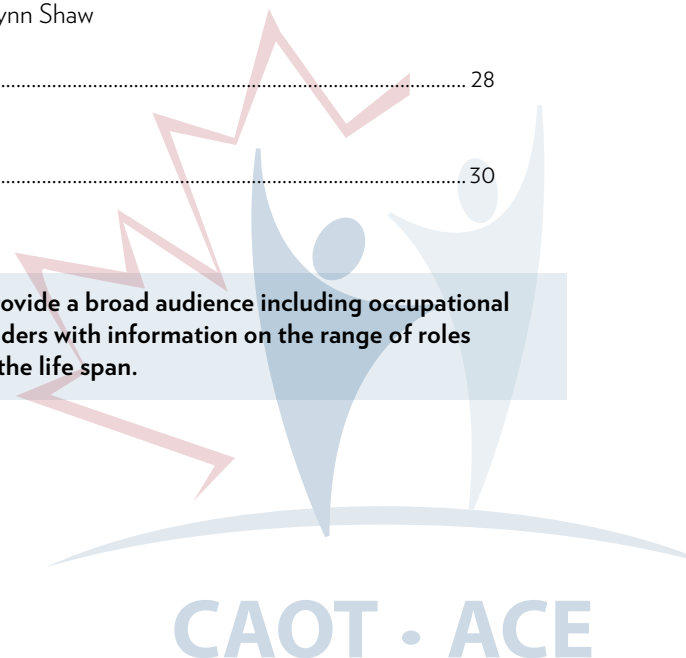


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The intention of this special issue of *Occupational Therapy Now* is to provide a broad audience including occupational therapists, health professionals, clients, policy makers and other stakeholders with information on the range of roles occupational therapists hold in pain prevention and management across the life span.



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# Pain and occupational therapy: The time is now

Cary Brown

**Pain is as diverse as man. One suffers as one can.  
(Victor Hugo 1802-1885)**

One in every five Canadians will experience significant pain at some point in their lives (Lynch, 2011). For some people, that pain will be short-lived or episodic. Other people will experience pain in the process of dying. And yet others will live with enduring pain that appears to have no clear reason or meaning. Pain will come to some people as infants, others during old age and all points in between. Pain is certainly not biased, nor is it discriminatory. Any one of us can find our life or the life of someone we care about altered by the experience of pain. Occupational therapists will not only work with children and adults who have pain but many of us will be doing that work as we cope with our own pain experiences. However, despite our daily involvement with some aspect of pain, as a society we still tend to minimize and discount what we cannot so readily see. In our evidence-based approach to health and well-being we have not yet fully grasped that the evidence we draw on to help us understand the pain experience of others must privilege and validate those people's voices. "To have pain is to have certainty; to hear about pain is to have doubt" (Scarry, 1985, p.13). The authors' contributions in this special issue demonstrate diverse and creative ways for the client's voice to be clearly heard and valued. This mutual communication is fundamental to any therapeutic relationship and Canadian occupational therapists are fortunate to have these role models.

It seems to me that in the diversity of when and how pain enters people's lives there are three common features. Firstly, unmanaged pain is inseparable from suffering (Morris, 1993). This is perhaps most true for vulnerable individuals like infants and older adults where the evidence shows that, despite the high risk of pain, assessment and intervention remains unacceptably low (Brown, 2010; Engel, Petrina, Dudgeon, & McKernan, 2006).

Secondly, each person's pain is unique and needs to be understood as a biological, a psychological, and a social

phenomenon. Pain arises from the interaction of these domains within the context of each person's life. Most pain researchers and clinicians agree that the biopsychosocial model (Gatchel, Peng, Peters, Fuchs, & Turk, 2007) is the most responsive framing of the complex, non-linear and highly interactive event we label pain (Brown, 2009). The biopsychosocial model is congruent with how occupational therapists understand the relationship between person, daily activities, and environment. Our level of familiarity with a biopsychosocial model should be shared to help team members develop a similar appreciation for the value of this approach.

A third common feature is that pain both contributes to, and is compounded by, loss of function. This loss of function occurs across all domains at both the individual and the macro societal levels. People with pain experience challenges to physical, emotional, cognitive and spiritual function and often feel isolated and misunderstood. People with enduring pain repeatedly tell us they are treated with suspicion and doubt (Brown, 2004). Individual functional challenges also have a negative effect at the family/social unit level. In this issue, Antao, Ollson, To-Miles, Bossers, Cooper, and Shaw present a compelling macro-level review of the societal costs in terms of lost productivity and wages. Although the emotional, spiritual and social capital costs of pain-related loss of function are much more difficult to quantify logically, they must be of equally staggering magnitude.

Why a special *OT Now* issue on pain? These are challenging times in health care. Occupational therapy, like all other health-care disciplines, is reflecting on what are the most effective, relevant and unique contributions of our profession. Because pain is growing in prevalence across the lifespan in Canada, there is no more urgent need than increasing our pain awareness and involvement in pain management. Health care in the 21st century requires innovation and this special issue helps provide the direction and vision occupational therapists need to achieve this goal.

We have a wealth of resources to guide occupational therapy pain practice. The Canadian Association of

## About the guest editor

**Cary A. Brown, FHEA, PhD**, is currently an associate professor in the Occupational Therapy Department at the University of Alberta. She has practiced clinically as an occupational therapist, department supervisor and academic in Canada, Saudi Arabia and the United Kingdom. Her teaching and research areas include knowledge translation, health literacy, sleep, and chronic pain across the life span. Much of Cary's recent research is disseminated through websites, one of which ([www.painanddementia.ualberta.ca](http://www.painanddementia.ualberta.ca)) received the Canadian Pain Society Pain Awareness Award in 2010 for knowledge translation activities. Cary has an active research lab with vacancies for new graduate students. She can be reached at: [cary.brown@ualberta.ca](mailto:cary.brown@ualberta.ca).



Occupational Therapists (CAOT) contributed to the development of the National Pain Strategy for Canada (Canadian Pain Society & Canadian Pain Coalition, 2012), hosted a professional issue forum on Pain Management and Occupational Therapy in 2011, developed a position statement on pain for occupational therapists (see announcement in this issue), and posted pain resources of relevance to occupational therapists on-line ([www.caot.ca/pdfs/PIF/resource%20sheet.pdf](http://www.caot.ca/pdfs/PIF/resource%20sheet.pdf)). Anita Unruh, a Canadian occupational therapist, is coordinating the International Association for the Study of Pain (IASP) project to revise curriculum guidelines in pain for occupational therapy. Jennifer Strong and her team are launching the second edition of *Pain: A textbook for therapists*, and the Canadian Pain Coalition now has a regular Ask an Occupational Therapist column in their newsletter (see Klinger and Klassen in this issue).

Additionally, many other pain health literacy and pain management materials are available to help guide practice. The IASP ([www.iasp-pain.org/](http://www.iasp-pain.org/)), the Canadian Pain Coalition (<http://www.canadianpaincoalition.ca>) and the Canadian Pain Society (<http://www.canadianpainsociety.ca>) all have a wealth of open-access resources. All of these organizations welcome occupational therapists as members. Of course, if we don't join and actively share in the responsibility for moving forward in addressing pain, occupational therapy's unique role will be lost. As Bronwyn Thompson asks in her pain management blog, where are the occupational therapists in pain management (Thompson, 2012)? I hope you join in the dialogue.

So here is where we stand - opportunity, welcoming pain organizations, extensive transferable skills, and many resources. We are well-positioned to take on this exciting and growing challenge in a proactive manner as opposed to being swept along scrambling to react to the swelling need. Are there still areas we need to develop? Yes, most certainly. We need to better understand the unmet needs of people in rural and remote areas (Riley-Doucet, Fouladbakhsh, & Vallerand, 2004), of aboriginal persons (Kaufert, 1999) and of adolescents living with pain (Huguet, Stinson, & McGrath, 2010). We also need to examine how sleep problems interact with pain (Lavigne, Sessle, Choiniere, & Soja, 2007) and work to clarify the conceptual ambiguity around pacing as a pain management strategy (Jamieson-Lega, Berry, & Brown, in press). We need researchers to work in the area of pain and university programs to embed basic pain education and management into curriculum. We also need occupational therapists to take advantage of the opportunity to acquire advanced post-professional training in pain management (for example, <http://www.rehabilitation.ualberta.ca/en/ContinuingProfessionalEducation/CertificateinPainManagement.aspx>). Most urgently, we need occupational therapists to join pain associations so we have a vehicle to ensure clients' unmet functional needs are addressed.

It has been such a pleasure being involved in this special issue. I want to thank everyone who found time in their busy

schedules to share their experience, knowledge and leadership with the rest of us. Chris Eccleston, an internationally respected pain psychologist, wrote "pain demands attention" (Eccleston & Crombez, 1999). It's time for occupational therapists to give pain its due.

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## What's new



### Position statement coming soon!

Work is underway to finalize the CAOT Position Statement on Occupational Therapy and Pain Management. When completed, it will be posted at [www.caot.ca](http://www.caot.ca) > Professional Practice > Position Statements.

Other pain management resources currently available on the CAOT website include:

- Report and Recommendations from the Pain Management and Occupational Therapy Professional Issue Forum, which took place at the 2011 CAOT Conference: [www.caot.ca](http://www.caot.ca) > Professional Practice > PIF Reports
- Occupational Therapy Pain Resources: <http://www.caot.ca/pdfs/PIF/resource%20sheet.pdf>

- “Ask an OT about managing pain”: [www.caot.ca](http://www.caot.ca) > About occupational therapy > How does occupational therapy help? > Ask an occupational therapist

### Change concerning periodicals for CAOT membership renewal

Starting on October 1st, hard copies of *CJOT* and *OT Now* will no longer be automatically sent to CAOT members. If you would like to continue receiving these periodicals in the mail, you will be given an opportunity to indicate this on your membership renewal form. Members can always access the online versions of *CJOT* and *OT Now* at [www.caot.ca](http://www.caot.ca).

## Just Say YES! ... Say YES When We Call COTF's 2012 Fundraising Campaign

COTF is a charitable organization that funds and promotes scholarship and research awards in Canadian occupational therapy. October will mark a very special event for COTF – its very first ‘phonathon’ fundraising campaign.

Why? Because COTF wants to increase its fundraising ability in order to continue its important investments in research and scholarships. These investments provide researchers with the opportunity to advance their work, and practitioners with the most current evidence for practice.

