

Session 2

Mindful Eating with a Raisin

Check-in: Introductions – in 3 minutes or less!

Name

What you would like to share about yourself or your diagnoses

What you are hoping for from these groups

What you would like to share about your self-portrait

Medications and Pain

Identify a buddy!

Introduction to Cognitive Behavioral Therapy, Goal-setting

Med Check

Homework:

Relaxation response Exercise 20 minutes per Day – check in with your buddy about this!

Pain Diaries and Feedback Form

Change Plan Worksheet

Keep a food diary for 3 days – everything that goes in your mouth!

Ways to be a Human “Being”, NOT a Human “Doing”

Be Here Now

Be Well

Be Enthusiastic

Be Kind

Be With Great Music and Art

Be Grateful

Be Silly and Playful

Be Compassionate

Be Courageous

Be Resilient

Be With Nature

Be at Peace

Mindfulness

Meditation is the art of paying attention, of listening to your heart. Rather than withdrawing from the world, meditation can help you enjoy it more fully, effectively and peacefully.

Mindfulness offers:

- A way of affecting and nurturing deep states of relaxation and of reducing stress - The practice of mindfulness brings a deep stillness that is profoundly relaxing and healing.
- An ability to be more responsive and less reactive to a wide range of situations - Often we react without any awareness of the larger range of possibilities.
- The development of mindfulness brings an inner quietude resulting in a felt-sense of "spaciousness" - of body-mind equanimity in the face of stimuli that, in turn, allows a person room to step back and choose a considered response.
- A capacity to be present, to be fully awake to life - Relationships become richer, connections more powerful as we actually listen and learn to speak from our direct experience.
- A method for increasing concentration and focus through the practice of mindfulness in daily life - By bringing attention to the habits of the mind and body, we become better equipped to direct the mind.
- A capacity to enhance creativity through the deliberate cultivation of a spacious, non-striving awareness - Only when we are present and open to unforeseen possibilities can we be creative. Quite literally, there is little possibility of creativity when we are habitually dwelling in conditioned attitudes and modes of thinking.

Mindfulness is:

- Mindfulness is paying attention.
- Mindfulness is being in the present moment without judgment.
- When we practice a mindful approach to our lives we find that we can meet our inevitable challenges in a more relaxed and perceptive manner.
- How many of us consciously cultivate a sense of connection, calm and well being so that our day to day lives can have more meaning and ease?
- When we practice mindfulness we develop greater awareness, clarity and acceptance. A non-judgmental attitude can often diffuse the tension in both ourselves and others.
- Mindfulness provides a simple yet powerful way to get ourselves unstuck, back in touch with our wisdom and vitality.
- We will learn some simple 'tools' for everyday use. This is a practice that you can carry with you into every aspect of your life, even your most pressured moments at work.

Meditation is like a Puppy

...meditation is very much like training a puppy.
You put the puppy down and say, "Stay."
Does the puppy listen?
It gets up and it runs away.
You sit the puppy back down again. "Stay."
And the puppy runs away over and over again.
Sometimes the puppy jumps up, runs over, and pees in the corner or makes some other mess.
Our minds are much the same as the puppy,
only they create even bigger messes.
In training the mind, or the puppy,
we have to start over and over again.

Mindful Eating Exercise

Mindful eating is being present, moment-by-moment, for each sensation that happens when chewing, tasting and swallowing. Often, we eat mindlessly, while talking, watching television, driving, and so on.

- When our mind is tuned out during mealtime, the digestive process may be 30% to 40% less effective.
- People who eat while doing other things weight 18% more than those who focus on eating.

When we eat on the run or while thinking about other things, we are often unaware of the taste, texture, color or sensation our apestat, the appetite control centre, in our brain needs to register ‘satisfied!’

