can help clear your mind of confusion so you can concentrate on problem solving.

32. One of the most obvious ways to avoid unnecessary stress is to select an environment (work, home, leisure) which is in line with your personal needs and desires. If you hate desk jobs, don't accept a job which requires that you sit at a desk all day. If you hate to talk politics, don't associate with people who love to talk politics, etc.

33. Learn to live one day at a time.

34. Every day, do something you really enjoy.

35. Add an ounce of love to everything you do.

36. Take a hot bath or shower (or a cool one in summertime) to relieve tension.

37. Do something for somebody else.

38. Focus on understanding rather than on being understood; on loving rather than on being loved.

39. Do something that will improve your appearance. Looking better can help you feel better.

40. Schedule a realistic day. Avoid the tendency to schedule back-to-back appointments; allow time between appointments for a breathing spell.

41. Become more flexible. Some things are worth not doing perfectly and some issues are well to compromise upon.

42. Eliminate destructive self-talk: "I'm too old to…," "I'm too fat to…," etc.

43. Use your weekend time for a change of pace. If you work week is slow and patterned, make sure there is action and time for spontaneity built into your weekends. If your work week is fast-paced and full of people and deadlines, seek peace and solitude during your days off. Feel as if you aren't accomplishing anything at work? Tackle a job on the weekend which you can finish to your satisfaction.

44. "Worry about the pennies and the dollars will take care of themselves." That's another way of saying: take care of the todays as best you can and the yesterdays and the tomorrows will take care of themselves

45. Do one thing at a time. When you are with someone, be with that person and with no one or nothing else. When you are busy with a project, concentrate on doing that project and forget about everything else you have to do.

46. Allow yourself time – everyday – for privacy, quiet, and introspection.

47. If an especially unpleasant task faces you, do it early in the day and get it over with; then the rest of your day will be free of anxiety.

48. Learn to delegate responsibility to capable others.

49. Don't forget to take a lunch break. Try to get away from your desk or work area in body and mind, even if it's just for 15 or 20 minutes.

50. Forget about counting to 10. Count to 1,000 before doing something or saying anything that could make matters worse.

51. Have a forgiving view of events and people. Accept the fact that we live in an imperfect world.

52. Have an optimistic view of the world. Believe that most people are doing the best they can.

Strategies for Sleeping

1. Exercise. Be as physically active as your condition allows you to be during the day. In this way you will have "earned" your sleep; in other words, your body will be tired enough for sleep. However, do not have vigorous exercise immediately prior to bedtime. Exercise stimulates the body and makes falling asleep soon afterward very difficult. Exercise just before bed does not tire us out but has the paradoxical effect of waking us up. In fact, people who are drowsy and trying to stay awake to study often engage in physical exercise to wake themselves up. Exercise in the late afternoon or early evening is a worthwhile pursuit and can be a good substitute for caffeine to ward off early evening drowsiness.

2. Napping. Don't! Most sleep experts are convinced that napping almost always disrupts the sleep arousal rhythm, making it harder to sleep at night. One reason for this disruption is that most people who do take naps do so some days but not others and take their naps at varying times each day. If you take naps you may also interfere with your body's natural ability to get the needed combination of all the different stages of sleep. So, if you are having trouble sleeping, it is best to avoid taking daytime naps at all.

3. Stimulants. Avoid food and drinks with caffeine for at least four hours before bed. Caffeine is a powerful and long-lasting stimulant that interferes with the natural sleep cycle. Caffeine is found in coffee, tea, many cola drinks and chocolate. If you smoke, try not to smoke within several hours of your bedtime. Like caffeine, nicotine is a powerful stimulant.

4. Alcohol. Do not drink alcohol later than two to three hours prior to bedtime. Although alcohol is a depressant, which if timed accurately may aid you to relax and fall asleep, it leads to restless, nonrestorative sleep and contributes to the tendency to wake up during the night.

5. Sleep Medication. Medication is typically intended for short-term use. Avoid continual use of tranquilizers or sleeping pills as a sleep aid. When you stop taking drugs after using them for a period of time, it might take a long time for your sleep to return to normal.

6. Eating. If you are used to it, you may have a *light* carbohydrate snack before bedtime. Avoid heavy meals within a few hours of bedtime.

7. Sleep Environment. Consider the light, temperature, mattress comfort, noise level and other factors that may interfere with sleeping. Most people sleep best in a quiet, dark, cooler environment. Try set up your sleep environment to make it conducive to sleep. For example, a white noise machine can mask outside noises (e.g., Sleep Mate II available through the Sears catalogue). Many people also find this steady sound to be soothing and sleep inducing.