COTF's awards programs are solely funded through donations from individuals, corporations, organizations and foundations. Some years are stronger than others. While there have been years where the Foundation has allocated up to \$80,000 for annual scholarships and research, in tougher times that figure has dropped to a quarter of that amount.

Like the vast majority of academics and clinicians in the

field of occupational therapy, COTF strongly believes in the importance of higher academic learning and ongoing research – and thus, has taken a step forward to ensure that the dollars are there to advance our profession and has launched this important fundraising campaign.

When you get a call in October, which happens to be Occupational Therapy Month, **Just Say YES! ... Say YES When We Call.** It's an investment in our future.

- A striking 99% of CAOT members polled agreed that research findings are important to their day-to-day practice.
- Since 1983, COTF has provided \$1.4 million for research in both academic and clinical settings.
- To date, 268 researchers and academics have benefitted from COTF funding.

*Two prominent occupational therapy researchers benefitted from the COTF awards program in a similar fashion. Mary Law states that “receiving the first grant from COTF gave me the confidence to go on to apply for larger grants from other organizations”, while Terry Krupa shares that “it developed my self-confidence when setting up a program of research, which seemed overwhelming ... this support helped to increase my ‘competitive edge’ when I went on to apply for funding from national granting agencies.”*

*According to COTF donor, Sandra Hobson, “We are a small group, and everyone needs help, even a little. If I don't, who will?”*



# What does an occupational therapist do for someone living with chronic pain?

Lisa Klinger and Bonnie Klassen

We were invited by the Canadian Pain Coalition (CPC) (<http://www.canadianpaincoalition.ca/>) to write a regular column in their newsletter to explain what occupational therapy is and how it can help people manage the challenges of living with daily pain. This was an exciting opportunity for occupational therapists to reach out to the many different stakeholders who read the CPC Newsletter and build bridges for knowledge exchange and collaboration. CPC generously gave us permission to share the following contents of the first column we wrote for the newsletter with *OT Now* readers in this special theme issue.

Our description of the occupational therapist's role in pain management was intended to be accessible to an audience of people who have pain, their family and friends, a diverse group of health professionals, and other stakeholders. Other occupational therapists may be able to expand

and further describe aspects of practice beyond what we have included in this article. It is hoped that this can be helpful as an example from which to develop your own accessible documents to explain the occupational therapy role in your unique practice context.

If you would like to share your pain management expertise from an occupational therapy perspective, please contact us about submitting an article to the CPC column.

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*“Occupational therapists address the issues that get in the way of being able to do the things that are important, including the activities that allow you to independently take care of yourself and your family, and those activities that give you satisfaction and a sense of purpose in life.”*

---

A question was received from a subscriber of the *Canadian Pain Coalition Newsletter*: “My family doctor has referred me to an occupational therapist for my chronic pain. I didn't know occupational therapists had a role in chronic pain? What would the occupational therapist do?”

Occupational therapists are health professionals who receive their training in accredited university programs. They are concerned about what people ‘do’. The ‘occupation’ in our name refers to the general idea of being occupied. So when occupational therapists talk about occupations, they're not talking just about jobs, but they mean all the activities that can occupy time during a day. Occupational therapists address the issues that get in the way of being able to do the things that are important, including the activities that allow you to independently take care of yourself and your family, and those activities that give you satisfaction and a sense of purpose in life. Chronic pain takes a major toll on your ability to engage in the activities that you need to do, want to

do, or are expected to do in the course of a day. So if you have a question about how to do those things, an occupational therapist might be the best person to talk to.

Some activities can actually stimulate pain, especially if they require more effort or range of motion than you have available or if they are very repetitive. Occupational therapists can help to find strategies to change the activity so it is not so taxing, or find ways to modify the way the environment around the activity is built or organized to make the activity more doable. Sometimes it's a question of breaking down the activity into manageable bits with rest breaks in between, which will allow the activity to be accomplished. Occupational therapists are good at such ‘activity analysis’ and their ideas can be very helpful. Occupational therapists are usually also very familiar with all kinds of adaptive

devices, and so they may be able to suggest a device that will make the job easier.

Some activities may actually be harmful, as they may be placing too great a strain on joints that are damaged by disease or under stress due to an inflammatory response. In these cases, an occupational therapist's

input can help identify potentially dangerous ways of carrying out an activity and provide suggestions for a safer way. This might involve using more ergonomically correct tools or ways to set up equipment, or might involve ways of carrying, lifting or handling that are biomechanically better. Sometimes it's a question of problem-solving how jobs and tasks are organized (either the order in which tasks are done or the way that the environment within which the tasks take place is set up), and occupational therapists generally have a lot of knowledge and experience to help guide you to do activities in ways that prevent injury.

When you have chronic pain, you often experience a great deal of fatigue, related either to constantly dealing with the pain, side effects of medication or difficulty sleeping. Occupational therapists can suggest ways of structuring your day to reduce the effects of fatigue. Alternatively, they may be able to suggest sleeping positions that will allow you to get a better night's rest. An occupational therapist may also be able to help you select an exercise program in your community that meets your needs to overcome fatigue and feel more refreshed. Helping you find the right activities in your community is also a great way to make sure your family and friends can participate along with you.

Occupational therapists pride themselves in working in a client-

centred fashion. This means that we work collaboratively with our clients, sharing ideas and problem-solving together. After all, every person is unique, and no one solution is going to fit everyone. Occupational therapists therefore have to be good listeners and often take on more of a coaching or consulting role. Sometimes our best ideas come from what we've learned from all the other clients we've worked with!

Living with chronic pain takes a heavy toll emotionally. Occupational therapists have training in counseling skills as well as in some aspects of cognitive behavioural therapy. They may be able to suggest and teach strategies that will make it easier to cope with the feelings of loss, anger and other emotional challenges of dealing with pain every day.

Finally, we have to recognize that there is a lot of stigma associated with having chronic pain. It's an invisible disability, and as such, the general public as well as many health professionals (sadly) have difficulty understanding and empathizing. Occupational therapists pride themselves on their role as advocates. As such, therapists usually have a good knowledge of community resources as well as an intimate knowledge of the way that the health and public systems work. An occupational therapist may be able to help you navigate the system or find the just-right resource.

How do you find an occupational therapist? They are often employed in hospitals, working with both in-patients and out-

patients. In such cases, a physician referral is usually required, so the best way to connect with an occupational therapist would be through your doctor or medical specialist. Occupational therapists also work in clients' homes, either through provincial home care providers or through special needs providers like the Arthritis Society. In these situations, a self-referral or referral by a family member may be all that is required. Some occupational therapists are referred through and paid by insurers like long-term disability carriers or auto insurers.

## Recommended Resources

For more information about finding an occupational therapist in your community check the Canadian Association of Occupational Therapists website: [www.caot.ca/default.asp?pageid=3622](http://www.caot.ca/default.asp?pageid=3622).

For educational resources on pain management and advocacy see the Canadian Pain Coalition website: [www.canadianpaincoalition.ca](http://www.canadianpaincoalition.ca).

For healthcare professional and scientific resources on pain management check the Canadian Pain Society website: [www.canadianpainsociety.ca](http://www.canadianpainsociety.ca).

*This article was reprinted with permission from the Canadian Pain Coalition. It originally appeared in the Spring 2011 Canadian Pain Coalition Newsletter (Volume 4(2), p. 12).*



Image created at [www.wordle.net](http://www.wordle.net).

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# Occupational therapists play an important role in managing pain in infants in neonatal intensive care units

Liisa Holsti

More than 12 million premature infants are born worldwide each year (March of Dimes, 2009). For these infants, being born early is 'developmentally unexpected' and they can experience many stresses (Als, 1995). In contrast to the intrauterine environment, the neonatal intensive care unit (NICU) can be very bright and noisy. In addition, in order to ensure they survive, premature infants must undergo many procedures, such as blood tests, which may be painful. Indeed, a recent Canadian survey showed that during a one-week period, 580 neonates received over 17,500 painful/stressful procedures, during many of which (46-57%) the pain went untreated (Johnston, Barrington, Taddio, Carabjal, & Fillion, 2011). Along with other health risks associated with prematurity, pain experienced this early in life may cause changes in the developing brain and lead to adverse long-term developmental outcomes (Brummelte et al., 2012).

## The occupational therapist's role

Along with other members of the health-care team, preventing pain and stress and promoting optimal development are primary goals for occupational therapists who work in NICUs (Nightlinger, 2011). To this environment, occupational therapists bring a unique set of skills; they are experts in assessing how an infant's environment influences his or her development, in how an infant's body moves and reacts, and in how activities of daily living, such as feeding, can be used as powerful, natural treatments for pain.

Because these infants cannot tell adults directly about their pain, assessing and treating pain effectively is challenging. These infants may respond differently than older infants because their brains and muscles are not fully mature. In addition, factors such as how early the infants are born and how long they have been in the NICU can affect their responses (Stevens, Pillai Ridell, Oberlander, & Gibbins, 2007). Even something as routine as changing a diaper before a painful procedure can intensify pain responses in some infants (Holsti, Grunau, Whitfield, Oberlander, & Lindh, 2006). Furthermore, aspects of the NICU environment itself, such as the light and noise, can increase an infant's pain response.

To improve the accuracy of pain assessment in this specialized population, an assessment developed by an

occupational therapist and her colleagues is available for health care practitioners (Holsti & Grunau, 2007a). This assessment, entitled the Behavioral Indicators of Infant Pain (BIIP), is being used in nurseries in North America and around the world. The tool evaluates the presence or absence of five anatomically defined facial actions, two hand actions and sleep/wake states. Introductory information about this tool is available at: <http://www.developmentalcare.net>.

## Interventions for pain management

When approaching the assessment of an infant, occupational therapists first evaluate how the larger nursery environment might be minimizing or enhancing pain. Working with members of the health-care team and with parents, occupational therapists can help determine how the environment affects each individual infant's pain responses and then can suggest ways to modify the environment that minimize pain and balance the needs of the staff to provide effective care. For example, lowering unit environmental lighting may protect the infant, but is hard for staff to work in during their long shifts; thus, finding ways to minimize light shining directly on the infant works best.

