Session 12

"The first day of the rest of your life."

A Vision of Healing

Check-in:

1. Share one or two items from your gratitude journal
2. One "pearl" – a thing you have figured out that you think might help others cope with their pain
3. What are some (2) areas you would like to focus on in continuing your healing path?

What do you want your health **FOR**? – pair up to share answers

Healing Plan and Coping with Stages of Pain
Appreciate Each Other!
Medication check

Homework: Continue to practice what you've learned from the program.

We will be offering a once a month group ongoing, though this will likely change after next month, when yoga groups will start.

First meeting March 17, same time as current group.

The Journey

One day you finally knew
what you had to do, and began,
though the voices around you
kept shouting
their bad advice --
though the whole house
began to tremble
and you felt the old tug
at your ankles.
"Mend my life!"
each voice cried.
But you didn't stop.
You knew what you had to do,
though the wind pried
with its stiff fingers
at the very foundations,
though their melancholy
was terrible.
It was already late
enough, and a wild night,
and the road full of fallen
branches and stones.
But little by little,
as you left their voices behind,
the stars began to burn
through the sheets of clouds,
and there was a new voice
which you slowly
recognized as your own,
that kept you company
as you strode deeper and deeper
into the world,
determined to do
the only thing you could do --
determined to save
the only life you could save.

~ Mary Oliver ~

The dictionary is the only place that success comes before work.
Anonymous

Every day you may make progress. Every step may be fruitful. Yet there will stretch out before you an ever-lengthening, ever-ascending, ever-improving path. You know you will never get to the end of the journey. But this, so far from discouraging, only adds to the joy and glory of the climb. - Sir Winston Churchill

A VISION OF HEALING

Become aware of your body, taking deep breaths, long and slow, breathing in through your nose and out through your mouth, or any way that feels relaxing and soothing to you. When you are relaxed and quiet inside, begin to imagine. . .

Begin to form a vision of yourself with healing, with your sweetest fruit, the thing for which you most yearn. Perhaps it is an absence of pain, perhaps it is a sense of vitality despite ongoing pain, perhaps it is the peace of acceptance of your current health and limitations. Having this sweetest fruit, the piece at the top of the tree, holds special meaning to you because it is the one thing that has seemed to elude you. Other things have come to you, but not this. So as you imagine this, you may feel strong feelings. These may be positive feelings – happiness, pride, gratitude, security – or difficult feelings, like anger, sadness, fear or guilt.

Please begin to form a vision of yourself – not the person next to you or your best friend – with no further suffering from pain, or isolation, or hopelessness. There may be waves of that particular discomfort, but those waves come infrequently, and for the most part they have little power. See yourself as having that aspect of healing for which you most yearn, and having an abundance of it, not smatterings, not just now and then, but most of the time.

See yourself moving through your day, deeply connected to yourself, plugged into your inherent strength, goodness, and wisdom, bringing up a nurturing inner voice that uses the tone and the words that you most need to hear, moment to moment throughout the day.

Form a vision of yourself keeping your fingers on the pulse of your inner life, feeling your feelings, letting them fade, and identifying your true needs. You fill yourself with positive, powerful thoughts and sidestep the thoughts that are powerless or negative. You step up to the plate and face life's essential pain, the unavoidable realities of the human condition. You move through life's unavoidable pain and you open your hands to receiving life's earned rewards. Life is difficult. But it is also wonderful. Some people will reject me, but I won't reject myself. I can't change the past, but I can change the future. I am alone, but I have myself, and if it is my belief, I have the spiritual.

See yourself fully committed to personal balance, to spending more moments of the day relaxed and in touch with your feelings, to doing the lifestyle surgery needed to keep your pain under control, to creating a manageable life for yourself. You have body pride, a sense of honoring your body and yourself, and an aversion to harming your body and yourself in serious ways. You take care of your body, being sensitive to your body's signals and giving yourself the health care and the self-care that you need. Your eating is reasonably balanced – you eat regularly and only when you are hungry, and you eat mostly healthy foods that support emotional balance and vibrancy. You have a life in which moving your body and enjoying your body, enhancing your endurance, strength, and flexibility is part of your day. You engage in meaningful pursuits, doing things in the world that matter. You take time to restore yourself physically, emotionally, mentally, and spiritually. Notice such a balance within you that you know you don't have to be perfect to be wonderful, that even when you cannot do the things you used to do you do not judge yourself. See yourself moving through your day with more happiness, more health, knowing that you have mastered these skills, that these are a part of your bones, and no one can take them away from you.

When you are ready, take a few deep breaths, reflect on what you just imagined, and take those images deeper into your inner life, and let them grow in your subconscious mind over the coming weeks..

Healing Plan

Name: Date:

Problems Diagnosed:

Risk Factors/Risk behaviors:

Strengths/Allies:

Goals:

Tools to use on an ongoing basis or resume in case of flare:

Diet/ Intestinal Health	
Exercise/Movement/Body Work	
Mind/Body/ Emotional Health/ Spirituality	
Vitamins/Nutritional Supplements/Herbs	
Standard Medical Therapies (meds, hormones, etc.)	

Be sure to consider sleep, hormones, infection, nutrition, detox issues

Coping with the Stages of Pain

Write a plan for additional measures to apply in a flare, from decrease in activities to adjustment of medications, calling friends for support, and so on.

Mild to Moderate Pain Increase:

Severe Pain Increase:

Panic Plan

Make a list of the options, techniques and skills you have to cope with pain flare-ups.
For my mind:

For my body:

For my spirit:

Make copies of this list to carry with you or keep handy in various places.

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FEEDBACK SHEET FOR HEALING GROUP

Name:_____ Date: ____/____/____

1) Please review your medication list and indicate any changes you have you 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	☐ Not at all	☐ Some	☐ Often	☐ Completely
Mood	☐ Not at all	☐ Some	☐ Often	☐ Completely
Ability to work (in or out of home)	☐ Not at all	☐ Some	☐ Often	☐ Completely
Interactions with other people	☐ Not at all	☐ Some	☐ Often	☐ Completely
Sleep	☐ Not at all	☐ Some	☐ Often	☐ Completely
Enjoyment of life	☐ Not at all	☐ Some	☐ Often	☐ 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?**
☐ Constipation:			☐ Yes ☐ No
☐ Difficulty sleeping:			☐ Yes ☐ No
☐ Dizzy, dopey:			☐ Yes ☐ No
☐ Nausea/vomiting:			☐ Yes ☐ No
☐ Difficulty waking in the morning:			☐ Yes ☐ No
☐ Loss of libido:			☐ Yes ☐ 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? _____
_____