



Taming the Beast: Use of Cognitive Behavior Therapy in Treatment of Co-existing Disorders of Chronic Pain, Depression and Addiction

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September 8th, 2011



Objectives

- ✦ Define one way the CBT approach can be used in chronic pain rehabilitation.
- ✦ Identify outcome measures used in this three-week rehabilitation program.
- ✦ Describe nursing strategies used when addressing the synergistic effect of these co-existing conditions
- ✦ Describe interventions used to address substance use in the context of chronic pain and depression.



Complexity of Co-Existing Conditions Chronic Pain, Depression & Addiction

- ✦ Chronic Non-Cancer Pain (CNCP) is a common, complex, disabling condition (Chen, Wong & Chu, 2004)
- ✦ Depression is often part of the symptom picture of chronic pain (Chen et al.; Thorn, 2004).
- ✦ Addiction and substance use problems may complicate the symptom picture of persons with chronic pain further (Ballantyne & LaForge, 2007)



Complexity of Co-Existing Conditions

Chronic Pain & Addiction

“Patients who experience either addiction or pain have historically shared being misunderstood, underdiagnosed, and undertreated. When individuals experience coexisting chemical dependency and pain, this experience is amplified.” (Trafton, Oliva, Horst, Minkel, & Humphreys, 2004 as quoted from St. Marie, 2010 page 623)



Assessment Tools for Chronic Pain & Addiction

“Addictions and pain literature have inspired tool development to identify patients who are at risk for abusing prescription pain medications used to treat their pain...specialists have criticized DSM-IV as inappropriate for identifying opioid misuse in pain patients” (Savage, 1999; Sees & Clark, 1993 as quoted in St. Marie, 2010, p. 621)



What is Chronic Pain?

✦ An unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage....Pain is always subjective....It is unquestionably a sensation in a part or parts of the body, but it is also always unpleasant and therefore also an emotional experience. (IASP, 1994)



What is Chronic Pain?

✦ The IASP and many pain experts deem that *in many cases, chronic pain is a disease in its own right* (EFIC, 2001), a position supported by the Institute of Medicine Report June 29, 2011



Chronic Pain

- ✦ Pain is a universal experience. Common chronic pain conditions affect at least 116 million U.S. adults
- ✦ Costing \$560–635 billion annually in direct medical treatment costs and lost productivity

Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education, and Research. Institute of Medicine Report June 29, 2011



Depression

- ✦ Depression rates among persons with chronic pain is 3-4 times higher than the general population. (Sullivan, Reesor, & Fisher, 1992)
- ✦ Overlapping symptoms of pain and depression
- ✦ CBT-evidence based treatment for management of depression



What is Addiction

✦ Primary, chronic, neurobiologic disease, with genetic, psychosocial, and environmental factors influencing its development and manifestations. It is characterized by behaviors that include one or more of the following: impaired control over drug use, compulsive use, continued use despite harm and craving.

American Academy of Pain Medicine, American Pain Society, American Society of Pain Management Nurses, and American Society of Addiction Medicine



Physical Dependence

✦ Physical dependence is a state of adaptation manifested by withdrawal syndrome, produced by abrupt cessation, rapid dose reduction, or decreasing blood levels of the drug.

American Academy of Pain Medicine, American Pain Society, American Society of Pain Management Nurses, and American Society of Addiction Medicine



“The Elephant in the Living Room”

✦ Addiction





“The Elephant in the Living Room”

✦Chronic pain





“The Elephant in the Living Room”

✦Depression





“The Elephant in the Living Room”

Chronic pain
+ Depression
+ Addiction
“The Beast”



Establishing the Efficacy of CBT for Treatment of Chronic Pain

International Association for the Study Pain in the 10th World Congress (2005)

- ✦ Cognitive Behavioral Therapy is as effective for a heterogeneous group of chronic pain sufferers as any published therapy for any specific type of pain



Efficacy of CBT for Chronic Pain

Turk (2002) Review of comprehensive pain rehabilitation programs

- ✦ More cost effective than implantation of spinal cord stimulators, intraspinal drug delivery systems/surgery.
- ✦ Significantly greater reduction in medication use, and health care utilization
- ✦ Significantly greater increases in functional activities, return to work, closure of disability claims
- ✦ Substantially fewer iatrogenic consequences/adverse events.