8. Beds Are for Sleeping. Use your bed only for sleeping and sexual activity. Reading, eating, and watching television in bed can condition your mind and body not to want to sleep there.

9 **Relax Before Bed.** Allow a period of "winding down" for about 1 hour before bedtime. Do not engage in any strenuous activities during this hour. Ways to relax may include drinking something warm (not alcohol or caffeine), taking a warm bath, and using a relaxation tape. If you go to sleep and then wake up again in the middle of the night, you may want to repeat this procedure.

10. **Go to bed when you are sleepy.** Lie down with the intention of going to sleep only when you feel drowsy and ready for sleep. Many insomnia sufferers go to bed before they are sleepy. If they had a hard time getting to sleep the night before, they probably feel tired and they reason that they should get an earlier start on their sleep tonight. Sometimes these people spend 10 to 12 hours in bed trying to get 8 hours of sleep. Let your body tell you when it is drowsy. If you go to bed when you are sleepy, you are more likely to go to sleep right away, reinforcing the association between bed and sleep. If you are not sleepy, you might toss and turn, begin to think, and get mentally and physically aroused. That would only reinforce the old habit patterns we are trying to eliminate. Remember, being tired does not necessarily mean you are drowsy or ready for sleep. If you find yourself tossing and turning for more than 20 minutes, get up and do something relaxing until you feel sleepy again.

    Some people worry that they will not get enough sleep if they follow this rule because the time they have to get up cannot change, due to work and schedule demands. But, by establishing a fixed time for getting up and allowing your bedtime to vary, your body can determine how much sleep you actually do need in order to function well. Eventually your body will send you this message by getting sleepy when it is time for you to go to bed.

11. **Stick to a schedule.** Get up at the same time every morning regardless of how much sleep you got during the night or how rested you feel. Use an alarm clock to make sure that you accomplish this consistent wake-up time. It is important to permit your body to establish a regular body rhythm of peaks and lows. Sleeping in late on some mornings will accomplish much the same kind of effect that traveling across time zones does to your sleep patterns. Many poor sleepers use weekend mornings for trying to recapture some of the sleep they lost during the week. This practice is firmly discouraged because it only exacerbates problems with sleep. If you sleep in on weekend mornings you will not be ready to fall asleep at your usual time at night, setting the stage for insomnia for the rest of the week.

    If you feel that getting up at the same time on weekends is a special hardship for you, it should be discussed further. It is important to follow this rule at least for the first several weeks until a routine has been established. If you continue to feel strongly about this point, once the routine has been established you may be able to allow yourself up to a maximum of 1 hour later arising on Saturday and Sunday. Follow this same weekend rule for vacation days.

Based on information from Hauri, 1990, Morin, 1993, and Jamison, 1996.

DEALING EFFECTIVELY WITH INTERPERSONAL STRESS

Perhaps the greatest source of stress in our daily lives comes from feeling the need to meet the expectations of others. Whether on the job, at school, or at home, seemingly every facet of our lives involves interacting with other people. When others expect or demand more than we can reasonably produce, interpersonal stress can be the result. It is sometimes hard to determine when we have the right to refuse a demand from somebody else, that is, whether the demand is reasonable or unreasonable, particularly if it comes from an employer, parent, spouse, or child. In these cases, it is sometimes easier to just give in to the demand and scramble to meet it even though it inconveniences us greatly. Over a lifetime, having to meet many such demands from others can lead to psychological burn out or exhaustion and chronic physical health problems because we never seem to get a chance to rest and meet our own needs for recuperation. Sometimes, we are driven more by our own need to provide for others, rather than what they might actually think if we say no, because we believe or have been taught to feel that it is impolite to refuse requests from others and that this is how we are judged as people. This section will cover ways in which to become more aware of interpersonal stress in your life and how to deal with it effectively.

