PAINWEEK

# Unveiling the Mask: The Relationship of Chronic Pain and Psychopathology

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## Biography

David Cosio, PhD, ABPP is the psychologist in the Pain Clinic and the CARF-accredited, interdisciplinary pain program at the Jesse Brown VA Medical Center, in Chicago. He received his PhD from Ohio University with a specialization in Health Psychology in 2008. He completed a behavioral medicine internship at the University of Massachusetts-Amherst Mental Health Services and a Primary Care/Specialty Clinic Post-doctoral Fellowship at the Edward Hines Jr. VA Hospital in 2009. Dr. Cosio has done several presentations in health psychology at the regional and national level. He also has published several articles on health psychology, specifically in the area of patient pain education. He achieved specialist certification in Clinical Health Psychology by the American Board of Professional Psychology in 2017.

There is no conflict of interest and nothing to disclose.

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## Disclosure

Dr. Cosio is speaking today based on his experiences as a psychologist employed by the Veterans Administration. He is not speaking as a representatives of or as an agent of the VA, and the views expressed are his own.

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## Learning Objectives

- Explain the relationship between chronic pain and different mental health disorders.
- Describe mental health disorders are defined in the new Diagnostic and Statistical Manual of Mental Disorders.
- Discuss the recommended treatments for these mental health disorders.
- Discuss the prevalence rates of these new DSM-5 disorders among chronic pain patients.

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## Chronic Pain & the Opioid Epidemic

- The opioid epidemic reflects a serious unmet need for better recognition and treatment of common mental health problems in patients with chronic pain (Howe & Sullivan, 2014)
- Patients attending pain specialty clinics have:
  - more difficult-to-treat pain conditions
  - comorbid, psychiatric disorders
  - use more outpatient services
  - receive a greater number of opioid prescriptions (Arout, Sofuoglu, & Rosenheck, 2017)
- Front-line practitioners may at times be faced with chronic pain patients suffering from undiagnosed mental health disorders when tapering opioid therapy
- These data support the inclusion of mental health care in the specialized treatment of chronic pain

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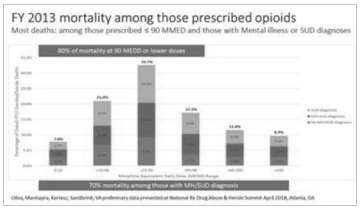
## Opioid Mortality & Mental Health

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## Role of Mental Health in Chronic Pain

- In most cultures, majority of mental health cases go unrecognized in primary care settings (Ballenger et al., 2001)
- About 60% of previously undetected depression cases could have been recognized if the patients had been evaluated for the mental health disorder (Katon, 1984)
- Numerous studies have documented strong association between chronic pain & psychopathology (Dersch, Polatin, & Gatchel, 2002)
  - most often associated with depression, anxiety, somatoform, personality, & substance use disorders
  - Less is known about the relationship with schizophrenia spectrum/ psychotic, sleep-wake, bipolar, neurocognitive, obsessive-compulsive, & dissociative disorders

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## Mental Health & Pain Relationship

- Individuals who suffer from pain and are diagnosed with a mental disorder have been found to experience a worsening of psychiatric symptoms (Elman et al., 2011)
- Healthcare professionals may fail to give complaints about physical health problems serious consideration among patients with serious mental illness (RETHINK, 2013)
- Patients are less likely to recognize or monitor comorbid medical conditions compared to the general population (Kilbourne et al., 2006)
- They have increased likelihood of experiencing conditions that cause pain and lower probability of receiving adequate care (De Hert et al., 2011)
- Associated with:
  - impaired recovery (Miller et al., 2013)
  - greater functional incapacitation (McIntyre et al., 2006)
  - lower quality of life (Ringenheir et al., 2013)
  - increased risk for suicide17 compared to individuals without pain (Ratcliffe et al., 2008)

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## Chronic Pain & Psychopathology