Multidisciplinary Pain Rehabilitation

- ✦ Cognitive-behavioral approach
 - ▣ Improvement of physical functioning
 - ▣ Improved general functional status (ADLs, social, household, recreational)
 - ▣ Improved vocational/school functioning
 - ▣ Reduction in health care utilization
 - ▣ Reduction/discontinuation of opioids, sedative-hypnotic and over the counter medications
 - ▣ Reduction in pain level (not always attainable)

The Journal of Pain, Vol 7, No 11 (November), 2006; pp 779-793
Available online at www.sciencedirect.com



FOCUS ARTICLE

Evidence-Based Scientific Data Documenting the Treatment and Cost-Effectiveness of Comprehensive Pain Programs for Chronic Nonmalignant Pain

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Written for the American Pain Society Task Force on Comprehensive Pain Rehabilitation, Glenview, Illinois.

APS Task Force Review (2006) - Compared to different treatment modalities including the standard medical approach or medication management, MPRP is the only therapeutic approach that has demonstrated treatment efficacy and cost-effectiveness for functional restoration and major outcome variables (pain severity, healthcare utilization, medication use, disability claims).



Overview of Mayo Clinic Comprehensive Pain Rehabilitation Center (PRC)

- Three week program developed in 1974 in Rochester, MN
- ~450 patients annually
- Patients average length with chronic pain ~ 9+ years
- Back pain, fibromyalgia & headache most common
- Participants range in age from 13 to 90
- Focus on functional restoration and quality of life
- Discontinuation of opioids for pain while learning other cognitive-behavioral strategies for coping



Overview of Pain Rehabilitation Center

- ✦ 3 week program with rolling admission
- ✦ 20-30 patients at any given time, divided in 2 teams
- ✦ Monday – Friday 8 a.m. to 5 p.m.
- ✦ 2 day family education program
- ✦ Aftercare program
- ✦ PREP - 2 day pain rehabilitation executive program
- ✦ 3 week Adolescent program with extensive parent programming



Comprehensive Multidisciplinary Team

- | | |
|------------------------------|---------------------------------|
| ✦ Patient | ✦ Pharmacist |
| ✦ Physicians | ✦ Dietitian |
| ✦ Psychologists | ✦ Chaplains |
| ✦ Clinical nurse specialists | ✦ Vocational counselor |
| ✦ RN case managers | ✦ Tobacco treatment specialists |
| ✦ Physical therapy | ✦ Clinical assistants |
| ✦ Occupational therapy | ✦ Secretary |



Pain Control Methods Commonly Used Prior to PRC

- | | |
|-------------------|--|
| ✦ Medications | ✦ Complementary & alternative medicine |
| ✦ Surgeries | ✦ Various procedures |
| ✦ Injections | ✦ Physical therapy |
| ✦ Stimulators | ✦ Rest |
| ✦ Implanted pumps | ✦ You name it! |

Just Say No to Drugs???


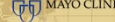


Can this **REALLY** be an **alternative treatment** to opioid therapy??

Opioid Therapy for Chronic Pain

- ✦ Early 1990s national pain organizations challenged the nation to provide better pain management to all patients
- ✦ It was determined that there need not be an “upper limit” for opioid prescriptions for those in pain
- ✦ In 1997, APS and AAPM issued consensus statement that opioid therapy for Chronic Non-Cancer Pain is a legitimate medical practice
 - ❑ Minimized concerns of addiction, respiratory depression and other side effects, and tolerance
- ✦ 1997 to 2006 - 90% increase in opioid prescriptions

But, is it Effective?