Along with modifying the environment, the occupational therapist can evaluate the effects of pain treatments. Unfortunately for these infants, the types of pain medications given to adults may not work well and have significant, unwanted side effects (Taddio et al., 2009). As an alternative, strategies called 'non-pharmacological treatments' can be used, which activate pain-modulating systems innate to the infant (Fernandes, Campbell-Yeo, & Johnston, 2011). Stimulating multiple pathways simultaneously tends to produce the greatest effects. For example, sucking a soother stimulates hormones, such as serotonin, which are known to play a role in pain reduction. By adding other routine activities of daily living, such as holding or feeding, natural pain treatments can be highly effective.

Occupational therapists also provide instruction in body positioning supports for pain relief. Facilitated tucking is a strategy whereby the caregiver places his or her hands so that the infant's arms, legs and head are held in a curled and contained position (Corff, Seideman, Venkataraman, Lutes, &

## About the author

**Dr. Liisa Holsti**, assistant professor and Canada Research Chair in the Department of Occupational Science and Occupational Therapy at the University of British Columbia, develops assessments and treatments to optimize development in high-risk infants. She can be contacted at: [lholsti@cw.bc.ca](mailto:lholsti@cw.bc.ca).



Yates, 1995). This treatment can be administered by parents and other family members, thus engaging them in the care of their infant. In addition to using the BIIP to identify pain behaviours, the occupational therapist can instruct parents and staff to help them identify other movements the infant displays that may indicate when they are feeling more or less stress (Holsti & Grunau, 2007b). Through repeated assessment, the occupational therapist can modify this information as the infant matures so that the family can be shown their infant's new competencies and can respond appropriately to provide targeted support that will promote optimal neurodevelopment.

Another holding strategy called kangaroo care (KC) is a technique whereby infants are placed skin-to-skin with their mothers and fathers; this strategy has been shown to reduce pain responses (Johnston, Campbell-Yeo, & Filion, 2011). Occupational therapists can provide support for families to use KC both for promoting optimal development and for managing procedure-related pain, such as during blood tests.

Feeding as a pain-relieving strategy is also becoming more routine in many NICUs. For example, providing sweetened oral solutions in conjunction with sucking for reducing pain in preterm infants is a standard of care in many nurseries. However, some health-care providers are hesitant to use this treatment because in those infants born very early, more frequent doses (>10/day) have been associated with sub-optimal development in early infancy (Johnston et al., 2002). These and other concerns raised recently have led to some recommendations for caution when applying these solutions (Holsti & Grunau, 2010). Finally, breastfeeding may reduce pain for those infants who are mature enough to feed effectively (Holsti, Brand, & Oberlander, 2011). In addition, this study found that the procedure time to take blood was significantly shorter for those infants who were breastfed during the blood test.

## Conclusion

Bringing a unique theoretical background and training, occupational therapists can work alongside the interdisciplinary health-care team to help prevent, assess and treat pain in these vulnerable infants so as to help ensure the best possible developmental outcomes following premature birth.

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# Cancer-related pain: The role of occupational therapy in prevention and management

Julie Lapointe

## Introduction: The context of cancer pain

In oncology, the contribution of occupational therapists is starting to be recognized and their services are increasingly offered (Institut de la statistique du Québec, 2010). Occupational therapists enable clients to maximise daily functioning and quality of life when cancer impacts their physical, emotional, relational, and spiritual well-being. Among the different physical symptoms related to cancer, pain is one of the symptoms clients fear when they are diagnosed. Unfortunately, pain is still frequent through the continuum of the cancer experience with prevalence varying from 30 to 50% during cancer treatment and more than 70% at advanced stages (Goudas, Bloch, Gialeli-Goudas, Lau, & Carr, 2005; Institut de la statistique du Québec, 2010).

Cancer-related pain is complex. Cancer pain can be experienced early on (i.e. before or around the time of the diagnosis), during the course of treatment, late into the survivorship or at the palliative and end-of-life stage. Pain can occur in multiple sites and have different causes and both can change over time. Pain can be caused by the tumour itself (e.g. nerve compression by a solid tumour) or by the adverse effects of a treatment modality (e.g. chemotherapy, radiotherapy or surgery). Indeed, chemotherapy can induce peripheral nerve damage leading to pain and sensory impairments (Raphael, Ahmedzai et al., 2010; Raphael, Hester et al., 2010). Radiotherapy can induce neuropathic pain with symptoms occurring either shortly after being treated with this modality or weeks or even months afterwards. Surgery, with its potential risks of perioperative nerve damage, can also be a cause of pain (Raphael, Hester et al., 2010). As an example, pain following breast cancer surgery was reported as frequently as in 50% of clients (Jung, Ahrendt, Oaklander, & Dworkin, 2003).

While pharmacological and medical interventions to manage cancer-related pain are clearly the most important measures to put in place, the benefits of an interdisciplinary, multi-modal, and personalized intervention should not be overlooked (Burton, Fanciullo, Beasley, & Fisch, 2007).

## Interdisciplinary, multi-modal, and personalized interventions

An interdisciplinary team can comprise the following professionals in addition to the occupational therapist: oncologist, physicians from other medical specialities, pharmacist, nurse, physiotherapist, social worker, chaplain, psychologist, dietician, and respiratory therapist. Furthermore, the client's participation with this team is essential; effective cancer pain management needs to

be client-centred. Finally, family members and/or caregivers are also important allies to consider in this context.

Cancer-related pain should first be assessed comprehensively (symptoms, location, severity, duration, frequency, quality, timing, and aggravating or alleviating factors). It is also important for occupational therapists to know the medical treatment approaches that have been used, that are currently in use, or that are considered. The client's use of complementary and alternative medicine like acupuncture, herbal medicine, and massage to treat their pain symptoms should be queried. A thorough assessment will also include the history of any previous conditions associated with pain, as well as previous behavioural or psychological coping strategies used to adapt to painful symptoms.

## Occupational therapy role in cancer-related pain prevention and management

The assessment of the functional impact of pain and of its consequences to participating in meaningful activities is the hallmark of an occupational therapist's contribution to the interdisciplinary team (Bloch, 2004). In other words, occupational therapists can help clients continue or resume usual roles despite cancer-related pain. Occupational therapists' role in this context encompasses active listening, education, prevention, problem solving, and provision of experiential learning. Interventions aim to build perceived personal control or self-efficacy to manage cancer-related pain (Bandura, 1977).

### Active listening

Active listening to the client's story, needs, fears, and beliefs is an important part of the occupational therapist's initial and ongoing assessment. It could also be the best way to help clients find meaning through this difficult experience (Unruh, Smith, & Scammell, 2000). Clients may hold different beliefs and fears about their cancer-related pain, such as the belief that pain is inevitable during a cancer treatment, that a good patient does not complain or that mentioning pain symptoms will interfere with their cancer treatment. For many clients, pain might be a sign of treatment failure or of cancer recurrence.

### Education

Teaching is an important part of an occupational therapist's intervention as it can be a means to improve clients' and caregivers' knowledge and capacity to take an active role in pain management. For example, a client may need to learn the technical vocabulary to describe cancer pain symptoms in order

**Table 1. Overview of some possible occupational therapy preventive or management intervention options, informed by Lloyd and Coggles (1988), Penfold (1996), and Reed (2001).**

<b>Occupation - productivity and leisure</b>
<ul style="list-style-type: none"> <li>• Support the maintenance or facilitate the resumption of productive, leisure, and social activities.</li> <li>• Promote or use artistic and leisure activities.</li> </ul>
<b>Occupation - self-care</b>
<ul style="list-style-type: none"> <li>• Maintain or increase autonomy in performing activities of daily living.</li> <li>• Provide appropriate aids and equipment. Teach and practice safe transfer techniques.</li> <li>• Create an action plan with clients to ease and optimize treatment adherence.</li> </ul>
<b>Physical and social environment</b>
<ul style="list-style-type: none"> <li>• Conduct a home safety assessment.</li> <li>• Encourage family and/or caregivers to balance the amount of support and help they provide with an attitude that encourages independence.</li> <li>• Teach ways to seek out positive social support within and outside the family. Suggest attendance at a cancer clients' support group.</li> </ul>
<b>Person – physical aspect</b>
<ul style="list-style-type: none"> <li>• Help clients regain/retain strength and joint mobility through a personalized graded exercise program and the performance of meaningful activities.</li> <li>• Teach proper postural alignment and correct non-optimal movement patterns or body alignment.</li> <li>• Teach techniques to protect areas of the body where sensation has been affected.</li> <li>• Teach energy conservation and work simplification principles.</li> </ul>
<b>Person – cognitive and affective aspects</b>
<ul style="list-style-type: none"> <li>• Assess client, family and/or caregiver expectations. Help clients set realistic goals.</li> <li>• Teach clients and their family and/or caregivers about cancer pain syndromes and their potential impact.</li> <li>• Teach and provide experiential learning opportunities to promote adapted coping mechanisms.</li> <li>• Promote and teach relaxation techniques.</li> </ul>
<b>Spirituality</b>
<ul style="list-style-type: none"> <li>• Assess clients' need and desire to discuss spiritual beliefs, faith, and religious practice.</li> <li>• Explore with clients what gives purpose and meaning to their life and whether this has changed due to pain.</li> <li>• Explore clients' sources of strength, hope and what allows them to go on with their life despite the pain.</li> </ul>

to optimize his or her interactions with the medical team and then benefit from optimal pain control. Indeed, systematic reviews have supported the benefits of educational interventions (Allard, Maunsell, Labbé, & Dorval, 2001; Bennett, Bagnall, & Jose Closs, 2009).

### Prevention

Preventive occupational therapy interventions are important for several reasons. First, since poorly managed acute cancer pain symptoms can evolve into chronic pain (Burton et al., 2007), early referral to an occupational therapist can help to put in place measures that will reduce the risk of chronicity occurring. Second, physical deconditioning due to guarding, decreased involvement in activities, and an overly sedentary lifestyle can cause or worsen painful symptoms. Again, this might be avoided with early referral. Third, the risk of painful syndromes like lymphedema can be greatly reduced with proper preventive measures (Tahan, Johnson, Mager, & Soran, 2010). Finally, strain and exhaustion of the client, the family and/or caregivers can be prevented with early occupational therapy interventions like home assessment and adaptation.