Tips for mindful eating:

- ❖ Remove distraction
- ❖ Sit in a comfortable position and become aware of your breathing for a few moments
- ❖ Become aware of your food: how it looks, feels and smells.
- ❖ Pay attention to how you are feeling about this food.
- ❖ Think about how the food connects you to the world around you – where it was grown, what it took to get to your table.
- ❖ Bring your awareness back to the food.
- ❖ Bring a bite of food to your mouth. Experience the movement of your fingers and arms.
- ❖ Notice the response of your salivary glands
- ❖ Chew your food. Become aware of all your sensations - notice the texture of the food, how it changes as it mixes with saliva, how your tongue moves it around, the mixture of flavors coming from it, etc.
- ❖ Prepare to swallow the food, and notice your swallow response, and of any sensations in your stomach.
- ❖ Notice your emotions as you eat.
- ❖ Repeat this process with the next bit of food.

Discuss your insights. The point of the exercise is not to eat your meals exactly in this way but rather to learn something about your own eating habits and to discover how eating mindfully might benefit you.

You might find value in applying this awareness to the first bite of each meal. This helps set an intention of being mindful through the course of your meal.

Other tips for applying this, and improving mindfulness around your eating in daily life:

- Do not skip meals
- Use a smaller plate, or use a plate period! – you can always have seconds if you are still hungry
- Make your plate colorful
- Turn off the TV/radio/etc. while eating

Medical treatments for pain

Non-opioid Analgesics

Tylenol/acetaminophen toxicity - Chronic tylenol ingestion of 4 g per day (8 vicodin) can produce liver damage

Lesser doses can be toxic when fasting/not eating well or when taken with alcohol

It is included in many combination medications (vicodin, norco, cold and flu medications)

NSAIDs: Adverse effects on Gut, Joints, Kidneys, etc.

May be safer to combine with Misoprostol or PPI like prilosec (but those have lots of side effects)

Devil's Claw: Standardized dose: 600 - 1,200 mg, standardized to 50 - 100 mg of harpagoside, 3 times daily

Ultram/Tramadol: milder opioid

Less addictive

Seizure risk, especially with antidepressants

Opioids

- Questions to ask before starting:
 - Have there been any other chemical (alcohol or drug) abuse problems in the person's life?
 - Is there a family history of substance abuse?
 - Is there a history of sexual abuse prior to adolescence?
 - Is there psychological disease? (Depression, bipolar, OCD, ADHD, etc.)
- Questions to ask when taking:
 - Is your day centered around taking medication?
 - Do you spend most of the day resting, avoiding activity, or feeling depressed?
 - Are you able to function (work, household chores, and play) with pain medication in a way that is clearly better than without?