Six meta-analyses and reviews of randomized, double-blind, placebo-controlled trials of opioids for CNCP

- ✦ **Flawed Empirical Efficacy**
 - ❑ Significant drop out rates/exclusion criteria
 - ❑ Very short-term outcomes (avg. **5 weeks!**)
 - ❑ Lack of clinically significant reduction in pain
 - ❑ No documented improvement in functioning
 - ❑ Possible publication bias



But, is it Effective?

◆ Additional Reasons for Concern

- ❏ Tolerance/Dependence, Addiction
- ❏ Possible Opioid-induced Hyperalgesia
- ❏ Opioids maintained despite decline in functioning and no improvement in pain (fear motivated?)
- ❏ Pain behaviors predict physicians' prescriptions





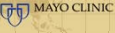
What did the Consensus statement REALLY say??

- ◆ "periodic reexamination is warranted to assess the nature of the pain complaint and to ensure that opioid therapy is still indicated. Attention should be given to the possibility of a decrease in global function or quality of life as a result of opioid use" [1997, p. 3].



What did the Consensus statement REALLY say??



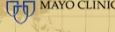
- ◆ "Consideration should be given to different treatment modalities, such as a formal pain rehabilitation program, the use of behavioral strategies, the use of noninvasive techniques, or the use of medications, depending upon the physical and psychosocial impairment related to the pain" [1997, p. 3].

What has Really Happened?

- Interactive map show state by state annual change in prescription narcotic consumption (1997-2006)
- AZ had a 640% increase in oxycodone consumption (#6 in country DE was #1)
- Money spent on Marketing for opioids increased from \$11 to \$30 billion
- Spending on outpatient prescriptions tripled in 10 years (4.2 in 1996 to 13.2 billion in 2006; AHRQ, 2009)
- 1999-2006, fatal poisonings involving opioids more than tripled from 4,000 to 13,800 (NCHS, 2009)

■ http://www.lasvegassun.com/multimedia/rx_interactive/

Evidence-based practice guidelines for CNCP and opioids

Conclusion

- ICSI, 2008; Sanders et al., 2005
- Controlled opioid trials have limited applicability to the long-term use of opioids in clinical practice
- Clinicians should consider other forms of treatment including rehabilitation approach that emphasizes self-management and functional restoration






Pain 140 (2008) 177-189

PAIN
www.elsevier.com/locate/pain

A longitudinal study of the efficacy of a comprehensive pain rehabilitation program with opioid withdrawal: Comparison of treatment outcomes based on opioid use status at admission

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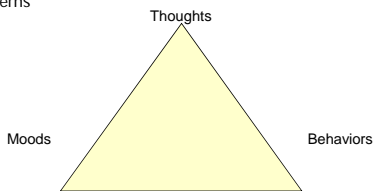
CBT Goals of the Mayo PRC

- Learn healthy ways of responding to flares of chronic pain
- Practice lifestyle self-management approach
 - ▣ Not from one prescription or procedure to the next
 - ▣ Focus on functional goals
 - ▣ Skills training
- Increase the controllability of own pain and quality of life
 - ▣ Developing Resiliency
 - ▣ Replace pain contingent lifestyle



CBT Triangle

- CBT Focused Groups
 - ▣ Identifying relationships between thoughts, moods, and behaviors
 - ▣ Identifying, challenging & changing maladaptive thought patterns





Cognitive-Behavioral Techniques

- No single coping technique has proven to be universally effective –
 - ▣ It is the combination of multiple personalized techniques incorporated into one's lifestyle that leads to success in restoring functioning and quality of life
 - ▣ CBT can be used at any time during course of pain – not solely after failure of other treatments



Cognitive-Behavioral Techniques

- ✦ Patient education –
 - Acute vs. Chronic pain
 - Central Sensitization
- ▣ Reinforce wellness behaviors
 - responses to pain, generates consequences
 - Behavior rewarded is behavior repeated
 - Behavior not rewarded is “extinguished”
 - ↓ avoidance
 - ↓ verbal/nonverbal pain behaviors