### Problem-solving

Problem-solving interventions might be needed to resolve obstacles to the proper management of cancer pain. Adherence to analgesic medication is one example. Occupational therapists

can propose different strategies and devices to promote ease of recall. Occupational therapists also have a significant role in solving problems related to the independent performance of productive, leisure, and daily living activities. For instance, if certain arm or trunk movements are limited due to pain, occupational therapists can offer advice on environmental and/or workstation reorganization and suggest the use of devices such as a long-handled reacher. Problem-solving can also include helping a socially isolated client recognize that taking part in a cancer clients' support group is a way to lessen feelings of isolation, normalize the experience, and benefit from the experience and the support of other clients.

### Facilitation of opportunities for experiential learning

Facilitating opportunities for experiential learning is another important role of occupational therapists (Reed, 2001). Experiential learning can be a powerful means to learn and integrate new skills. It is also a way to learn how to adjust to a new behaviour or to adapt to a new activity. For example, with cancer pain, such hands-on learning can be used to practice relaxation techniques or activity pacing. Artistic activities can also be used to allow clients to explore, express or be temporarily distracted from pain. Through this role, occupational therapists can support engagement in meaningful occupations, whether it is a familiar activity or not. Resuming familiar activity can restore feelings of normalcy and of retrieving one's everyday life, while engaging in

new activities can be an opportunity to discover new interests and a new sense of self (Unruh et al., 2000).

Table 1 presents an overview of some possible occupational therapy preventive or management intervention options for clients with cancer pain. It is important to underline the fact that not all options will work or be possible for all clients in all situations. Indeed, a specific resource might not be available at one specific health centre or the role division within an interdisciplinary team might devote a specific management option to another health professional.

## Conclusion

Much still has to be learned about the nature, intensity, frequency, and duration of an optimal occupational therapy intervention in cancer-related pain prevention and management. For this reason, adopting an evidence-based practice in this area is a challenge for therapists (Burton et al., 2007; Raphael, Hester et al., 2010). However, considering the multiple causes and contexts of cancer pain, one hypothesis is that an optimal intervention should be both multi-modal and personalized. Personalized interventions should be well chosen, carefully graded and monitored, and appropriate to a client's cancer stage (Raphael, Ahmedzai et al., 2010; Raphael, Hester et al., 2010). Therapists also need to be aware of populations at higher risk for unmanaged cancer-related pain such as the frail elderly, children, and individuals with cognitive impairments, mental illness, language barriers or suspected substance abuse (particularly opioids) (Raphael, Ahmedzai et al., 2010). A successful occupational therapy intervention will support clients suffering from cancer pain and allow them to gain or regain perceived personal control over their physical and emotional well-being through meaningful occupations and an improved functional status (Vallerand, Templin, Hasenau, & Riley-Doucet, 2007). Helping each client to live their days to the fullest while maintaining a sense of control and dignity are the primary contributions of occupational therapy in the management of cancer-related pain (Vallerand et al., 2007).

Further information about cancer pain management can be found at the following websites:

- [http://www.cancer.ca/Canada-wide/Publications/Alphabetical%20list%20of%20publications/Pain%20relief%20A%20guide%20for%20people%20with%20cancer.aspx?sc\\_lang=EN](http://www.cancer.ca/Canada-wide/Publications/Alphabetical%20list%20of%20publications/Pain%20relief%20A%20guide%20for%20people%20with%20cancer.aspx?sc_lang=EN)
- [http://www.iasp-pain.org/AM/Template.cfm?Section=Global\\_Year\\_Against\\_Cancer\\_Pain](http://www.iasp-pain.org/AM/Template.cfm?Section=Global_Year_Against_Cancer_Pain)
- [http://www.britishtainsociety.org/patient\\_pmp.htm](http://www.britishtainsociety.org/patient_pmp.htm)

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# Are you ready? Readiness to return to work for people living with chronic pain

Bronwyn Thompson

*"I can't think about going back to work, I have to get this pain sorted out first."*

*"I've thought about working again, but I don't know who would employ me when I can't get through my day at home."*

*"I know I want to go back to work, and I've started looking around at what I can do, but I don't know where to start."*

*"I've sorted out my resume, I'm thinking about some study to brush up on my computing skills. I wonder if I should do some voluntary work to see how much I can do."*

*"I'm applying for jobs and have an interview for voluntary work on Tuesday. I hope I can manage!"*

*"I've been doing voluntary work for a few weeks and although I've had a flare-up, I'm going fine. My boss said I might be offered a permanent position."*

For fifteen years, chronic pain self-management programmes (CPMP) at Burwood Pain Management Centre in Christchurch, New Zealand have included vocational management. An interdisciplinary team of clinicians including occupational therapists, physiotherapists, nurses, social workers and psychologists encourage people with persistent pain to consider working as an area for goal-setting, despite their pain. Occupational therapists take the lead in developing participants' return to work plans.

Participants in the three week CPMP range in age from their late teens to their 70s, and may have diagnoses of chronic low back pain, neuropathic pain, migraine, complex regional pain syndrome, or fibromyalgia. People have had, on average, four years of pain before being referred to the centre. Most people are not working (about 70%), and have been away from work for 12 months or more, with about half on compensation, and another 25% receiving a state benefit.

## About the author

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## Why work when you have chronic pain?

Working, in paid or unpaid work, is good for people (Waddell & Burton, 2006). Participants attending the CPMP say that work is part of their identity, gives them social contact, keeps their brain stimulated, gives them a reason to get out of bed in the morning, maintains their connection with their community, and maintains their economic independence.

The effects of being out of work have been examined in detail by Professors Gordon Waddell and Kim Burton (2006). In their review of research of the health effects of working, they found that unemployment "causes, contributes to or accentuates the negative effects" of cardiovascular disease, suicide, poorer general health, increased risk of lung cancer, respiratory infections, and poorer mental health and psychological well-being (Waddell & Burton, 2006).

## Why do people stop work when they have chronic pain?

Reasons for leaving work given by participants include receiving direct instruction from a doctor or other health care provider, employer uncertainty about functional limitations or lack of suitably selected duties for the person with pain, and personal reasons such as being unable to carry out work tasks to a level or intensity required or fears of being unable to cope with pain fluctuations. Once a person is off work, getting back to work depends on agreement from their doctor, having suitable work from the employer, and adequate support through the process.

While most people with chronic pain acknowledge the importance of returning to work at some point, at the same time they can be very anxious about doing so. This may be expressed as resistance to the efforts of health professionals, case managers or employers.

## What can be done to reduce resistance?

Miller (1983) discovered that certain interpersonal behaviours by clinicians promoted greater change. In the resultant



'Motivational Interviewing' approach, motivation to change is conceptualized as a combination of the importance of the change and the confidence that the change will be successful (Shannon, 2009). Efforts to increase the importance of change and build confidence to do so supports engagement or 'motivation'. Occupational therapists have used this approach in mental health (Lloyd, Tse, Waghorn, & Hennessy, 2008; Orchard, 2003), and it has been recommended in vocational management (Manthey, Jackson, & Evans-Brown, 2011).

Prochaska and DiClemente developed the Transtheoretical Model to describe the process of making decisions to change behaviour (1997). The model describes five stages of decision-making about making a change – from not thinking about it (Precontemplation), thinking about it (Contemplation), getting ready to change (Preparation), beginning to change (Action) to finally maintaining change (Maintenance) (Prochaska & DiClemente, 1997) - although the progression through these stages is not linear. By tailoring the approach to the stage of the person, resistance is reduced and behaviour-change achieved. Occupational therapists' skills in generating individualized pathways toward goals support individuals to progress in a way best suited to their needs (Shannon, 2009).

## The CPMP Approach

A motivational approach to return to work was introduced to the three-week CPMP six years ago. Psychometric questionnaires, including measures of importance and confidence about returning to work are taken at assessment, before the CPMP, at completion, and at six-week, six-month and twelve-month follow-ups. This questionnaire battery includes the Numeric Rating Scale for pain (Williamson & Hoggart, 2005), Pain Disability Index (Tait & Chibnall, 2005); Depression Anxiety Stress Scales (Lovibond & Lovibond, 1995); Pain Self Efficacy Questionnaire (Nicholas, 2007); Tampa Scale for Kinesiophobia (Kori, Miller, & Todd, 1990), Pain Anxiety Symptoms Scale (Burns, Mullen, Higdon, Wei, & Lansky, 2000), and Chronic Pain Acceptance Questionnaire (McCracken, Vowles, & Eccleston, 2004). The questions about returning to work ask participants to rate importance and confidence on a 0 – 10 Likert scale, where 0 = not at all important/not at all confident, and 10 = extremely important/extremely confident. The average level of importance for returning to work among a cohort of 300 people assessed at the Pain Management Centre between June and November 2011 was 7.6 (standard deviation = 2.3), while the average level of confidence to return to work was 2.4 (standard deviation = 2.1).

During the course of the CPMP, participants explore why working is important to them and in particular, the value of making plans for returning to work after the programme has ended. Along with the usual CPMP content such as self-regulation, activity management, exercise and pain physiology, participants also identify their position in the Transtheoretical Model, and explore the factors that will help them take 'the next best step'. By CPMP completion, participants will have generated plans for at least one action to complete over the following six weeks to take them 'one step along' the process

towards returning to work. The occupational therapists contribute to this process by helping participants consider a variety of ways to undertake these small steps towards work.

In the first session, participants are asked to indicate how important work is to them on a line where at one end it is "not at all important" while at the other end it is "extremely important". Participants are then asked "Why have you put your mark *so high?*" or "Why is your mark here (pointing to the mark) and *not down here* (pointing to zero)?" In answering this question, participants generate personal reasons for working, and are encouraged to write down the top five reasons for work being important to them. It's important to note that people are not asked why their mark is *so low*, because this results in reasons for not making change. Attention is then turned to confidence, and the same process is followed. Participants then explore their responses, in particular the reasons they lack confidence to return to work, often discovering that many share worries (see Table 1).

**Table 1. Common concerns about returning to work from participants of the Chronic Pain Self-Management Programme.**

Being unclear about what is and isn't safe to do at work.	Concern about negative labels from having had time off work.
Being worried about further damage or harm.	Not knowing how to communicate about different ways of working (e.g., safe handling techniques, paced approaches to activity).
Not knowing how many hours a week is sustainable.	Uncertainty about the effect of increased pain on sleep, relationships, mood, compensation.
Being unsure of the kind of job to look for.	Worry about entitlements to financial support.
Being unclear about the effect of medications.	Lack of knowledge about job seeking.
Not knowing how to tell an employer about a pain problem.	Lack of confidence to use coping strategies at work.
Dealing with pain fluctuations.	

