Amplified Musculoskeletal Pain Syndrome (AMPS): A team approach to treatment

Presented by:
The Goryeb Children’s Hospital
AMPS Program Team

Disclosures
- Dr. Nativ: Novartis educational speaker for auto-inflammatory disorders (less than $10,000 received)
- No other disclosures from remainder of speakers

Objectives
- Participants will be able to define the term Amplified Musculoskeletal Pain Syndrome (AMPS)
- Participants will be able to identify the common features of an individual with AMPS
- Participants will be able to create an appropriate treatment plan for an individual with AMPS

Pain
- Subjective expression of an unpleasant sensation or emotional experience associated with actual or perceived tissue damage
- “Pain is what the patient says it is, and exists when he says it does”
- Prolonged malingering in children is exceedingly rare
Introduction

- 20-30% of children and adolescents with significant muscular fatigue and MSK pain
- DDX:
  - Infectious
  - Metabolic
  - Autoimmune
  - Oncologic
  - Mechanical
  - Genetic
  - Orthopedic
  - Other

Historical review of AMPS

- 1951: Naish and Apley study on pediatric limb pains that are non-arthritic in nature
- Reflex neurovascular dystrophy first described in a child in 1971
- Fibromyalgia in 1985

Pain Amplification Syndromes (AMPS)

- Diagnosis of Exclusion (lack of diagnostic testing)
  - Unclear definition
  - Lack of physical, laboratory or imaging findings
  - Pain
    - Maximal (10/10)
    - Allodynia, hyperesthesia
    - Psychologic distress associated with pain, but with indifferent affect (La Belle Indifference)
  - Multiple Somatic complaints
    - Headaches
    - Abdominal pain

Criteria for Different Subsets

- Complex Regional Pain Syndrome Type I: AKA: Reflex Sympathetic/Nerve vascular Dystrophy (RSD, RND)
  - Difficult to diagnosis
  - Immobile posture of affected area accompanied by burning pain, as well as allodynia
  - Patients will not walk, or allow any touch of the area
  - Accompanied by color and temperature with autonomic changes
  - Affected area is typically distal
  - Predominantly occurs in teenage girls
Criteria for Different Subsets of AMPS

- Complex Regional Pain syndrome Type II
  - Pain, allodynia, or hyperalgesia that is disproportionate to any inciting event
  - Edema, changes in skin blood flow evident-autonomic changes may or may not be evident
  - Exclusion of other diagnosis

- Childhood fibromyalgia (Yunus and Masi criteria):
  - **Major**
    - Generalized MSK aching at 3 or more sites for >3 months
    - Exclusion of other causes
    - Normal lab tests
    - 5 or more tender points
  - **Minor**
    - Chronic anxiety
    - Fatigue
    - Poor Sleep
    - Chronic headaches
    - IBS
    - Numbness
    - Pain with weather, anxiety or physical activity
Epidemiology

- Fibromyalgia frequency of 2-6% in pediatric population
- 5-8% of new patients
- Great increase over past 2 decades
- Age at onset
  - As early as 2 years old
  - Mean age is 12-13 years old
  - F>M 4:1
- No formal investigations include ethnicity involvement
- CHOP studies-disproportionately Caucasians

Pathogenesis of AMPS

- Genetic Factors
  - Known familial component with AMPS (also with IBS and TMJ)
  - ? Role of polymorphisms that inactivate catecholamines responsible for human stress response
- Other Factors
  - Physical Trauma-fractures, truncal injuries, microtrauma from hypermobility
  - Infections (Hepatitis, Lyme disease, EBV, parvovirus)
  - Emotional stressors-bullying, gender identity issues, psychological stress
  - Autoimmune disorders: JIA, SLE
  - Hormonal factors (?)
Clinical Characteristics of Patients with AMPS

- Disturbed sleep pattern → lack of restorative sleep, difficulty concentrating in school
- Poor stress and pain coping mechanisms
- School avoidance
- ADL
  - Headaches
    - Frontal
    - Numbness, paraesthesias
    - Arthralgias, myalgias worse after activity
    - Many cannot be touched
    - Lack of response to typical OTC medications
      - NSAIDS, Acetaminophen

Testing in Patients with AMPS

- Reasonable degree of testing should be done
  - Help reassure patients and physicians
  - Repeated or prolonged testing may prolong time to diagnosis and treatment
  - Referral to Pediatric rheumatology or experienced center dealing with AMPS

Pain Assessment

- No single instrument provides complete evaluation
- Vital Signs: Provide little information and not enough data to support reliability in AMPS
- Behavioral Measures:
  - CHEOPS
  - Videotaping
  - Unidimensional pain measures
    - VAS (visual analog scale)
  - Multidimensional pain measures
    - Varni/Thompson Pediatric pain questionnaires

Treatment Modalities

- Lack of clear understanding of pathophysiology=difficulty with treatment modalities
- Multidisciplinary Treatment Plan
  - Key=REASSURE, UNDERSTAND, REASSURE!!!!!!!
  - Sensitivity
  - Pain is real
  - NOT PSYCHIATRIC ILLNESS
Treatment Modalities

- **Goal of treatment**
  - Restore function
    - Back to school and normal age appropriate activities
    - Accommodations may be needed for school and gym
  - Education re: role of stress, sleep, pain, and exercise
- **Best course of Success**
  - Exercise-daily cardiovascular exercise
  - Physical therapy
  - Occupational therapy
  - CBT, psychological support