Fishbain et al., 1986 study

- 283 chronic pain patients
- Comprehensive Pain Center of the University of Miami School of Medicine
- Extensive 3-day evaluation period
- 2 hour detailed, semi-structured psychiatric interview based on DSM-III

- Statistical comparison between male and female patients with regards to the prevalence of each diagnosis
  - 156 males
  - 127 females
  - No significant difference with regards to age or race
- Primary locations of pain:
  - low back 73%
  - neck pain 17%
  - other (abdominal, chest, etc.) 8%
    - headache 2%

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## Fishbain (1986) Study & DSM-III

| Diagnosis | Males | Females | Total |
|---|---|---|---|
| Total Anxiety | 58.8 | 66.3 | 62.5 |
| Personality | 62.3 | 55.1 | 59.0 |
| Total Depression | 49.9 | 63.8 | 56.2 |
| Substance Use | 20.4 | 7.9 | 14.9 |
| Intermittent Explosive | 16.7 | 1.6 | 9.9 |
| Dementia | 5.1 | 11.0 | 7.8 |
| Somatization | 0.6 | 7.9 | 3.9 |
| Bipolar | 0.6 | 2.4 | 1.5 |
| Obsessive-Compulsive | 0.6 | 1.6 | 1.1 |
| Psychosis | 0 | 0 | 0 |
| Sleep-wake | n/a | n/a | n/a |
| Dissociative | n/a | n/a | n/a |

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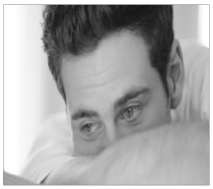
## What Do We Know?

- Anxiety
  - Earlier research listed prevalence between 16.5% and 28.8%; Newer studies suggest up to 60% (Fishbain et al., 1998)
  - Dependent on the methods used to assess
  - DSM criteria used (III versus 5)
  - Spectrum of disorders included
  - panic disorder and generalized anxiety disorder (GAD) are most common (Demyttenaere et al., 2007)
  - **PTSD and OCD no longer under anxiety disorders in DSM-5**



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## What Do We Know?

- Personality
  - Rate ranges between 30% to 60% (Sansone & Sansone, 2012)
  - 51% met criteria for one personality disorder, and 30% for more than one (Polatin et al.,1993)
  - 60% chronic met criteria for a personality disorder versus 21% of acute low back pain (Kinney et al., 1993)
  - **Predate the onset of injury and complicate the course of a pain syndrome** (Elliot et al., 1996)
  - Specifically met criteria for cluster C (dependent 10.6%; OCPD 24.5%) (Elliot et al., 1996)

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## What Do We Know?

- Depression
  - Most research & theoretical interest among people with chronic pain (Dersh et al., 2002)
  - Ranges from 15% to 100% (Bair et al., 2003)
  - Ranges from 5% to 10% (in primary care) (Katon et al., 1992) to 85% (specialty clinics)- creates linear increase in prevalence from community to inpatient medical samples (Bair et al., 2003)
  - **Less depression when condition is more defined than in medically unexplained pain** (Magni & Merskey, 1987)
  - Pain symptoms associated with 2-fold increased risk for coexisting depression (Kroenke & Price, 1993)
  - Multiple symptoms are 3 to 5 times more likely to be depressed (Von Korff et al., 1988)
  - Association also strengthens severity of either condition (Lamb et al., 2000)

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## What Do We Know?

- Substance use
  - Patients being treated for substance use report chronic, noncancer pain (Potter et al., 2008)
  - Hx SUD occurs frequently among patients treated for chronic, noncancer pain (Fleming et al., 2007)
  - 3% to 48% of chronic pain patients have a current substance use disorder (Morasco et al., 2011)
  - Lifetime prevalence (16% to 74%) (Morasco et al., 2011) higher than general population (16.7%) (NIDA, 1991)
  - 94% of chronic pain patients with lifetime SUDs experience onset before pain (Polatin et al., 1993)
  - Chronic pain patients no more likely than other patient in primary care to have a current SUD; not associated with unique risk for substance use disorder (Brown et al., 1996)
  - Most commonly misused/abused substances were alcohol (current and lifetime) and narcotics (current); **did not consider marijuana and tobacco use** (Dersh et al., 2002)

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## What Do We Know?