Cognitive-Behavioral Techniques

- ✦ Regular exercise – reverse deconditioning
 - hurt ≠ harm;
 - gradual and progressive
- ✦ Appropriate Pacing of activities
 - ↓ “push-crash-burn” cycle
 - Appropriate ergonomics (PT/OT)
- ✦ Sleep hygiene, sleep restriction
 - ↑ sleep efficiency
 - Treat as primary insomnia using CBT



Cognitive-Behavioral Techniques

- ✦ Distraction
 - humor, leisure and pleasant activities, hobbies
- ✦ Stress management
- ✦ Relaxation Training
 - biofeedback, diaphragmatic breathing imagery, progressive muscle relaxation, yoga



Cognitive-Behavioral Techniques

- ✦ Grief and Loss –
 - ▣ New Identity beyond pain and being a patient
- ✦ Communication/Assertiveness training
- ✦ Family education and training
- ✦ Relapse prevention/problem solving
 - “difficult day plan for managing flares”



Cognitive-Behavioral Techniques

- ✦ Cognitive restructuring
 - ↓ pain catastrophizing;
 - ↑ controllability,
 - ↑ positive coping
 - Challenge rigid thinking



Thought Record: One Technique (ABCDE format by Aaron Beck)

- ✦ Activating Event
 - ▣ Triggers, context (i.e. losing a job and having chronic pain)
- ✦ Belief
 - ▣ Negative, inaccurate, automatic thoughts (i.e. “I’m a loser!”)
- ✦ Consequences
 - ▣ Feelings (i.e. angry, sad)
 - ▣ Behaviors (i.e. isolate, don’t take care of self)



Thought Record

(ABCDE format by Aaron Beck)

Debate

- ❏ Evidence supporting belief
 - (i.e. lost job; feel like a loser)
- ❏ Evidence not supporting belief
 - (i.e. look at other successes; chronic pain is not synonymous with being a "loser"; focus on what is possible)

Exciting New Conclusions

- ❏ (i.e. "Losing a job and having chronic pain does not mean I am a loser! I can focus on taking care of myself and what is possible.")



Managing Co-Existing Conditions

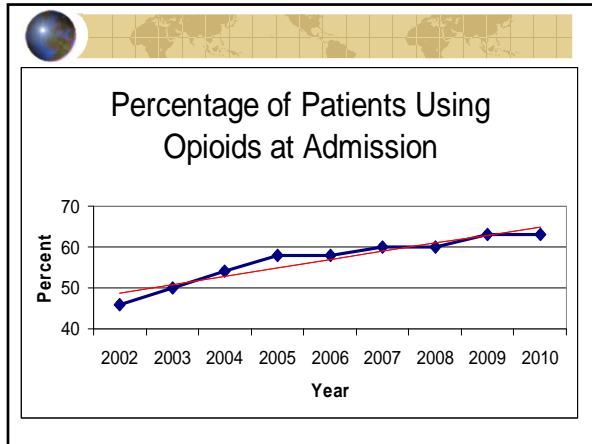
Chronic pain, depression & addiction

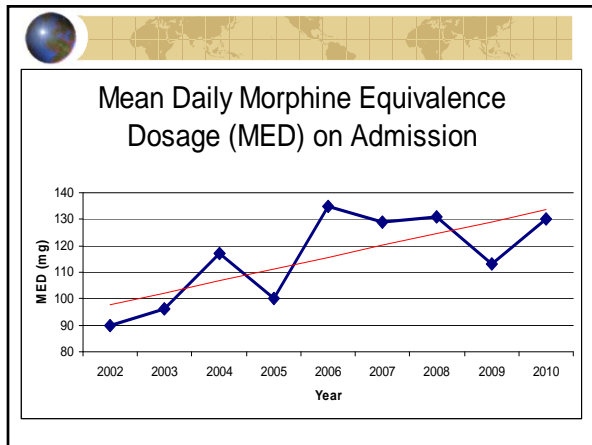
- ❏ Cognitive behavioral strategies have been shown to improve depression and help persons effectively manage chronic pain (Bennett & Nelson, 2006; Chen et al, 2004; Turk, 2003; Wells-Federman, Arnstein, Caudill, 2002; Wells-Federman, Arnstein, Caudill-Slosberg 2003)
- ❏ Cognitive behavioral strategies including pain management combined with relapse prevention has been shown to help persons with substance use disorders and chronic pain to decrease pain, manage emotions, and reduce medication reliance (Currie, S., Hodgins, D., Crabtree, A., Jacobi, J. & Armstrong, S., 2003)