The remainder of the vocational portion of the program discusses aspects of returning to work based on the general headings of:

- Identifying transferable skills
- Strategies for job seeking
- Interviewing and communicating at work
- Determining functional abilities for work
- Pain management strategies in the workplace

During these sessions the specific concerns expressed by participants about the process of returning to work are discussed, with contributions from various participants about their experiences and problem-solving strategies used to challenge assumptions about return to work with chronic pain.

## How well does this process work?

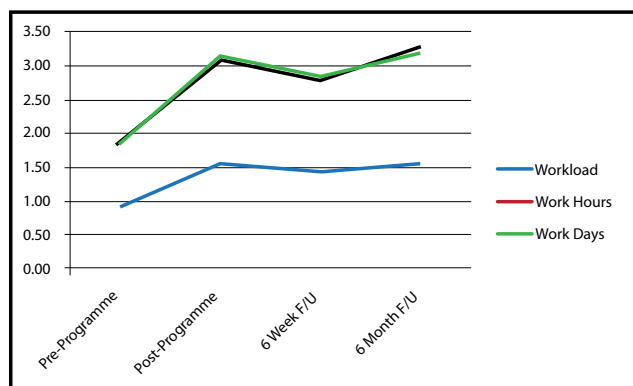
People with chronic pain face reduced prospects for returning to work. An Australian study identified that if a person is off

work because of ill health for:

- 20 days the chance of ever getting back to work is 70%;
- 45 days the chance of ever getting back to work is 50%;
- 70 days the chance of ever getting back to work is 35%. (Johnston & Fry, 2002).

Most of the participants in the CPMP have been off work for 12 months or more, and the outlook for returning to work is slim. Without addressing specific concerns about working with chronic pain, few people progress from 'not thinking about' to 'maintaining' their return to work. Estimating return to work rates is complicated by base rates of unemployment in the community, educational level, literacy and numeracy, and varying definitions of return to work.

While mean ratings of importance change little at the five measurement points, mean confidence ratings increase by the end of the Programme, drop slightly at the six week follow-up (but not to pre-programme levels), and trend upward at the six-month and 12-month follow-ups (see Figure 1).



**Figure 1. Participant predictions about ability to manage aspects of work taken at pre-programme, immediate post-programme, 6 week follow-up, and 6 month follow-up. N=18.**

**Scale definitions: Workload: 0 = no capability – 4 = heavy. Work hours: 0 – 8 per day. Work days: 0 – 5 days per week.**

While returning to work remains a challenge for people with chronic pain, what seems evident is that breaking the goals down into smaller 'next best steps', and shifting the focus to what helps individuals move one step along the 'stages of change' continuum provides an approach that reduces resistance to returning to work.

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**Editor's Note:** Brownwyn Thompson's blog, "Health Skills: Skills for healthy living for health professionals working in chronic pain management" (<http://healthskills.wordpress.com/>), provides a stimulating platform for occupational therapists from around the world to share and build a global community of practice.

# Occupational therapy for pain management in the compensation setting: Context and principles

Michele Moon, Rebecca McDonald and Jacqueline Van den Dolder

Treating people with pain, it has been argued, is more challenging within a compensation context because compensation negatively impacts the response to rehabilitation (Teasell, 2001). Occupational therapists practising in this setting face a number of challenges such as clients with complex needs, multilayered rehabilitation issues, and collaboration with multiple stakeholders with potentially competing interests. Despite these challenges, it is a very rewarding practice environment in which occupational therapists assume a leadership role because of their clear focus on optimizing functional abilities and appreciation for the value of work. Persistent pain can be one of many barriers impacting a client's ability to return to work in a compensation context. With many variables at play, occupational therapy practice for pain management in non-litigation or workers' compensation settings is shaped by a specific context and distinct principles.

## THE CONTEXT

### Return-to-work focus

The services and programs are funded by workers' compensation boards or insurance companies and clients are referred to occupational therapy by case managers. Return-to-work is most often the desired program outcome. As a result, pain management programs aim to provide clients with pain management strategies meant to facilitate improved engagement in all occupations, including paid employment. Goal setting, which encourages the inclusion of self-care, productivity and leisure goals, is a critical component of a successful, client-centered program. In this way, occupational therapists meet referrer expectations while remaining client-centred.

### Limited timelines

Timelines in the workers' compensation system are generally rigid. However, in the context of return-to-work, this inflexibility is an asset for the promotion of improved functional abilities. Contrary to common belief, time is not an injured worker's friend; the longer a person is not working, the less likely he/she is to return to employment (Crook & Modolsky, 1994).

Early return-to-work contributes to a decrease in overall work disability (Lydell, Grahn, Mansson, Baigi, & Marklund, 2009). The strict timelines established by referral sources encourage a treatment approach that propels progress while assisting clients to return to their occupations as early as can be accomplished safely and durably.

### Perceived threat

Clients may face many barriers to rehabilitation success including the 'perceived threat' of activity, specific environments, certain people, and symptoms. Further, the rehabilitation setting, and in particular the occupational therapist on the team, can also seem intimidating to clients in that both represent expectations that clients will return to their jobs. Returning to work is often a fearful topic for clients to contemplate for several reasons, including past failed attempts at going back to work, and concerns related to returning to those activities that precipitated the original injury. Open discussions about these concerns are challenging, but by addressing a client's concerns about returning to his/her job, the ensuing conversation can facilitate problem solving. Educating clients about the compensation system and demystifying the claims process are important for clients in the development of realistic expectations about the future and for planning for program discharge. Occupational therapists provide a unique perspective about the real and perceived threats that are present for a client; they can assist with understanding the relationship between perceiving tasks and activities as threatening and the associated heightened pain response and risk for further disability.

## THE PRINCIPLES

### The value of work

Occupational therapists working in the compensation environment must fundamentally believe in the value of work. To some individuals, this belief may require a shift in thinking – away from the belief that clients must first get better to be able to return to work, toward the belief that clients must return to work to get better. Work is both a determinant of health and a health behaviour. Not only does work provide financial

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stability, it also provides meaning, purpose, social status, identity, structure, routine and social interaction to our lives. Work also assists in the performance of non-work-related activities and promotes independence along with social, emotional and physical well-being.

### Biosychosocial frame of reference

Clients referred to pain management programs within a non-litigation or workers' compensation system have typically reached a medical plateau, and further medical treatment is ruled out. Pain management programs and services are designed using the biopsychosocial model in which response to injury is regarded as multidimensional in scope (Schultz, Crook, Fraser, & Joy, 2000). The biopsychosocial model promotes linkages with the environment, including the family and the workplace, and views the client holistically. Viewing a client as a person with multiple strengths and a variety of barriers, allows issues to be addressed best through a collaborative approach. One of the tenets of the biopsychosocial model is that "organic

pathology does not reliably predict impairment and disability" (Schultz et al. 2000, p. 286). Rather, disability from pain is determined by a number of complex and interacting factors. Therefore, understanding pain through a biopsychosocial lens

validates that the pain is real and can have a profound impact on life. Occupational therapists are well equipped to partner with clients to address pain when the source of pain is no longer driven from damage at a tissue level. By capturing a client's experience of pain, occupational therapists are able to remain client-centered and move away from the perceived need to focus on 'proving' the pain (Robinson, Kennedy, & Harmon, 2011), which tends to reinforce disability.

### Self-management

Occupational therapists assist clients to develop and practice self-management strategies that address pain and the common sequelae of persistent pain (e.g., frustration, depression, anxiety, and social isolation). Clients are coached to implement strategies to improve physical, social and functional ability and are provided with tools (e.g., ergonomic equipment and graduated return-to-work plans) to support independent engagement in activity. Supporting clients to participate in activities in the presence of pain empowers them to move forward with less reliance on the medical and compensation systems.

## THE OCCUPATIONAL THERAPIST'S INVOLVEMENT

Occupational therapists are involved in assessment and treatment of clients with persistent pain. Services may be provided as part of a group in the community or as part of an interdisciplinary team in a clinic setting. In either context, the services that occupational therapists provide require

collaboration with a number of stakeholders in the community including primary physicians, employers, union representatives, family members and case managers.

Occupational therapy assessments include functional evaluations (including formal Functional Capacity Evaluations), job site visits, ergonomic assessments, adapted equipment assessments, among others. Treatment includes grading activity to increase functional tolerances and to develop and implement self-management strategies. Occupational therapists recommend strategies such as pacing, optimizing body mechanics and ergonomics (in self-care, leisure and work), develop return to work plans, and provide also, where indicated, on-the-job support and coaching at the workplace. Occupational therapists that are involved in return-to-work planning are called upon to provide stakeholder education and often use negotiation and mediation skills in their practice. They may also be involved in vocational planning when a client presents without a job or is unable to return to his/her pre-accident employment.

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*"By validating pain, taking a biopsychosocial approach to care, and employing self-management strategies, occupational therapists help clients to become empowered to achieve their rehabilitation goals and return to their jobs."*

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Interdisciplinary pain program teams traditionally include occupational therapists, physical therapists, kinesiologists, psychologists, pharmacists and physicians, and some programs have contributions from additional professionals

including nurses, chiropractors, massage therapists, dieticians, etc. These programs are intensive with most programs being between six to ten weeks long. Clinical teams work closely and collaboratively to address client goals, following a formal goal setting process that is regularly reviewed as a clinical team and with the client. Community clinics have exercise and work conditioning facilities and daily education classes on wide ranges of topics including pain neurophysiology, nutrition, meditation, leisure and the value of work. Occupational therapists have strong voices and advocacy roles on these interdisciplinary teams, in particular given their role in assisting clients to translate the knowledge and skills they develop into improved functioning. Further, occupational therapists benefit from reciprocal 'transdisciplinary' skill development by working on teams. Concepts like cognitive behavioural therapy and Motivational Interviewing inform the team approach to client interactions and strengthen team effectiveness.

Occupational therapists also have active roles in adjunct programs such as vocational rehabilitation, medication management and interdisciplinary treatment for traumatic incidents. While the best outcome of these programs is for clients to return to their work, the emphasis for the occupational therapists is on engaging the client in activities that prepare him/her to return to employment, managing activities while experiencing withdrawal symptoms (from opioid pain medications), and managing anxiety in work environments.