- **Somatic Symptom Disorder**
  - Old somatoform disorders; Lifetime rates comparable to community and primary care (Atkinson et al., 1991)
  - Lifetime prevalence of somatoform was 34% and 6-month rate of 17%, but dropped to 12% and 5% with DSM-IV (Grabe et al., 2003)
  - 95% of patients with chronic low back pain in intensive rehab setting had current SSD (Grabe et al., 2003)
  - Correlation between pain intensity and presence of somatization and hypochondriasis (Polatin et al., 1993)
  - Frequency in chronic pain patients varies from 0% to 53%; Conversion 2% to 38% (Dworkin & Caligor, 1988)

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## What We Know Less…

- Neurocognitive
  - **Prevalence rate of patients with dementia that are in pain from 20% to 50%** (Tosato et al., 2012)
  - 60-80% of individuals with NCD in care homes experience pain (Corbett et al., 2012)
  - **Few studies in subtypes (e.g. dementia due to vascular, frontotemporal, and Lewy bodies)**
  - Prevalence of some type of pain in Parkinson's disease ranges from 68-85% (Lee et al., 2006)
  - TBI-associated disability, prevalence is about 52% among civilians (Nampiaparampil, 2008) and 42% among Veterans (Lew et al., 2009)
- Bipolar
  - Prevalence of clinical pain is 29%; of migraine is about 14%; and of chronic pain is 24% (Stubbs et al., 2014)
  - **Almost four pain complaints at any one time** (Birgenheir et al., 2013); Musculoskeletal conditions (e.g. lower back pain, arthritis, and hip problems) more prevalent (Kilbourne et al., 2004)
  - Migraines most common (Ortiz et al., 2010) and are 3x more likely to experience (Stubbs et al., 2014)
  - Lifetime prevalence of migraine is 40%, and 65% in bipolar-II disorder (Low, Galbaud du Fort, & Cervantes, 2003)
  - Multifactorial etiology (vascular, cellular, molecular, neurochemical, genetic) in both (McIntyre et al., 2006)

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## What We Know Less…

- Obsessive-compulsive
  - Prevalence of OCD among treatment seeking patients is about 1.1% (Fishbain et al., 1986)
  - Prevalence of 12-month and lifetime is about 2% (Knaster et al., 2012)
  - Among low back pain patients, prevalence from 2.0% to 8.2% (Polatin et al., 1993) and lifetime of 13.4% (Atkinson et al., 1991)
  - Prevalence among musculoskeletal pain patients was 0.0% (Asmundson et al.,1996)
  - Lifetime prevalence in treatment seeking MS patients was 8.6% (Korostil & Feinstein, 2007)
- Schizophrenia spectrum
  - 38% reported pain (Delaptaine et al.,1978); similar to general population of similar age (de Almeida et al., 2013)
  - Most common complaint is headaches (Torrey, 1989); common sites are head, leg, and back pain (Watson, Chandarana, & Merskey, 1981)
  - Present with bizarre sensory or tactile hallucinations difficult to distinguish from pain (Bar et L., 2002)

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## What We Know Less…

- Sleep-wake
  - Classic chicken and egg problem to determine direction of causation between pain and sleep disturbance
  - Both share common neurobiological systems, in particular central serotoninergic neurotransmission (Foo & Mason, 2003)
  - 50-70% of chronic pain patients suffer from a sleep disturbance (Morin, Gibson, & Wade,1998); 89% seeking treatment report at least one sleep complaint (McCracken & Iverson, 2002)
  - Sleep apnea, restless leg syndrome, and periodic limb movements in sleep are most common
  - Sleep apnea is diagnosed in 17% of headache patients (Paiva et al., 1997)
  - People with chronic pain reported more chronic insomnia (48.6%) than without (17.2%) (Taylor et al., 2007)
  - Increased daytime pain is linked with poor subsequent nighttime sleep and poor sleep is associated with more next day pain; evidence of a bidirectional relationship between pain and sleep (Raymond et al., 2001)