Opioid-induced Hyperalgesia

The pain medicines can actually make pain worse

Stopping opioids

Medical treatment of withdrawal – suboxone and symptomatic treatment

Adjunctive Medications

Topical

Lidocaine
Capsaicin
Anti-inflammatories

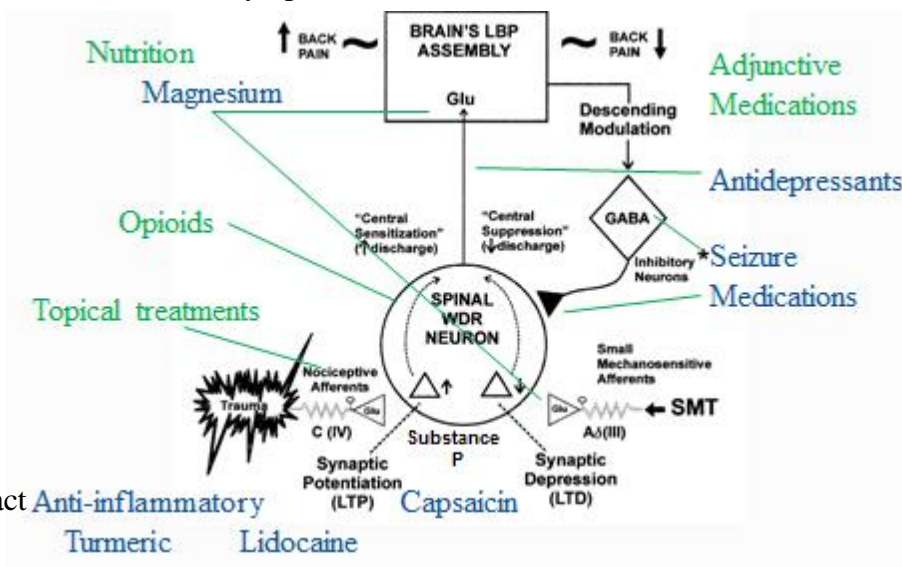
Antidepressants

Anticonvulsants

Antiarrhythmic drugs

Nutraceuticals

- Glucosamine sulfate
- Hydrolyzed Collagen
- Pycnogenol or Grape seed extract
- Vitamin D
- Fish oil
- Boswellia, Cat's Claw, Cherry, Curcumin, Ginger and others



Developing SMART(ER) Goals

A SMART goal is a goal that is specific, measurable, attainable, relevant and time based. In other words, **a goal that is very clear and easily understood.**

SPECIFIC

The goal must clearly state **what** is to be achieved, by **whom**, **where** and **when**.

Sometimes it may even state why that goal is important. “Relax” can be too vague a goal to help you make change, but “*Practice a relaxation response technique once a day*” is much more clear.

MEASURABLE

Measurability applies to both the end result and the milestones along the way. It answers the question of quantity – how much, how often, how many? For example: *Swim three times a week for 30 minutes.*

ATTAINABLE

You should ensure that the goals you set are achievable. The goal must be possible, all things being equal. There is no point setting a goal to float in the air and defy gravity using only your mind, for instance. No matter how hard you try this won't be achievable.

RELEVANT

Your goals must be relevant to what you want to achieve in the short term and the long term. If your goal is to have less tension in your neck so you will have fewer headaches, “*Take a stretch break every 45 minutes*” may be a way to move in that direction.

TIME-BASED

A goal is a dream with a time-frame to it. It can prevent you from procrastinating because you know that you are working to a deadline. For instance, “*join the YMCA and start going to swim classes by the end of the month.*”

To make your goals even **SMARTER**, add these steps:

EVALUATE

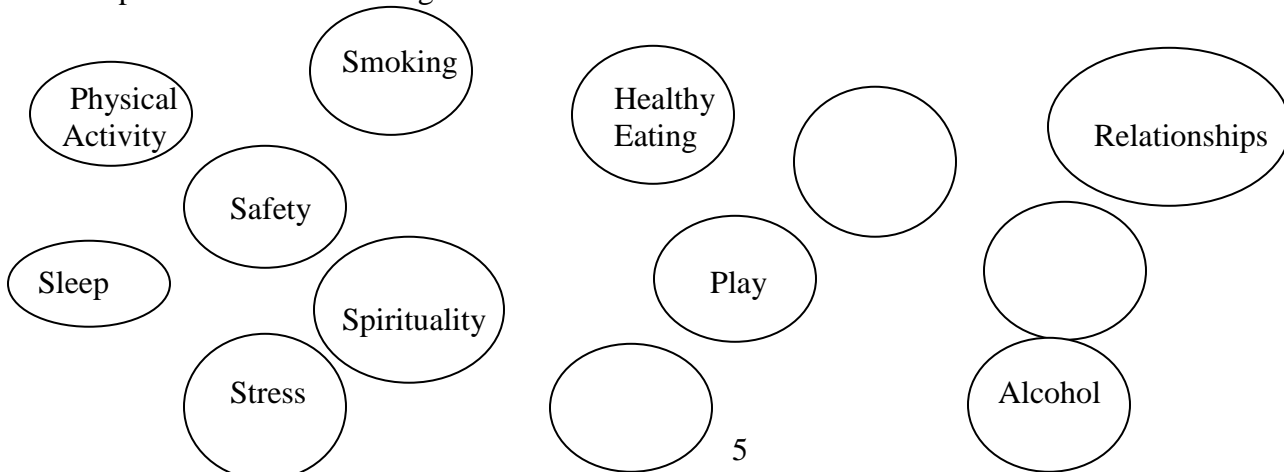
Part of the process is to look back at the goals you have set and see how well you are meeting them. There is something to learn whether you meet your goals or not.