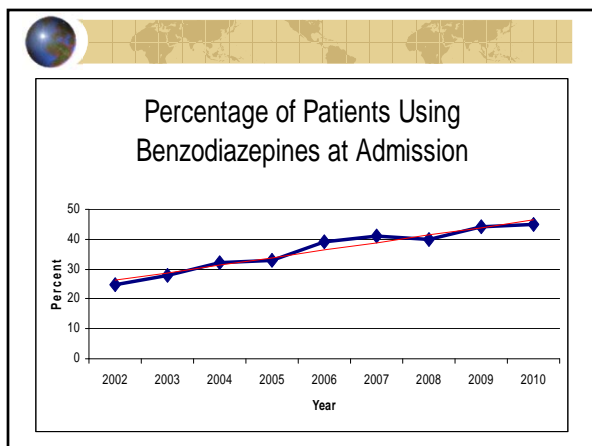


Bewildered by the Beast

- ❏ Programs not equipped to deal with these co-existing disorders
- ❏ Increased number of patients on opioids
- ❏ Increased polypharmacy
- ❏ Higher daily morphine equivalents
- ❏ Dissatisfaction of medication use by patients, providers, and families
- ❏ Multitude of risks associated with use of opioids

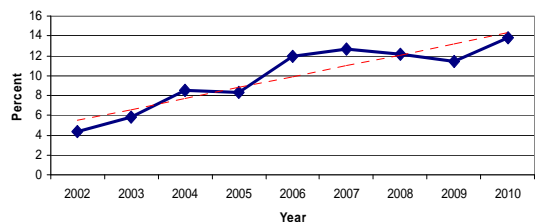






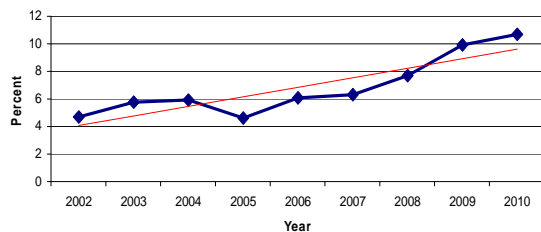


Percentage of Patients Using Trifecta at Admission





Percentage of Patients Using Stimulants at Admission





Acknowledging the Beast in the Room

- ✦ Talking about our preconceptions and biases
- ✦ Improve knowledge and skill of tapering opioids- Clinical Opiate Withdrawal Scale
- ✦ Ongoing discussions with staff, patients/families
- ✦ Creating and using neutral language
- ✦ Allowing the process of change to occur



Taming the Beast

- ✦ Building rapport – developing trust
- ✦ Nonjudgmental approach
- ✦ Hybridized-skilled assessment
- ✦ Validating patient's personal experience
- ✦ Patient Advocate
- ✦ Establishment of safe medication tapers
- ✦ Knowledge and understanding of substance use disorders & pain



C.O.R.E. versus M.O.S.T.

- ✦ Continued Opportunity for Rehabilitative Experience
- ✦ More Opportunity for Successful Tomorrows

- ✦ Which option?
- ✦ Criteria for recommendation



M.O.S.T

- ✦ Stronger focus on risks of mood altering substances misuse/abuse based on:
 - ❑ Past /present use of mood altering substances
 - ❑ Use of pain medications in ways other than prescribed, (i.e. anxiety, stress)
 - ❑ Concerns expressed by family or healthcare providers
 - ❑ Aberrant behaviors
 - ❑ Genetic predisposition
 - ❑ Health risks



M.O.S.T.