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## What We Know Less…

- Dissociative
  - Headaches were most frequent somatic complaint (more than 60%) (Saxe et al.,1994)
  - Headaches, joint pain, back pain, pelvic pain, and pain in the extremities, were more common than in controls (Agargun et al.,1998)
  - **More dissociative experiences have higher pain thresholds** (McFadden & Woitalla, 1993)
  - Different identities could "take over" at times of more severe pain (Saxe, Chawla, & van der Kolk, 2002)
  - Difference in pain perception, location, and estimates of secondary functional impairment among different identities (Saxe, Chawla, & van der Kolk, 2002)
  - Case of Phillip/Jasmine

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## We Know Nothing About "Taboos"

- Neurodevelopmental
  - Caregivers report 15% of their sample was experiencing pain for an average of 6 years
  - Significantly more females than males, although age, communication ability, and level of intellectual disability were not found to be associated
  - Presence of pain associated with cerebral palsy, physical disability, and reports of challenging behavior (Walsh, Morrison, & McGuire, 2011)
- Feeding/eating
  - Odds of bulimia nervosa and binge eating disorder predicting musculoskeletal pain (1.6-2.8) and other pain conditions (1.9-2.8) are generally comparable (Kessler et al., 2013)
- Elimination
  - Most frequent problem in urologic practice is recurrent or chronic genital pain with no physical cause; Very little has been written and treatment is generally ineffective (Kursh, 2001)
  - 2/3 of adolescents with a high pain dysfunctional profile will develop pain-related gastro-intestinal disorder; Profile characterized by low coping efficacy and high levels of negative affect, pain catastrophizing, and functional disability (Walker et al., 2012)

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## We Know Nothing About "Taboos"

- Sexual dysfunction
  - 73% of respondents had pain-related difficulty with sexual activity; Few differences between men and women (Ambler et al., 2001)
  - Several difficulties and in various combos, including arousal, positioning, performance, and relationship issues
  - Predicted by psychological factors and pain duration (Kwan, Roberts, & Swalm, 2005)
- Gender dysphoria
  - Chronic pain has negative impact on an individual's gender identity (Deaux & LaFrance, 1998)
  - Men with chronic pain perceived as less masculine/more feminine; women as more masculine/less feminine; and were more similar to each other than other men/women (Bernardes & Lima, 2010)
  - **Transgender and/or gender nonbinary people witness an increase in pain especially in areas of body that change as a result of cross-sex hormone treatment**
  - 30% MTF reported headaches, breast, and musculoskeletal pain.22; 62% of FTM reported pain that improved after testosterone administration (Aloisi et al., 2007)

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## We Know Nothing About "Taboos"

- Paraphilic
  - 29% of men with pain were not able to fantasize about a sexually attractive person; erotic parts of a woman's body; erotic or romantic situations; caressing, touching, undressing, or foreplay; and/or sexual intercourse, oral sex, touching to orgasm (Monga et al., 1998)
- "Process" addictions
  - Such as gambling, internet/video game, food, shopping/spending, exercise, and sex addictions
  - These behaviors activate the brain reward system with effects similar to those of substance use (APA, 2013)
  - Little has been documented regarding problematic internet usage (Chrismore et al., 2011)
  - Addiction recovery institutions began treating internet addiction after screening for other process addictions like gambling (Chrismore et al., 2011)

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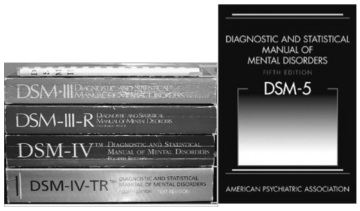
## APA (2013) New DSM-5