Consider the following statements:

	Do you think that:	Or do you think that:
1.	*You should always take other people's advice seriously, especially doctors and health care professionals who take time out of their busy schedules just for you?*	*You have a right to question or disregard the advice of others?*
2.	*You should always respect the views of others, especially if they are in a position of authority?*	*You have the right to your own opinions and convictions?*
3.	*It is selfish to put your needs before others' needs?*	*You have the right to put yourself first sometimes?*
4.	*You shouldn't take up others' valuable time with your problems?*	*You have a right to ask for help or emotional support?*
5.	*You should always try to be logical, consistent, and in control?*	*You have a right to make mistakes, change your mind, or decide on a different course of action?*
6.	*You always have the right to say and do exactly what you feel?*	*You realize that sometimes you can and need to hear the other person out and can initially keep your opinions to yourself?*

Statements 1 through four in the left column can lead to passive behavior. When people behave passively, they tend to let others push them around, do not stand up for themselves, and do what they are told, regardless of how they feel about it. **Passive behavior communicates the interpersonal message: *"You count, I don't."***

Statements five and six in the left column can lead to aggressive behavior. When people behave aggressively, they tend to blame, threaten, and accuse people without regard for their feelings. Also, they tend not to listen to what others have to say. **Aggressive behavior communicates the interpersonal message: *"I count, you don't."***

All of the statements in the right column are assertive statements. Assertive behavior involves direst statements and actions regarding your feelings, thoughts, and wishes. You stand up for your own rights and take into account the rights and feelings of others. You listen attentively and let other people know that you have heard them. You are open to negotiation and compromise, but not at the expense of your own rights and dignity. You can make direct requests and direct refusals. You can deal effectively with criticism, without becoming hostile or defensive. **Assertive behavior communicates the interpersonal message: *"I count, you count."***

While passive behavior leads to being taken advantage of by others, and aggressive behavior leads to alienating yourself from others, assertive behavior helps you deal more effectively with interpersonal stress and the symptoms of chronic pain. Problems in clear and direct interpersonal communication on the job, at home, or in the doctor's office can be corrected with assertiveness.

Consider the following examples:

Example 1: Your reckless brother wants to borrow your car. You don't want to lend it to him because you don't feel confident that he won't crash it. What do you say?

Passive: *Oh, all right, but please be careful.*

Aggressive: *You've got a lot of nerve asking to borrow my car. I'm not that stupid.*

Assertive: *I don't feel comfortable about the way you drive, so I won't be lending it to you. That doesn't mean that I don't want to help you. Have you thought of renting a car while yours is in for repairs?*

Example 2: Waiting in line at the post office, you are about to be served when someone cuts in and says, "I just have a quick question." There are many people waiting, for various reasons. What would you do?

Passive: *Okay, go ahead.*

Aggressive: *Don't you think I've got better things to do than to wait here and listen to your problem?*

Assertive: *I've been waiting quite a while and it is my turn now. I don't expect to be very long either.*

Based on the responses provided in examples 1 and 2 on the previous page, complete the following example with responses that you think fit the three categories:

Example 3: You are just about to answer a question that your brother has asked you and, while considering your answer, your father answers for you. He has done this ever since you were young. You would like to answer for yourself. Your responses to your father are:

Passive:

Aggressive:

Assertive:

Provide two recent examples of nonassertive behavior (i.e., passive or aggressive) from your own experience. Describe the situation, recall your response, and provide an alternative assertive response.

Situation 1:

Nonassertive:

Assertive:

Situation 2:

Nonassertive:

Assertive:

INTERPERSONAL RIGHTS AND RESPONSIBILITIES

Rights	Responsibilities
To speak up	To listen
To take	To give
To have problems	To find solutions
To be comforted	To comfort others
To work	To do your best
To make mistakes	To correct your mistakes
To laugh	To share in others’ happiness
To have friends	To be a friend
To criticize	To praise
To have your efforts rewarded	To reward others' efforts
To have independence	To be dependable
To cry	To dry tears
To be loved	To love others
To take time for rest and relaxation	To allow others to rest and relax

CHRONIC PAIN: EFFECTIVE COMMUNICATION

Managing Interpersonal Stress

- Adopt an effective communication style (ie., Assertive rather than passive or aggressive)
- Avoid “mind reading” others’ thoughts
- Avoid trying to fool others about your pain
- Be honest and communicate clearly (eg, today I can participate 25%, 50%, 75%)
- Be flexible (ie, have a plan B or C for any given day)
- Attend to your basic needs before trying to assist others
- Encourage flexibility in others and tell them how they can help you

GOAL SETTING AND CHRONIC PAIN

Several unfortunate effects of living with chronic pain are that it can wear you down both physically and mentally, cause you to lose your focus during day-to-day activities, and leave you with little hope of having a normal life in the future. Without being able to concentrate fully on what you would like to achieve each day, it is likely that your symptoms will take over control of your entire life, if they haven't done so already.