If you succeed: congratulations, give yourself a pat on the back and think about the next goal you want to set. If not: look for things that got in the way adjust so you can succeed with the next try.

RELAPSE, RE-EVALUATE

Plan for relapse. This is an ongoing process. Keep checking in and coming back to your goals. Over time, you will see your life changing as a result.

Some potential areas for change in health:



Write a SMART goal on the lines below:

1. The change I want to make is: _____
2. The steps I plan to take in changing are:

Now look at the factors that can affect your chances of succeeding.

1. How important is it to me (on a scale from 1 to 10) to make the change?
1-----2-----3-----4-----5-----6-----7-----8-----9-----10
not at all important extremely important
2. The most important reasons why I want to make the change:

3. How confident am I that I can make the change?
1-----2-----3-----4-----5-----6-----7-----8-----9-----10
not at all confident extremely confident

4. Reasons I am this confident are:

5. Some things that could interfere with my plans are:

6. The ways other people can help me are:

Person	Possible ways to help me	Told them about it? (Y/N)

I will know my plan is working if:

Symptom Diary

Name _____

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	Describe situation	Physical Sensation (0-10) before meds	Physical Sensation (0-10) 45 min. after meds	Describe physical sensation	Emotional response (0-10)	Describe emotional response/thought	Action taken, including medications
Monday							
Date:							
Time 1:							
Time 2:							
Time 3:							
Total:							Sleep: hours _____
Average:							Quality: _____
Tuesday							
Date:							
Time 1:							
Time 2:							
Time 3:							
Total:							Sleep: hours _____
Average:							Quality: _____
Wednesday:							
Date:							
Time 1:							
Time 2:							
Time 3:							
Total:							Sleep: hours _____
Average:							Quality: _____

	Describe situation	Physical Sensation (0-10)	Physical Sensation (0-10)	Describe physical sensation	Emotional response (0-10)	Describe emotional response/thought	Action taken, including medications
Thursday:							
Date:							
Time 1:							
Time 2:							
Time 3:							
Total:							Sleep: hours_____
Average:							Quality: _____
Friday:							
Date:							
Time 1:							
Time 2:							
Time 3:							
Total:							Sleep: hours_____
Average:							Quality: _____
Saturday:							
Date:							
Time 1:							
Time 2:							
Time 3:							
Total:							Sleep: hours_____
Average:							Quality: _____
Sunday:							
Date:							
Time 1:							
Time 2:							
Time 3:							
Total:							Sleep: hours_____
Average:							Quality: _____



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FEEDBACK SHEET FOR HEALING GROUP

Name: _____ Date: ____/____/____

1) Please review your medication list and indicate any changes you have made in your medications, supplements, or over the counter meds since the last group (i.e. stopped any, increased any, decreased any, added new ones).

What refills do you need today? _____

2) Have you had any injuries, events in your personal life, any nerve blocks, physical therapy, other treatments, exercise, etc. since our last group that made your pain worse or better? Yes No
If yes, please give details. _____

3) Over the past 2 weeks has your pain level:
 Decreased Stayed the Same Increased All over the place
What changes have you noticed? Please be as specific as you can: _____

4) Rate your average pain score for the past 2 weeks:
NO PAIN 1 2 3 4 5 6 7 8 9 10 VERY SEVERE PAIN

5) Rate your pain score today:
NO PAIN 1 2 3 4 5 6 7 8 9 10 VERY SEVERE PAIN

6) Over the past 2 weeks has your emotional state:
 Decreased Stayed the Same Increased All over the place
What changes have you noticed? Please be as specific as you can: _____

7) Rate your average mood for the past 2 weeks:
VERY SAD 1 2 3 4 5 6 7 8 9 10 VERY HAPPY

8) Do you address special nutritional needs as part of your healing plan? Yes No If yes, what nutritional goals are you addressing? _____

9) For how long and how often did you do physical exercise in the past 2 weeks?