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## Cosio (2018) Study & DSM-5

- The purpose of the pilot study was to statistically compare chronic pain patients for the types of DSM-5 disorders identified using emerging measures
  - sample of 272 Veterans aged 18-89 years old (11% dropped)
  - 57% AA; 89% male; and 37% were 55-64 years old
  - November 1, 2013 to October 31, 2014 participated in the Pain Education School program
  - mixed, idiopathic pain conditions (back, neck, extremity, head, and fibromyalgia)
  - males and females did not differ significantly with regards to age or race
  - only 1.5% of cases reported no domains; 18.5% had endorsed 1-6 domains; 80% endorsed 7-12 domains
- These measures are being used as potentially useful tools to enhance clinical decision-making
- In addition, the current study serves as a replication of previous studies using the most recent version of the APA's *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5)

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## Measures

As part of introduction of program, all participants completed a pre-education assessment:

- World Health Organization Disability Assessment Schedule (WHODAS 2.0)
  - 36 item, self-administered measure
  - Assesses disability in adults across six domains (cognition, mobility, self-care, getting along, life activities, and social participation)
  - Each item asks the individual to rate how much difficulty they had in specific areas of functioning during the past 30 days
- DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure-Adult (CCSM-A)
  - 23 item, self-administered measure
  - Assesses 12 psychiatric domains (depression, anger, mania, anxiety, somatic symptoms, psychosis, sleep problems, memory, repetitive behaviors, dissociation, personality, and substance use)
  - Each item inquires about how much (or how often) the individual has been bothered by the specific symptom during the past two weeks

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## Cross-Cutting Symptom Measure-Adult

| | During the past **TWO (2) WEEKS**, how much (or how often) have you been bothered by the following problems? | **None** Not at all | **Slight** Rare, less than a day or two | **Mild** Several days | **Moderate** More than half the days | **Severe** Nearly every day | **Highest Domain Score** (clinician) |
|---|---|---|---|---|---|---|---|
| I. | 1. Little interest or pleasure in doing things? | 0 | 1 | 2 | 3 | 4 | |
| | 2. Feeling down, depressed, or hopeless? | 0 | 1 | 2 | 3 | 4 | |
| II. | 3. Feeling more irritated, grouchy, or angry than usual? | 0 | 1 | 2 | 3 | 4 | |
| III. | 4. Sleeping less than usual, but still have a lot of energy? | 0 | 1 | 2 | 3 | 4 | |
| | 5. Starting lots more projects than usual or doing more risky things than usual? | 0 | 1 | 2 | 3 | 4 | |
| IV. | 6. Feeling nervous, anxious, frightened, worried, or on edge? | 0 | 1 | 2 | 3 | 4 | |
| | 7. Feeling panic or being frightened? | 0 | 1 | 2 | 3 | 4 | |
| | 8. Avoiding situations that make you anxious? | 0 | 1 | 2 | 3 | 4 | |
| V. | 9. Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)? | 0 | 1 | 2 | 3 | 4 | |
| | 10. Feeling that your illnesses are not being taken seriously enough? | 0 | 1 | 2 | 3 | 4 | |
| VI. | 11. Thoughts of actually hurting yourself? | 0 | 1 | 2 | 3 | 4 | |

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## Cross-Cutting Symptom Measure-Adult