The first step in regaining control of your life is identifying specific areas in which you can exercise some positive influence and ignoring those in which you can't. All too often we have a tendency to worry about things that are out of our control, such as the behavior of others or how things will turn out for us in the long-run.

Areas in which you do have some control include how you spend your time and how you choose to respond to situations and other people in your daily life. Unfortunately, it is quite easy to get swept up in the pace of modern life and, in order to meet others' expectations, neglect to provide for our own needs.

Goal setting is the systematic activity of specifying behavioral objectives (steps) that will guide us toward making desirable improvements in our lives. Activities that are typically decreased or stopped by chronic pain include the ability to work at full capacity, pleasurable leisure activities, sexual activity, attending social events, physical exercise, family activities, sports, and thinking positive thoughts and having positive feelings about one's self. Through goal setting, we can identify target areas for improvement, specify behavior that will help us to improve, and measure how effective our program is, in order to make further changes when necessary.

Goal Setting Guidelines

The following guidelines will help you to set effective goals:

1. **Set goals that target what you want to do (positive goals), not what you don't want to do (negative goals)**. For example, a positive goal might be, "I will spend 30 minutes in the evening, just after supper, listening to my relaxation tape." A negative goal might be, "I'll try to spend less time worrying about ...." The problem with a negative goal is that it doesn't tell you how you are actually going to achieve it.

2. **A goal should be behavioral and specific**. It should specify an observable action you can take. For example, a behavioral goal would be, "I will take a 20 minute walk every day when I get home from work." A nonbehavioral, nonspecific goal would be, "I will get more exercise this month."

3. **A goal should be realistic**. It should specify something you are not doing now but you could do with a moderate amount of effort. Goals which are too difficult to achieve set us up for failure and disappointment. A realistic goal would be, "I will

take a 5 minute break to rest and recuperate for each hour that I work at my desk." An unrealistic goal would be, "By the time I complete this group, I expect to be pain-free."

4. **A goal should be measurable**. You should be able to identify when the goal has been achieved. For example, the goal: "To practice relaxation training twice per day" can be recorded each time it is completed and tracked over time.

5. **Set process-oriented goals as opposed to outcome-oriented goals**. Process-oriented goals are behaviors that we have direct control over such as using relaxation, thought restructuring, exercising, spending more time with family, giving a good job interview, and how we choose to respond to others. Outcome-oriented goals are outcomes that we have no direct control over such as eliminating pain, how others choose to behave, how things will turn out next week, and whether we will actually be hired after a job interview.

6. **A goal should be desirable**. That is, will achieving the goal be worth putting forth the necessary effort?

GOAL SETTING PLAN FOR PAIN SELF-MANAGEMENT

General Goals for My Self-Management Plan:

To reduce the frequency of severe symptoms I experience. To handle everyday stresses more effectively. To spend more quality time with my friends and family.
I will spend 30 minutes in the evening, just after supper, listening to my relaxation tape. I will take a 5 minute break to stretch, rest, and recuperate for each hour that I work at my desk. I will eat lunch or dinner at a restaurant with a friend at least once per week.

Steps I Will Take to Attend Sessions Regularly, Practice Coping Skills at Home, and Achieve My Goals are:

I will tell others about my plan so they will understand when I need to leave work early or practice my coping skills. I will set aside a regular amount of time on my daily calendar to practice my coping skills. I will delegate some of my responsibilities to others during the treatment period.

How I Will Know That My Plan is Working:

I will feel calm. I will have more energy. I will feel better about myself. I will feel more in control of my life. I will be thinking in the "here and now" instead of worrying about the past or future.
There will be a better balance of time spent on my needs and the needs of others.

How I Will Reinforce (Reward) Myself for Completing Weekly Exercises and Making Progress:

I will treat myself to a small gift each week during the treatment program. I will allow myself some time to do something I really enjoy doing. I will allow others to do something nice for me.

Some Things That Could Interfere With My Plan are:

Feeling tired. Feeling frustrated. A Pain flare-up. A symptom-free period. Being too busy with work and family responsibilities.