- Aerobic Time _____ How often? _____
- Stretching Time _____ How often? _____
- Strengthening Time _____ How often? _____

10) Did you meditate? Yes No How long? _____ How often? _____

11) Did you use other relaxation techniques or mini relaxation response exercises? Yes No
What did you do? _____ How often? _____

12) What goal did you set last time? _____

Did you accomplish it? Yes No If no, can you come up with a plan to help you succeed by identifying the obstacle and a solution to the obstacle?

Obstacle

Solution

FUNCTIONAL IMPACT OF PAIN

13) Did you miss social events, work, or other appointments this month because of your health?
 Yes No What did you miss and why? _____

14) Indicate the word that describes how, during the past 24 hours, pain has interfered with your:

General activity	<input type="checkbox"/> Not at all	<input type="checkbox"/> Some	<input type="checkbox"/> Often	<input type="checkbox"/> Completely
Mood	<input type="checkbox"/> Not at all	<input type="checkbox"/> Some	<input type="checkbox"/> Often	<input type="checkbox"/> Completely
Ability to work (in or out of home)	<input type="checkbox"/> Not at all	<input type="checkbox"/> Some	<input type="checkbox"/> Often	<input type="checkbox"/> Completely
Interactions with other people	<input type="checkbox"/> Not at all	<input type="checkbox"/> Some	<input type="checkbox"/> Often	<input type="checkbox"/> Completely
Sleep	<input type="checkbox"/> Not at all	<input type="checkbox"/> Some	<input type="checkbox"/> Often	<input type="checkbox"/> Completely
Enjoyment of life	<input type="checkbox"/> Not at all	<input type="checkbox"/> Some	<input type="checkbox"/> Often	<input type="checkbox"/> Completely

15) What did you do for fun or pleasure this month? Or what gave you pleasure this month? _____

16) Have you used any recreational drugs this month? _____

17) How many drinks of alcohol did you drink this week? _____ What kind? _____

18) How many cigarettes did you smoke this week? _____

19) How much caffeine did you drink this past week? _____ What kind? _____

20) How much candy, soda, or other sweets did you eat this past week? _____

21) The following could be medication side effects or from your underlying condition. Are you feeling/experiencing:

Symptom(s): Check box if present	Medication(s) or other condition(s) you think caused it:	How did you deal with it:	Do you want suggestions?
<input type="checkbox"/> Constipation:			<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Difficulty sleeping:			<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Dizzy, dopey:			<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Nausea/vomiting:			<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Difficulty waking in the morning:			<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Loss of libido:			<input type="checkbox"/> Yes <input type="checkbox"/> No

22) Any other physical complaints or questions you'd like your physician to respond to _____

Can this be discussed in group? Yes No *If no, please ask physician if you should make an appointment.*

23) Any feedback or suggestions you would like to share with the staff? _____

Name _____

Date _____

3 Day Food Log
Instructions for Completing the Food Log

Please complete this 3 Day Food Log for three consecutive days with one day being a weekend day.

- Record information as soon as possible after the food has been consumed.
- Do not change your eating behavior at this time unless your doctor advises you to. The purpose of this food record is to analyze your present eating habits.
- Describe the food or drink consumed. e.g., milk - what kind? (whole, 2%, or nonfat); toast - (whole wheat, white, buttered); chicken - (fried, baked, breaded), etc.
- Record the amount of each food consumed using standard measurements as much as possible, such as 8 ounces, 1/2 cup, 1 teaspoon, etc.
- Include any added items. For example: tea with 1 teaspoon sugar, potato with 2 teaspoons butter, etc.
- Please record all drinks, including water. List them in the “Drink” category.

Day 1

Time	Food	Amount	Time	Beverage	Amount
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