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| VII. | 12. Hearing things other people couldn't hear, such as voices even when no one was around? | 0 | 1 | 2 | 3 | 4 | |
| | 13. Feeling that someone could hear your thoughts, or that you could hear what another person was thinking? | 0 | 1 | 2 | 3 | 4 | |
| VIII. | 14. Problems with sleep that affected your sleep quality over all? | 0 | 1 | 2 | 3 | 4 | |
| IX. | 15. Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)? | 0 | 1 | 2 | 3 | 4 | |
| X. | 16. Unpleasant thoughts, urges, or images that repeatedly enter your mind? | 0 | 1 | 2 | 3 | 4 | |
| | 17. Feeling driven to perform certain behaviors or mental acts over and over again? | 0 | 1 | 2 | 3 | 4 | |
| XI. | 18. Feeling detached or distant from yourself, your body, your physical surroundings, or your memories? | 0 | 1 | 2 | 3 | 4 | |
| XII. | 19. Not knowing who you really are or what you want out of life? | 0 | 1 | 2 | 3 | 4 | |
| | 20. Not feeling close to other people or enjoying your relationships with them? | 0 | 1 | 2 | 3 | 4 | |
| XIII. | 21. Drinking at least 4 drinks of any kind of alcohol in a single day? | 0 | 1 | 2 | 3 | 4 | |
| | 22. Smoking any cigarettes, a cigar, or pipe, or using snuff or chewing tobacco? | 0 | 1 | 2 | 3 | 4 | |
| | 23. Using any of the following medicines ON YOUR OWN, that is, without a doctor's prescription, in greater amounts or longer than prescribed [e.g., painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)]? | 0 | 1 | 2 | 3 | 4 | |

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## Results Comparison

| Diagnosis | Fishbain (1986) | Cosio (2018) |
|---|---|---|
| | Total | Total |
| Depression | 56.2 | 67 |
| Anger | 9.9 | 74 |
| Mania | 1.5 | 52 |
| Anxiety | 62.5 | 60 |
| Somatic Symptoms | 3.9 | 74 |
| Psychosis | 0 | 18 |
| Sleep Problems | n/a | 77 |
| Memory | 7.8 | 54 |
| Repetitive Thoughts & Behaviors | 1.1 | 40 |
| Dissociation | n/a | 43 |
| Personality Functioning | 59.0 | 44 |
| Substance Use | 14.9 | 17 |

| Diagnosis | Fishbain (1986) | | Cosio (2018) | |
|---|---|---|---|---|
| | Males | Females | Males | Females |
| Depression | 49.9 | 63.8 | 65 | 79 |
| Anger | 16.7 | 1.6 | 71 | 88 |
| Mania | 0.6 | 2.4 | 54 | 36* |
| Anxiety | 58.8 | 66.3 | 58 | 71* |
| Somatic Symptoms | 0.6 | 7.9 | 73 | 75 |
| Psychosis | 0 | 0 | 17 | 25 |
| Sleep Problems | n/a | n/a | 76 | 79 |
| Memory | 5.1 | 11.0 | 54 | 52 |
| Repetitive Thoughts & Behaviors | 0.6 | 1.6 | 40 | 50 |
| Dissociation | n/a | n/a | 43 | 44 |
| Personality Functioning | 62.3 | 55.1 | 43 | 50 |
| Substance Use | 20.4 | 7.9 | 20 | 11* |

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*Significant differences at p<.05

## Cosio (2018) Study & DSM-5

| Diagnosis | Fishbain (1986) | Cosio (2018) |
|---|---|---|
| | Total | Total |
| Sleep Problems | n/a | 77 |
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| Psychosis | 0 | 18 |
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## Summary

- Individuals had mild-moderate difficulty in specific areas of functioning during the past 30 days
  - Latinos reported significantly more disability (M=105.78) then Caucasians (M=97.62), African Americans (M=86.24), and other races (M=35.33); F(3,268)=4.19, $p$<0.01
- Witnessed more mania, memory, and repetitive thoughts and behaviors in this sample
  - May be due to dimensional vs. categorical measurement of DSM-5
  - May be because of a high rate of false positive answers on the measure--perhaps may want to use the lowest threshold
  - The differential diagnosis of bipolar disorder includes other conditions that may have manic-like symptoms, including organic mood disorders such as endocrine or metabolic conditions, drug intoxications, and tumors
  - Does the patient truly has memory loss or another cognitive problem? Some degree of memory loss with aging, medications, and depression
  - The differential diagnosis of OCD includes depression, phobic disorders, anorexia nervosa, cluster c personality, and schizophrenia