GOAL SETTING PLAN FOR PAIN SELF-MANAGEMENT

General Goals for My Self-Management Plan:

Steps I Will Take to Attend Sessions Regularly, Practice Coping Skills at Home, and Achieve My Goals are:

How I Will Know That My Plan is Working:

How I Will Reinforce (Reward) Myself for Completing Weekly Exercises and Making Progress:

Some Things That Could Interfere With My Plan are:

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Relapse and Recovery

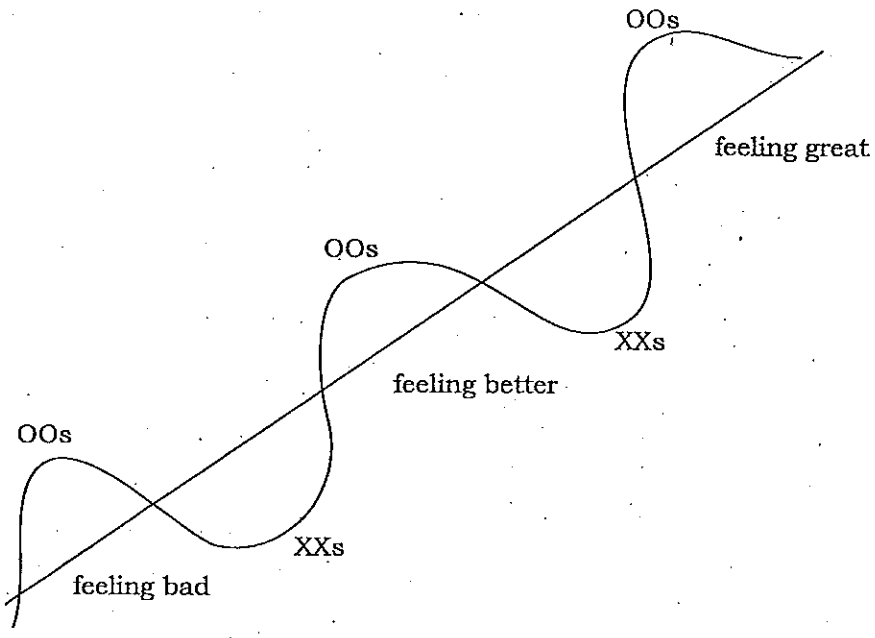
It is not unusual for episodes of chronic pain to flare up from time to time, tempting you to feel like you are right back where you started. John had entered a pain clinic program with the set expectation that after a certain period of time his pain condition would completely disappear. He did enjoy a tremendous decrease in pain while participating in the program, until after about eight weeks when a muscle spasm incapacitated him for several days. He felt despondent at the thought that all the skills he had learned were of no use. He was sure that his pain was returning in full force, never to be controlled again.

By now you are familiar with the ideas presented in this book, and you have probably already identified the errors in John's thinking that led him in unproductive directions. First, he had an unrealistic expectation at the start of the program that his pain would *never* return. Second, at the first sign of pain, he "catastrophized" his setback into a disaster and honestly convinced himself that all he had learned before was useless. Third, by letting his anxiety levels escalate, he experienced increased physical tension. This made his painful spasm worse and made it harder for him to practice his skills.

But for all his doubts, John stuck with it. He learned to control his catastrophic thinking so that the next time he had a pain episode, he was prepared. Every time the negative thoughts surfaced, he reminded himself that he "controlled the pain, the pain didn't control him." He learned to religiously follow his doctor's orders about proper medication use and exercise. Staying consistent in the face of intermittent flare-ups and discouragement required real tenacity. But he gained confidence in his ability to use the relaxation skills and programmed himself to use them immediately upon the first sign of pain.

Probably the most important factor in John's comeback was his introduction to a way of thinking about pain relapses that was used by Dr. Ian Wickramesacra, a behavioral medicine psychologist at Eastern Virginia Medical School in Norfolk, Virginia. Dr. Wickramesacra explains that whenever you make major behavioral changes, there are inevitably some setbacks. But if you sincerely want to cope better, you cannot let those set backs dictate the rest of your life. Put them into perspective. Accept the fact that there will be times when you cannot cope as well as you'd like, and that you may need to pull back and regroup. Dr. Wickramesacra devised the graph on the next page to illustrate his point.

As you make your way along your coping road, you know that you will have "up times" and "down times." The double Os on the graph are those up times, when you feel bursts of energy, well-being, and mastery. But sometimes the pain causes you to slip down to where the double Xs are



on the graph. These are the times when things are not going so well, when you may have a pain relapse and feel depressed and frustrated.