### Conclusion

Enabling a client's return to work is a fundamental component of assisting clients with chronic pain, regardless of the referral

source. Within the compensation system, with employability typically the goal of the program, it is an appropriate and easily measurable outcome of successful therapy intervention and client health. Work fosters the performance of non-work-related activities, provides financial and social benefits and promotes independence. By validating pain, taking a biopsychosocial approach to care, and employing self-management strategies, occupational therapists help clients to become empowered to achieve their rehabilitation goals and return to their jobs.

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# Occupational therapy: Contributions to an acute care pain management strategy

Diana Bissett

Occupational therapists working within an interdisciplinary, tertiary care environment play a key role in direct patient care. Specifically, this patient care can be described as providing functional assessment and intervention to optimize level of function, independence and quality of life in the areas of self-care, productivity and leisure. Within an acute care environment, this will include interventions in the following areas:

- encouraging independence with personal care.
- recommending home equipment or modifications to ensure patient safety.
- helping clients to find solutions to manage self-care, work-related, household or leisure activities in spite of fatigue, pain or dysfunction.
- suggesting positioning strategies to reduce pressure on skin and to increase comfort.

Working directly with clients is the primary role of an occupational therapist within an acute care environment, often necessitating careful prioritization of clients' needs within a busy clinical caseload. (Gauthier, Straathof, & Wright, 2006). However, formal involvement with policy development and making contributions to educational resources for staff and in-patients are also essential components of the work of all health care providers. They allow for systemic improvements in quality of care and improved outcomes for in-patients.

Much of the pain literature supports early intervention to manage pain as a means of decreasing the risk of developing enduring or persistent pain (Butler & Moseley, 2003). In fact, the International Association for the Study of Pain (IASP) identified 2010-2011 as the Global Year Against Acute Pain. Many excellent resources including fact sheets and other publications are available on their website: <http://www.iasp-pain.org/Content/NavigationMenu/GlobalYearAgainstPain/GlobalYearAgainstAcutePain/default.htm>. Multi-focal intervention strategies, which address the biopsychosocial nature of the pain experience, are critical to initiate early in the management of acute pain (Brown et al, 2011). Attention to the value of the interdisciplinary team in providing these interventions allows for their delivery in an efficient manner (Strong, Unruh, Wright, & Baxter, 2001).

An example of this idea in practice is the work of the Pain Management Committee at The Ottawa Hospital. This large tertiary care facility created a interdisciplinary team to address pain management practices in the hospital as part of a quality

improvement initiative. The committee was comprised of health-care professionals (nurses, physicians, rehabilitation therapists, pharmacists, social workers and others) as well as risk management/quality management professionals and patient advocates. The work of the committee took place in stages, and ultimately resulted in highly developed policies, procedures, protocols and algorithms for pain management practices in the hospital, and also prudent selection of pain assessment tools.

Occupational therapy has played a role in many aspects of this work, including providing input from an occupational therapy perspective into:

- the choice of pain assessment tools for use in a hospital setting.
- the development of practice guidelines for inclusion of rehabilitation professionals.
- the selection of patient controlled analgesia (PCA) pumps for usability/ergonomic design, thereby ensuring that patients can adequately perform the manual task of using this technological device to administer their own pain medications
- participation in pain prevalence day surveys amongst the patient population.



The author assists a client with pain to be comfortably positioned in a tilt wheelchair.

Additionally, the occupational therapist on the committee has provided leadership in the organization and implementation of activities in the hospital which support National Pain Awareness Week. During this week, which is designed to align with the annual theme chosen by the IASP, speakers and special events are organized to help to meet the hospital's needs for education and awareness of pain management issues. These have included: poster presentation days, speakers at 'lunch and learn' sessions to address various aspects of pain management, and resource tables in the main foyers of the hospital with public education materials on display as a means to educate the public on matters related to pain management. These opportunities have served as important reminders to all health-care providers of the role of the occupational therapist in helping to manage pain in the acute care setting.

Finally, an innovative approach to educating new staff of The Ottawa Hospital is in the process of being launched through the newly named Pain Resource Centre. The Pain Resource Centre is an online resource portal for hospital employees, and will include guidelines and resources to assist with all aspects of pain management. An exciting new project is the development of a series of online interdisciplinary staff education modules addressing various aspects of pain management strategies. Occupational therapy is partnering with physiotherapy for a module entitled: *Pain Management: Reducing the Impact on Function. Practical tips for helping your patients, and rehabilitation therapy interventions*. This online educational resource has the following objectives for the learner:

1. To define the roles of occupational therapy and physiotherapy in pain management, and define cognitive behavioural approaches
2. To acquire knowledge on how the rehabilitation team can assist with pain management strategies
3. To learn practical tips to help in-patients manage their pain

It is the intention of the module to provide new health-care employees within the organization with evidence-based strategies to assist with early interventions for pain management. These strategies emphasize early return to functional activity, self-management techniques, and strategies such as positioning, pressure reduction, pacing, and avoidance of prolonged inactivity. Occupational therapists are well equipped to provide expertise in these areas, thereby providing cost-effective, early intervention strategies in the management of pain within an acute care environment. (Brown et al, 2011)

Strategies for pain management in acute care are multi-faceted, and to be most effective, require input from the interdisciplinary team. Innovative approaches to patient and staff education allow for rehabilitation-based pain management principles to be shared amongst all health-care providers, providing a foundation for excellent, evidence-based pain management practices for all in-patients within an acute care environment.

## Recommended resources

- Acute pain fact sheets: <http://www.iasp-pain.org/Content/NavigationMenu/GlobalYearAgainstPain/GlobalYearAgainstAcutePain/FactSheets/default.htm>
- Editorial: 2011- The global year against acute pain: <http://www.iasp-pain.org/AM/Template.cfm?Section=Resources7&Template=/CM/ContentDisplay.cfm&ContentID=13632>
- Overcome Pain: An optimistic scientific model: [http://www.lifeisnow.ca/wp-content/uploads/Optimistic\\_%20Scientific\\_Recovery\\_Model\\_explained\\_2011\(5\).pdf](http://www.lifeisnow.ca/wp-content/uploads/Optimistic_%20Scientific_Recovery_Model_explained_2011(5).pdf)

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# Occupational therapy and mindfulness meditation: An intervention for persistent pain

Bethany Stroh-Gingrich

Mindfulness meditation (MM) has recently gained momentum as a promising treatment for chronic pain. This article asserts that MM is an effective intervention to use within occupational therapy to assist individuals with persistent pain to increase their participation in occupation. The following describes MM, reviews the evidence, and outlines why it is well suited to occupational therapy. The article discusses current evidence and my personal experience with persistent pain. The term persistent pain will be used as an alternative to chronic pain as it is congruent with evidence on the impermanence of pain and represents a client-centered approach by providing hope that pain can change.

## Mindfulness meditation

There are various forms of meditation, however, MM is the most common form used within clinical practice (Gardner-Nix, 2009). Current use of MM has been within programs that are an adjunct to standard care, such as the Mindfulness-Based Stress Reduction program (MBSR) (Kabat-Zinn, 2000). MM is described as a practice of cultivating awareness of the present moment and observing one's internal state in a nonjudgmental, nonreactive manner (Ludwig & Kabat-Zinn, 2008). The goal of MM is to "maintain awareness moment by moment, disengaging oneself from strong attachment to beliefs, thoughts, or emotions, thereby developing a greater sense of emotional balance and well-being" (Ludwig & Kabat-Zinn, 2008, p. 1350).

## Current evidence

When compared to relaxation techniques, meditation has been shown to be more effective in diminishing stress reactivity by developing an increased ability to regulate and appraise distress (Jain et al., 2007). Studies have found that MM affects areas in the brain responsible for regulating attention, awareness and emotion (Creswell, May, Eisenberger, & Lieberman, 2007; Farb et al., 2007; Tang et al., 2007). Having capacity to use one's mind to change their brain suggests

neuroplasticity is a mechanism of change in meditation (Greeson, 2009).

MM has been shown to decrease the anticipation of and reactivity to pain by cultivating a sense of acceptance and nonjudgmental awareness (Brown & Jones, 2010). Self-regulation and metacognitive skills can be developed by objectively observing fluctuating negative and positive thoughts, feelings and sensations when they arise. This can decrease the tendency to limit engagement in activity, which can result from a fear that the pain will be dangerous (Greeson, 2009). MM teaches to let go of attachment and the desire to be pain free and to accept one's mental, physical, and emotional experiences without labelling or judgment (Selfridge, 2011). The proven long-term effectiveness of MM provides people with an effective life skill that enables self-management of health (Merkes, 2010).

## Occupational therapy and meditation

A recent review stressed the need for occupational therapists to go beyond education and talk-based interventions, and move towards evidence based task-orientated interventions (Robinson, Kennedy, & Harmon, 2011). As occupational therapists strive

to address all elements of a person's health and well-being, meditation integrates the physical, cognitive, psychological and spiritual components and also fits a biopsychosocial approach to pain management (Gatchel, Peng, Peters, Fuchs, & Turk, 2007). Meditation supports the occupational therapy focus of providing strategies that enable clients to increase participation in meaningful daily activities.

The act of meditation can be both an occupation on its own, as well as a tool to use while doing an activity (Gutman & Schindler, 2007). One outcome of MM is mindful awareness, the ability to consciously observe your habitual thoughts and actions, which can be transferred into other daily activities. Both the process (mindful practice) and outcome (mindful awareness) of engaging in meditation can positively affect neurological functions that promote health (Shapiro, 2009).

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*"the meditation gave me a tool to address the depression that came following the pain"*

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## About the author

**Bethany Stroh-Gingrich** is a MScOT graduate from Queen's University. For her master's degree, she co-wrote a research proposal that explored mindfulness meditation for persistent pain and its effect on occupational performance. She can be contacted at: bdsgh@hotmail.com.

The act of *doing* meditation allows a person to *be* with themselves while reflecting on their true nature and *become* different or transform themselves from moment to moment. This description of meditation fits well with the concept of 'doing, being and becoming', postulated by Wilcock (1999). She states there is a need for a balance between these three elements in order to maintain health and well-being. The process of 'doing, being and becoming' in MM results in change within a person. Theoretically, this change within the person will affect their engagement in other occupations, and therefore continue the process of 'doing, being and becoming.'

When suitable to client goals, occupational therapists should apply the enablement skills of advocating and educating (Townsend & Polatajko, 2007) to support the integration of MM as an effective evidence-based intervention within standard care for persistent pain. Occupational therapists providing MM would require training and would need to maintain a meditation practice themselves. If providing MM within occupational therapy services is not possible, therapists can offer referrals to community MM practitioners.