- ✦ Goal: Increase awareness of substance use risks and provide ongoing education, recommendations and resources as needed.



Preparing the Patient for MOST

- ✦ Motivational interviewing and Stages of Change
- ✦ Gathering information
 - ▣ Patient-history of substance use, current use, misuse/abuse of substances including medications, alcohol, illicit drugs, and patient concerns
 - ▣ Family and home provider input
- ✦ PRC treatment team makes recommendation based on information gathered
- ✦ Patient can ultimately make the choice



What happens in MOST

- ✦ Therapist style-**nonjudgmental**
- ✦ Confidential-trust within group (no labels, judgment, criticism, blame)
- ✦ Focus on how substance use affects life (not pain stories)
- ✦ Provide an environment for self reflection
- ✦ Education regarding substance use



Group Topics in MOST

- ✦ Physical/medical aspects of substance abuse including disease model
- ✦ Cycle of pain and substance use
- ✦ Personal use patterns-sharing time line
- ✦ Family aspects, history, effects on relationship, family concerns
- ✦ Managing high risk situations, triggers for use, avoiding cross-addiction and other risks



Possible Next Steps for MOST Patients

- ✦ When the patient is ready
 - ▣ Using SAMSHA, provide information about treatment programs
 - ▣ Provide support and encouragement during transition
- ✦ When the patient is not ready
 - ▣ Provide a clear message to patient, his/her support persons, and home providers about PRC recommendation for treatment
 - ▣ Using SAMSHA, provide information about treatment programs
 - ▣ Keeping the doors open



Outcome Measures

- ✦ Multidimensional Pain Inventory (MPI)
 - Pain Severity and Suffering
 - Life Interference
- ✦ Pain Catastrophizing Scale
- ✦ Pain Self-Efficacy Scale
- ✦ CES-D
 - Depression

Demographics	CORE (n=230)	MOST (n=246)
Age	47	47
Education (years)	14.8	14.6
Duration of pain (years)	12.1	11.3
Years taking narcotic	5.2	5.2
% Married	48%	51%
Admit BMI	29.5	29.5

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**OPIOIDS, BENZOS, AND SEDATIVES/HYPNOTICS...
A LETHAL TRIFECTA**

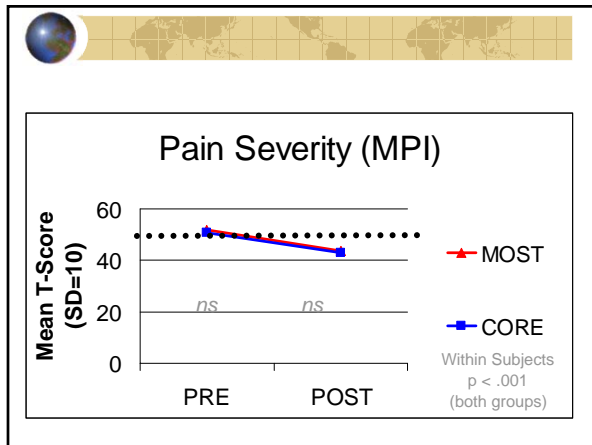
N=476	CORE	MOST	
Opioid	36%	64%	p < 0.001
Benzodiazepine	38%	62%	p < 0.001
Sedative/hypnotic	43%	57%	P=0.08
LETHAL TRIFECTA	7%	18%	p < 0.001