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## Summary

- DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure-Adult (CCSM-A) may serve as a good measure to use to screen chronic pain patients for mental health concerns
  - CCSM-A fails to measure PTSD, which is prevalent in the Veteran population
  - The differential diagnosis of PTSD includes anxiety disorders, phobias, and OCD
  - CCSM-A fails to measure "taboo", or polarizing disorders
- CCSM-A may function better in helping to identify the negative prediction of symptoms
  - Represent symptoms commonly seen in clinical practices, regardless of a client's subsequent diagnosis
  - Assessments could help providers:
    - document all of a client's symptoms
    - aid in developing more precise treatment plans
    - monitor treatment progress
    - improvements even if the symptoms do not disappear completely

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## Examples of Interventions

| Domain | |
|---|---|
| Neurocognitive | Behavioral Interventions |
| Obsessive-Compulsive | Exposure and Response Prevention |
| | Cognitive Therapy |
| | Acceptance and Commitment Therapy |
| Dissociative | Hypnosis |
| | Cognitive Behavioral Therapy |
| | Eye Movement Desensitization and Reprocessing (EMDR) |
| | Exposure Therapy (for trauma) |
| Personality | Social Skills Training |
| | Dialectical Behavior Therapy (cluster b) |
| | Mentalization-Based Treatment (borderline) |
| | Schema-Focused Therapy (borderline) |
| Substance Use | Motivational Interviewing/Motivational Enhancement Therapy |
| | Cognitive Behavior Therapy (integrated with MI) |
| | Contingency Management |
| | Seeking Safety |
| | Behavioral Couples Therapy (for alcohol) |
| Anger | Cognitive Behavioral Therapy (most common) |

(APA Division 12, 2016)

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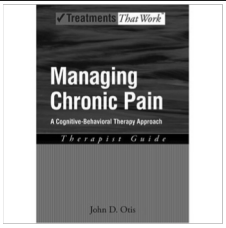
## CBT Manualized Treatment




- Managing Chronic Pain: A Cognitive-Behavioral Therapy Approach (Treatments That Work) by John Otis
- Sessions are as follows:
  1. Education on Chronic Pain
  2. Theories of Pain and Diaphragmatic Breathing
  3. Progressive Muscle Relaxation and Visual Imagery
  4. Automatic Thoughts and Pain
  5. Cognitive Restructuring
  6. Stress Management
  7. Time-based Pacing
  8. Pleasant Activity Scheduling
  **9. Anger Management**
  **10. Sleep Hygiene**
  11. Relapse Prevention and Flare-Up Planning
  12. Feedback and Termination

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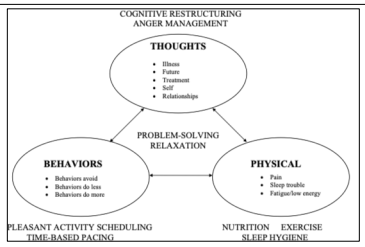
## Cognitive-Behavioral Therapy Model

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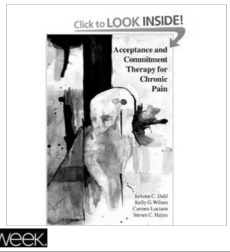
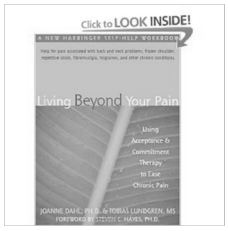
## ACT Manualized Treatments

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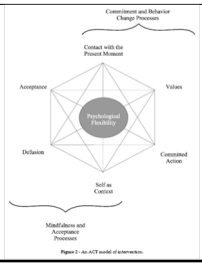
## Acceptance & Commitment Model

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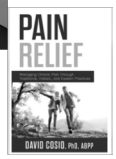


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