### My personal experience

I changed how I perceived my persistent pain after participating in a 10-day Vipassana meditation course. Vipassana is a non-sectarian MM practice that focuses on self-observation of one's thoughts, feelings, judgments and sensations. Through direct experience, one realizes the interconnection between the state of the mind and the body, and thereby increases their awareness and self-control (Ontario Vipassana Centre, 2012).

Following the Vipassana course, I began to see my so-called 'chronic' pain as something that could change, despite being previously told that it was permanent. I learned to see my persistent pain objectively and observe other sensations in my body, without holding onto the pain. Once I developed this skill, I applied the same principles to my everyday life. As a result, I learned how to manage my health and began to engage more in my meaningful occupations. Participating in meditation training and developing my personal meditation practice allowed me to experience for myself the impermanence of the pain. I still experience pain, but rather than avoiding it, I have learned how to appreciate it as an internal monitor to keep me balanced. Additionally, the meditation gave me a tool to address the depression that came following the pain. I learned how to accept, nonjudgmentally observe and let go of my emotions when the pain is high.

### Finding hope

Those with persistent pain often fall through the cracks in the health-care system. This, combined with persistent pain commonly referred to as 'chronic', may give people who are experiencing prolonged pain little hope that their pain will ever change. As a 'survivor' of persistent pain, and as an emerging occupational therapist, I see hope at the forefront of changing the way people manage pain. Integrating a form of MM into

occupational therapy practice is one intervention that could develop this sense of hope.

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## Putting pain into perspective

Mary-Lou Halabi

Pain is often a private and intimate feeling that may be difficult to articulate into words. As practitioners, we strive to empathize with our clients in an attempt to establish rapport and trust to foster a therapeutic relationship. At times, however, when dealing with personal subjects such as pain, the communication between a client and a practitioner can seem to jar, which may lead to frustration and a sense of being stuck (Padfield, 2011).

During my master of science in occupational therapy studies, I partook in a student-selected module called *Understanding Pain Through the Medium of Art* at the University of Alberta during the winter term of 2009, with special guest lecturer Deborah Padfield. For more information pertaining to this module and infusing theory into practice please refer to Brown, Halabi, MacDonald, Campbell, and Guenette (2011). In this module, we explored the therapeutic benefits of using photography as a means of communicating about pain. We were asked to think of a time when we experienced pain and to capture that sentiment into a photograph. Initially, I struggled to think of a way that I could convey the sentiments that I felt when I had injured my knee. The task of relating my pain was a very abstract process; where do I begin? When I tried to describe the feeling verbally, it was difficult to do.

Nevertheless, when I took the picture (see Figure 1) and presented it to the class, it became much easier to express what the pain felt like because I had a starting point. I felt as though people in the class understood where I was coming from and what I was trying to describe. The visual imagery, I felt, incited the same emotions from the class as I had felt from the injury. I could not quite capture the sensation of my pain into words, but I felt as though the picture captured that sentiment and was allowing others to experience it vicariously. Photographs can convey emotions or sensations that are otherwise too difficult to articulate using the right words (Padfield, 2011). As other students presented their work, their images allowed me to experience their feelings.

Now, reflecting back on the course and after a few years of clinical experience, I have increased my appreciation of the therapeutic value of this medium.

In practice we often come across communication barriers such as language, cultural differences, or even the inability to verbally express the emotions associated with pain. Pictures are a means of sparking the conversation and getting it going (Padfield, 2011). Pictures illustrating the sentiment of pain can be the nucleus around which ideas and expressions start to crystallize and become more concrete. A photograph

can get the conversation started and take it to depths that may not have been otherwise attained by means of traditional interviews or assessments (Berman, Ford-Gilboe, Moutrey, & Cekic

2001). It bestows upon practitioners a privileged access into their client's world and experiences. The use of pictures as a form of therapy has been shown to be effective in different populations, whether in the pediatric population as described by Berman et al. (2001), or in adults with chronic pain as described by Padfield, Janmohamed, Zakrzewska, Pither, and Hurwitz (2010) and Padfield (2011). Berman et al. (2001) used

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*“I could not quite capture the sensation of my pain into words, but I felt as though the picture captured that sentiment and was allowing others to experience it vicariously.”*

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Figure 1: *Jarring knee pain.* Photo by: Mary-Lou Halabi.

### About the author

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the concepts of 'photo novella' to allow children who survived the Bosnian war in the late 1990s to explore meaningful events in their lives. Children were asked to take pictures of what they felt was important in their life. When the children proceeded to explain the meaning of their photographs, they recalled events pertaining to the war. The researchers felt that the information that was elicited from the use of the pictures went well beyond anything they could have discovered from a conventional questionnaire (Berman et al., 2001). Sixty-seven percent of clients surveyed in the research by Padfield et al. (2010) stated that the images that they had selected from a series of photographs illustrating different qualities of pain made communication between them and their clinician easier. Much like what I felt and what many of the subjects and interviewers felt in studies by Padfield et al. (2010), Padfield (2011) and Berman et al. (2001), photographs can be powerful catalysts in initiating conversations.

With that said, as with any therapeutic approach, one size does not fit all. At the end of the day, it is about finding

what works for our clients. The use of photography is merely another innovative approach that we can add to the bag of occupational therapy tools that we can use as a conduit in our interactions with clients.

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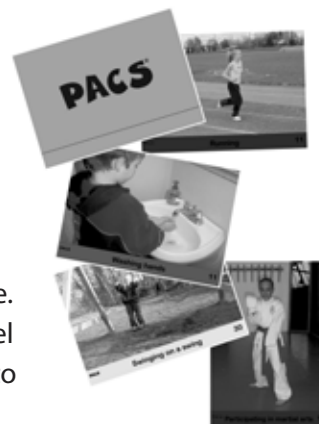
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# Bridging the gap: Managing work transitions with persons suffering from chronic pain

Lilian Antao, Kaitlyn Ollson, Flora To-Miles, Ann Bossers, Lynn Cooper and Lynn Shaw

## A call to action

Chronic pain is an under-treated health crisis affecting an estimated one in five Canadian adults (The Canadian Pain Society, 2012). In Canada, the cost of chronic pain is estimated between 56-60 billion dollars annually (Institute of Medicine, 2011). Chronic pain is inadequately managed and is associated with the poorest quality of life when compared with other chronic diseases such as chronic lung or heart disease (Choiniere et al., 2010). Ongoing illness evoking chronic pain can also be classified as episodic illness, which is “an illness that is permanent however can often result in recurring and unpredictable periods of good health and poor health” (Canadian Aids Society, 2003, pg. 1). An increasing number of Canadians are living with long-term episodic illness and chronic pain, and in turn, many are left facing employment and income support challenges (Canadian Working Group on HIV and Rehabilitation, n.d.).

## The strategies

Occupational therapists assist individuals in a holistic manner to reduce disability and improve participation in productive, meaningful activities. A targeted synopsis of strategies identified in a scoping review on chronic pain and episodic illness (Antao et al., in press) will be offered throughout this article. The review by Antao et al. (in press) examined existing literature pertaining to episodic illness (multiple sclerosis, breast cancer, fibromyalgia and HIV), chronic pain and the

barriers and strategies that exist regarding maintaining and obtaining paid employment. Occupational therapists are encouraged to use the identified strategies to assist with work-related rehabilitation and to facilitate accommodations for individuals in the workplace. These strategies help to maintain, retain or gain employment by making an impact at the person (micro), workplace (meso) and/or policy (macro) level. Within the literature, strategies addressing work disparities for persons with intermittent work capacity (IWC) and chronic pain are offered primarily at the micro level.

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*“Chronic pain is inadequately managed and is associated with the poorest quality of life when compared with other chronic diseases such as chronic lung or heart disease.”*

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Micro level strategies emphasize different approaches that may be used at the level of the person; for example, physical or cognitive approaches, or education programs on self-advocacy

and building work capacity. Based on the scoping review (Antao et al., in press), we encourage occupational therapists to use a variety of strategies to enable work-related transitions in a holistic manner. For instance, the literature emphasizes the importance of physical strategies, such as proper body mechanics, assistive device use, and the implementation of pacing and energy conservation techniques. The literature also stresses the need to stay active to avoid deconditioning. Of equal importance are cognitive strategies that consist of various interventions relating to coping skills and cognitive behavioural training for managing pain. The knowledge base suggests therapists incorporate coping training programs on topics such as stress and anger management, as well as assertiveness training (Salz, 2001) and body awareness training to effectively manage internal body changes and external

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**Lynn Cooper, BES**, is the President of the Canadian Pain Coalition.

**Lynn Shaw, PhD**, is an Associate Professor at Western University, London, ON.

environmental demands (Presnell, 2006). Another issue to address is learning how to live with the uncertainty that comes with disability, and therapists can help counsel individuals to manage the pain and the fluctuations in their health (Teasell & Merskey, 1997). Further, it is beneficial to engage individuals in meaningful activity to cope with pain and to transition into other activities which contribute to improved quality of life (Winfield, 1999).

Additional micro level findings in the literature highlight education about the rights of the individual. The literature suggests the need to educate workers on their rights pertaining to issues such as living and working with pain and disability (McKenna, Fabian, Hurley, McMahon, & West, 2007), as well as strategies that will help to maintain quality of daily and work life, such as pacing techniques (Kelley & Clifford, 1997). Advocacy by both the client and therapist were identified as key strategies in enabling work transitions and maintaining employment for those with IWC due to pain. Self-advocacy strategies were most prevalent in the multiple sclerosis and fibromyalgia literature. Occupational therapists can help clients learn how to self-advocate for various workplace accommodations, to obtain resources and assistance to overcome barriers to job retention, and to continuously assess their job-related needs in accordance with the fluctuations of their conditions (Rumrill Jr., Tabor, Hennessey, & Minton, 2000). Based on our review (Antao et al., in press), we recommend that it would be useful to advocate for ongoing counseling in terms of social and mental health issues, specifically addressing loss of identity and the difficulty in finding meaningful employment.