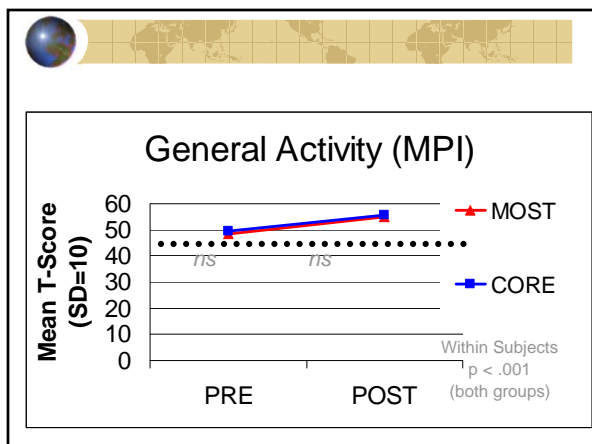
Other Drugs

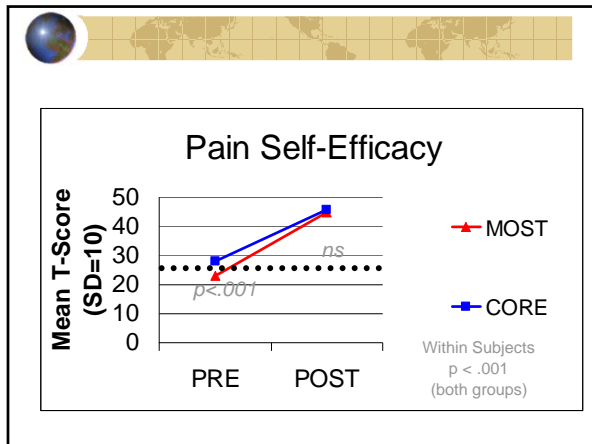
N=476	CORE	MOST	
Muscle relaxant	49%	51%	ns
Tricyclic antidepressant	55%	45%	p=0.003
SSRI	39%	61%	p=0.007
Other antidepressant	45%	55%	ns
Stimulant	35%	65%	p=.054

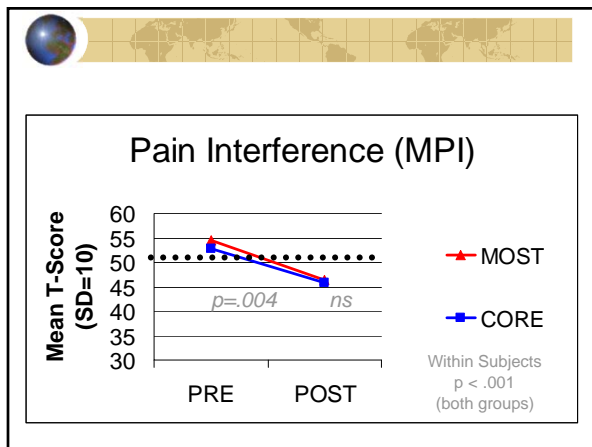
Other Drugs

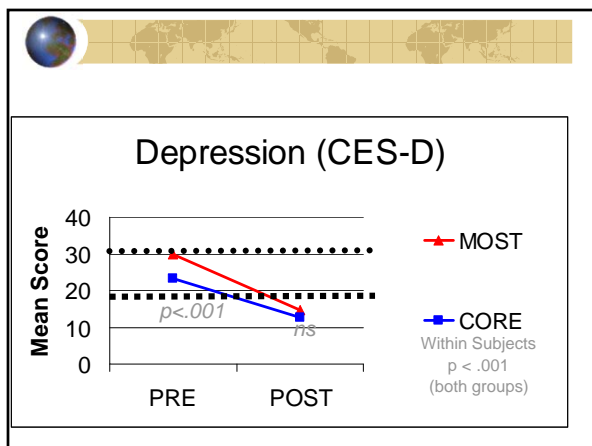
	CORE	MOST	
Tobacco use	20%	80%	P < 0.001
Past CD Tx	17%	83%	P < 0.001
% Current alcohol use	50%	50%	ns
% Past heavy Alcohol Use & Daily alcohol use	6%	27%	
Marijuana use	0.4%	13%	P < 0.001













Revelations: The Beast Can be Tamed!

- ✦ The way we approach patients matters
- ✦ Language matters
- ✦ Timing matters
- ✦ The relationship matters



Revelations: The Beast Can be Tamed!

- ✦ Awareness of their cycle of pain, substance use or depression is important, more so focusing on ways these can be broken
- ✦ Gaining knowledge specific to addiction, depression, chronic pain is beneficial
- ✦ Acceptance and application of concepts lead to positive outcomes



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