The trick here is to have a plan to get you through those low periods. You might pull out the plan of action contract you started at the beginning of this book and review it. Have you strayed from any of your goals and activities? Are there any outdated goals you could now replace with goals that are more appropriate? Or perhaps you simply need a boost of support from your friends or counselors. Make an appointment to see your doctor or health care professional who you know will be supportive. If you've tried biofeedback, hypnosis, or another type of pain control program, now might be a good time to make an appointment for a refresher session.

Remember that everything you learn and do adds another coping skill to your repertoire and takes you a step further along the road to recovery. Remind yourself that you do have the stamina to get through any difficult period and that you will eventually improve again. When you tell yourself that, believe it! Getting better means holding on to your commitment to healing yourself. The doctors and health care practitioners are only resources. You are the real healer, the one who marshals the helping resources, learns the essential skills, and keeps on working through the grim days of pain until you gain control of your body and your life again.

Counselling Resources

Crisis/Urgent Resource List

Klinic (24 hour Suicide Crisis Line)	204-786-8686
Mobile Crisis Unit (24 hour crisis assessment)	204-940-1781
Crisis Response Centre (Health Sciences Centre)	817 Bannatyne Ave.
Crisis Stabilization Unit (WRHA)	204-940-8374
Sara Riel Crisis Stabilization Unit	204-940-8374
Seneca House Warm Line (non-crisis support)	204-942-9276
Osborne House (domestic violence, emergency shelter)	204-942-3052
Ikwe-Widdjitiwin (24 hour crisis line)	1-800-362-3344

Counselling Resources

Addictions Foundation of Manitoba, 1031 Portage Ave. (http://www.afm.mb.ca/)	944-6200
Age and Opportunity, 200-280 Smith Street (http://www.ageopportunity.mb.ca/)	956-6441
Anxiety Disorders Association of Manitoba (ADAM) 100-4 Fort Street (http://www.adam.mb.ca/)	925-0600
Aulneau Renewal Centre, 601 Aulneau St. (bilingual counselling for adults, children, families, and couples) (http://members.shaw.ca/aulneau.renewal/)	987-7090
Aurora Family Therapy Centre, 515 Portage Ave. (http://aurora.uwinnipeg.ca/)	786-9251
Community Financial Counselling Services, 203-290 Vaughan St. (individual and group financial counselling services) (http://www.creditcounsellingcanada.ca/)	989-1900
Cornerstone Counselling Service, 302-1200 Portage Ave. or 159 Henderson Hwy. (individual, couple, and family counselling)	663-0050
Elizabeth Hill Counselling Centre, 301-321 McDermot Ave. (couple and family therapy, individual therapy for aboriginal and immigrant clients) (http://www.elizabethhill.ca/)	956-6560
Family Centre of Winnipeg, Unit 401-393 Portage Ave. (individual, couple, and family counselling) (http://www.familycentre.mb.ca/)	947-1401

Fort Garry Women's Resource Centre, 1150-A Waverley Street (counseling for women) (http://www.fgwrc.ca/)	477-1123
Indian Family Centre, 470 Selkirk Ave. (spiritual healing/sharing circle) (http://www.indianfamilycentre.com/)	586-8393
Klinic Community Drop-In Counselling Program 545 Broadway Ave., or 400A-1615 Regent Ave. West (http://www.klinic.mb.ca/)	784-4067
Post Trauma Counselling	784-4059
Sexual Assault Counselling	784-4049
Domestic Abuse Counselling (EVOLVE)	784-4208
Laurel Centre, 62 Sherbrook St. (individual counselling for women sexually abused in childhood or adolescence)	783-5460
Ma Mawi Wi Chi Itata Centre, 800 Selkirk Ave. (individual, family, adolescent and child counselling) (http://www.mamawi.com/)	925-0300
Manitoba Psychological Society (find a psychologist link)	www.mps.ca
Mood Disorders Association, 4 Fort Street, Suite 100 (Self Help Support Groups) (http://www.depression.mb.ca/)	786-0987
Mount Carmel Clinic, 886 Main Street (individual and family counselling) (http://www.mountcarmel.ca/)	582-2311
New Directions for Children, Youth, and Families, 777 Portage Ave. (family therapy and other resources) (http://www.newdirections.mb.ca/nd/home)	786-7051
Psychological Service Centre, U. of Manitoba (http://www.umanitoba.ca/faculties/arts/psychology/psc/)	474-9222
Recovery of Hope, 300-309 Hargrave (individual, family, and marriage counselling)	475-2039
Youville Centre, 33 Marion Street (counselling for parenting, family, relationship and personal issues) (http://www.youville.ca/)	233-0262