At the meso level, occupational therapists are encouraged to develop educational programs and/or resources for the employer, co-workers and the employee with the episodic illness and chronic pain. With increased awareness by all parties, stigma and discrimination, which often contribute to individuals leaving the workforce, may be reduced or eliminated. Meaningful employment and respect for individuals as productive workers can be enhanced by educating others on the fluctuating nature of episodic illness, the potential need for rehabilitation and the importance of procedural supports, such as flexibility in the employee start time to maximize energy and output (Rumrill Jr. et al., 2000). Furthermore, proactive strategies such as early contingency planning to consider career or assignment changes within the workplace for persons with episodic illness provide options to match individual performance capabilities as changes occur (Shaw, Pye, & Dodman, 2009).

At the macro level, occupational therapists can bring about change by assisting with policy development that can be implemented in the workplace. Knowledge from the literature suggests specific interventions are needed to help employers and workplaces identify and remediate incidents of harassment and intimidation that might cause persons with episodic illnesses to voluntarily leave their job (Neath, Roessler,

McMahon, & Rumrill, 2007). Across the literature, social supports were also identified as important. These supports must primarily focus on emotional support by affirming actions in order for the individual with episodic illness to feel safe in their work environment to act on their thoughts (Reid, Leierer, & Millington, 1999).

## Conclusion

Overall, the strategies presented here emphasize the capacity of the person to live with and manage their illness and work disparities. The literature demonstrates that early planning to maintain paid employment over the long term is warranted. This involves numerous stakeholders coming together to identify opportunities for adjustments and work redesign. Several studies also recommended the need for ongoing counseling on social and mental health for persons with IWC (Kelley & Clifford, 1997), an area occupational therapists

have the skills to facilitate.

Occupational therapists can also play a critical role in advocating for clients' needs (Rumrill Jr. et al., 2000). Currently, many clients are required to advocate for themselves and for

appropriate supports, resources and accommodations, while simultaneously facing barriers at the meso and macro levels. As occupational therapists, we need to advocate for our clients and implement support programs, so that upon seeking or maintaining employment, clients will be able to regain a sense of control and the burden of self-advocacy will be lessened. Therapists can also use education, and physical and cognitive strategies to enable individuals to manage and cope with their pain and disability in daily work and life routines.

Accommodation for individuals with IWC is an ongoing process requiring enduring advocacy for workplace policies that reflect evaluation, change and the inclusion of the worker. In addition, policies will need to support access to professional support and resources for consultation or workplace redesign. Occupational therapists can use information from the literature on episodic illness to identify new strategies that may be considered in a tailored, client-centered approach. It is important to draw on expertise across disciplines to assist co-workers, employers and clients. In the absence of policy, occupational therapists can begin the change process by advocating for the rights of persons with chronic pain and IWC. Identifying their unique needs and accommodation strategies will help maintain the ability of all individuals to access work.

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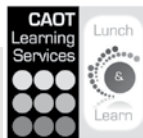
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**Community Development and Occupational Therapy: A natural, fruitful fit**  
Date: October 9th | Register by: October 2nd  
Presenter: Dr. Rachel Thibeault

**Occupational Therapy Interventions that Matter**  
Date: October 16th | Register by: October 9th  
Presenter: Dr. Mary Ann McColl

**Advocacy 101: Practical Strategies on Advocacy and the How-to's to Being Heard**  
Date: October 30th | Register by: October 23th  
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# Improving coping together

Bonnie Klassen and Lisa Jasper

There is a growing awareness of the importance of involving clients as active participants in self-management of pain, and this is an area that often involves occupational therapists. Dewar, Gregg, White, and Lander (2009) summarize the importance of incorporating peer input into support groups or educational opportunities for clients with pain. A further benefit has been suggested; by converting tacit knowledge that an individual may have gained through their experience to explicit knowledge that may be shared with others, this shared knowledge may become tacit in the receiving clients. This expansion of tacit knowledge may increase their unconscious competence (Hardy, 2004) with the goal in this situation of improved self-management of chronic pain. Programs such as the Stanford Chronic Disease Self-Management Program and the United Kingdom's Expert Patients Programme are two examples that emphasize the role of active client participation in learning chronic condition self-management skills (Hardy, 2004).

## Chronic Pain Clinics

The Chronic Pain Clinics in Camrose and Vermilion, Alberta are two clinics utilizing active client participation. Camrose, with a population of 17,286 (Camrose, Alberta, n.d.) and Vermilion, with a population of 3,930 (Vermilion, Alberta, n.d.) are two rural communities where access to specialized medical services is a challenge, often requiring many hours of driving. The Chronic Pain Clinics, funded by Alberta Health Services, operate two days per month in each location and offer interdisciplinary assessment, case review, pain education and referrals and liaison with community-based services such as occupational therapy, physical therapy, social work, mental health and home care. The teams facilitating the clinics include an occupational therapist, a physical therapist, a nurse, and a physician. As mentioned, client education, emphasizing self-management, is an integral component of the Chronic Pain Clinics.

## About the authors

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Optimizing attendance and delivery of information is an ongoing challenge. Several pain education classes are offered regularly in the clinics. The classes are one hour long and include topics such as living with chronic pain, back and neck care, stress management, medication and how pain affects the brain. All clients from the pain clinics and their families are invited to attend free of cost, and these classes are considered to be a part of their care plan. We struggle with finding the best way to encourage clients to attend these classes. Some

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*“Our goal is to create an environment where our clients will not only want to attend, but where they will start taking a more active role in creating supportive circles for themselves, without dependence on the pain clinic.”*

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pain clinics require mandatory attendance, but we also want to be sensitive to the challenges our clients face. Our goal is to create an environment where our clients will not only want to attend, but where they will

start taking a more active role in creating supportive circles for themselves, without dependence on the pain clinic. This article describes our most recent effort towards this goal.

## Pain education day

In addition to our regular one hour classes, we recently hosted an education day at both the Camrose and Vermilion clinics. In the past, the occupational therapist and physical therapist presented on various topics, incorporating stretch breaks and interactive activities. Results we loved seeing were the connections happening between people, the sharing of stories, and the discovery that each one is not alone in their experience with chronic pain. We noticed that the participants were learning as much if not more from each other as from the health professionals.

We called the pain education day “Improving Coping Together”. We encouraged clients of the pain clinics to present to an audience of their peers on 15-20 minute topics that reflected something they do that helps them cope. We started with an icebreaker: “What’s your name and what do you like to do for fun?” Most introduced their topic with a short background about themselves and their pain problem. The two sites had different topics and participants, but similar



outcomes in terms of allowing a supportive environment and connections to be created. We included several stretch breaks and encouraged participants to get up and move around if they needed to at any time. There were 11 and 10 participants in the two groups.

In Vermilion, topics included spirituality, being in the moment, deep breathing, pacing and letting go of the guilt that can go with it, topical analgesics and the benefits of being with animals. Each topic led to discussion. One of the most powerful moments occurred during the discussion of pacing. Several of the participants expressed that they felt strong pressure to do more than they should and then would suffer the consequences. The presenter stated, "I stopped feeling guilty about it." He explained that he paces himself so that he can do more. Others questioned him, "But how do I stop feeling guilty?" He kept saying, "You just stop." At the end of the day when each participant said what they would remember most from the day, several said, "I will stop feeling guilty." Another great moment was when the presenter on deep breathing demonstrated that when her abdominal pain is severe, she will stand, hold the back of a chair or other surface, breathe deeply, and simply be in the moment. This helps to reduce her pain and also her distress about the pain, which makes it worse. Seeing her do this encouraged the others to use this strategy more often. We discussed how certain activities can help you to 'be in the moment' or to have a feeling of flow.

In Camrose, we talked about the use of mobile devices and computers, the process of getting a medical marijuana license, cooking great food on a tight budget, being organized for medical appointments, and had an amazing and creative performance by one presenter with a story/poem about the Chronic Pain Clinic, complete with a fun costume and noise makers for participants to blow when they heard something they could relate to. It sounded like a party!

## Lessons learned

These sessions really were about sharing stories and experiences, offering support, and realizing the barriers that

stop us from doing the things that help us to cope. Similar themes emerged in our two groups as in the written narratives in a study with a small group of clients with chronic pain (Brown, Dick, & Berry, 2010). While there is still an important place for our health-professional-led education sessions to help our clients understand better how chronic pain affects the brain, how pain can become chronic and how to reduce the impact of pain on function, we are willing to involve our clients more and more as teachers. Each person has pieces of understanding and insight that when shared are reinforced and built on. Learning to live with pain is such a difficult process. Sometimes it takes many small steps towards understanding the problem and finding ways to cope day-to-day.

A comment from the evaluation forms regarding what change the participant was planning to make after attending the session summed it up: "Live my life." While for many people chronic pain is a daunting barrier, it can be overcome.

We thank the participants from the Vermilion and Camrose Chronic Pain Clinics who presented on topics of their choice, and we thank everyone who joined in the discussions. We welcome feedback and comments from other health-care professionals about pain education strategies and encourage health-care professionals to maximize the use of the wealth of knowledge and experience our clients possess.

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#### Margaret Brockett:

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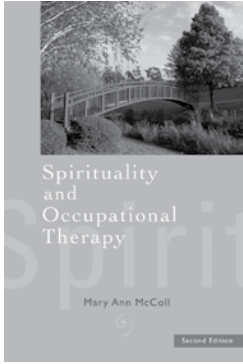
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Second Edition

Mary Ann McColl

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This edition has authors from a number of disciplines including chaplains, social workers, psychologists, clergy, and theologians, as well as occupational therapists. We benefit from understanding how they relate to clients with regard to spirituality, and learning from them what we can. We benefit also from coming to a better understanding of how they see occupational therapists, and how they seek to relate to occupational therapists in practice.

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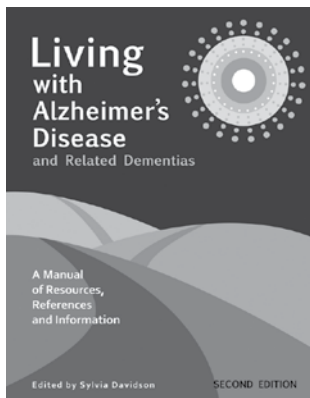
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# Living with Alzheimer's Disease and Related Dementias

Second Edition



Edited by Sylvia Davidson

*Living with Alzheimer's Disease and Related Dementias* provides answers to complex questions as caregivers struggle to understand behaviour and provide the best care possible to those with this illness. As the number of persons being diagnosed with dementia continues to rise, there is a growing need for skilled assessment, careful planning and linking with supports.

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