Treatment Modalities

- **Cognitive Behavioral Therapy:**
  - Helps patients control pain via guided imagery and distraction
- **Exercise Intervention:**
  - Chronic deconditioning and decreased functioning may exacerbate pain level
  - Cardiovascular exercise has positive effects on mood and physical functioning
  - Pain may be increased at onset of exercise
- **Occupational Therapy/physical therapy**
  - Intensive daily desensitization with experienced therapist
  - Sleep Hygiene

Pharmacologic Therapies

- Off label in children
- TCAs, SSRIs, CNS acting medications (pregabalin and gabapentin)
- Tramadol-variable efficacy in adult fibromyalgia
- Should be used as adjuncts not as primary therapy modality

Treatment options:

- Outpatient- IOP vs. piece meal approach
  - Goryeb IOP program only one in NJ
- Inpatient treatment center

Prognosis of AMPS

- Limited Pediatric studies looking at prognosis
- Better prognosis for children vs. adults
- Rate of relapse or long term functional outcomes are not known
The Team Approach:
- Coordinator
- Nurse
- Physical therapist/Athletic Trainer
- Occupational therapist
- Aquatic Therapist
- Cognitive Behavioral Therapist
- Art Therapist
- Music Therapist
- Physicians

15 year old Female
- 7 years old diagnosed with Chronic recurrent multifocal osteomyelitis (CRMO) of the femur.
- Pain management at 12 years old started on tramadol and lidocaine patch
- Increased dosages without pain relief
- Follow up with Rheumatology
  - Normal whole body MRI without any active inflammatory lesions suggestive of active CRMO
- Now 15 yo
  - Pain is hip/groin in nature bilaterally with radiation down the legs to the knees or whole leg. No numbness/tingling in legs, legs feel weak when has pain, no bowel/bladder changes
  - Screaming episodes at home
  - Avoidance of social activities “stuck in the house”

15 year old Female
- Diagnosed with AMPS
- Discontinued all pain medication
- Outpatient AMPS program at Goryeb Children’s Hospital
- At last follow up appointment
  - No episodes of intense pain/screaming
  - Cognitive Behavioral Therapy VERY helpful
  - Pain Currently 4-5/10, worse 8/10
- Baseline Currently 2/10, Best 1/10, Worst 10/10
- Planning to do a 5K race
- Off all pain medications
- Playing soccer for first time in 9 years
- Back to dance

11 year old Female
- Right Achilles tendon pain x 11 months with no inciting event/trauma
- Numbness and tingling, cold but no color changes
- Began in May 2015, saw Primary in September 2015, then Ortho 2015 - X-ray normal
- Ortho recommended walking boot
- Pain free December 2015
- Pain returned with no inciting event/trauma, walking boot then cast for 2 weeks - MRI normal
- Ortho diagnosed with CRPS and recommended PT
- Podiatrist second opinion recommended additional immobilization and ultrasound – normal
- We were third opinion/tie breaker!
- Pain is causing difficulty with sleeping, concentrating in school and walking (using crutches and walking boot)
- In school but resistant
- Out of gymnastics (competitive)
- Is a part of a trio of best friends and in September there was some friend issues with a big change in the friendship as well as the friend’s parents
- Per mom very much internalizes everything
- Walking with axillary crutches and walking boot, independent in ADLs.
11 year old Female
- Agreed with Ortho – CRPS
- Participated in AMPS Program at Goryeb Children’s Hospital
- Returned to school full time
- Returned to gymnastics
  - Very fearful of coach
- Back in PT other foot is hurting

16 year old Male
- Foot fracture at 10 years of age
- Foot pain for 1 month
- Using crutches and walking boot
- No inciting event/trauma
- X-ray normal
- Walking boot for 1 month
- X-ray normal
- Blood Work –
  - Nl cbc, bmp, RF, thyroid function, ESR, Lyme
  - EBV IgG +
- Pain worse with any movement, better with rest
- No relief with pain medication
- + Allodynia
- Limited ROM
- Skin color changes
- Quiet, VERY flat affect

16 year old Male
- Inpatient AMPS program at Children’s Specialized Hospital
- Back in school, pain returned with marching band, home instruction
- Outpatient AMPS program at Goryeb Children’s Hospital
- Back in school, home instruction
- Inpatient AMPS program at Children’s Specialized Hospital

16 year old Male
- Diabetes mellitus type I
- Migraines
- History of prolonged recovery from illnesses
- Chronic Lyme evaluation and AMPS suggested 1 year prior
  - Self treated with massage and gradual return to activity
- Now:
  - Freshman in college
  - Living on campus
  - 3 classes a semester
  - Walking with single point cane
- October 1st 2016 woke up with neck pain
- Progressively worsened
- Massage and OTC medications no help
- Ortho
  - X-ray straightening of spine
  - Tizanidine, naproxen, and gabapentin
- Stopped going to school
16 year old male

- Diagnosed with AMPS October 24th
- Started AMPS program at Goryeb Children’s Hospital October 31st
- Improvement in function after 2 weeks, no improvement in pain
- Week 3 symptoms worsened
- Completed program but back on home instruction

- Interventional PM&R trialed trigger point/MSK injections no relief

Goryeb Children’s Hospital Amplified Musculoskeletal Pain Program

- 4 week intensive outpatient program
  - Physical Therapy
  - Occupational Therapy
  - Aquatic Therapy
  - Cognitive Behavioral Therapy
  - Art Therapy
  - Music Therapy
  - Group Therapy Session
  - Parent Therapy Session

Admission Criteria

- 8 – 18 years of age
- Musculoskeletal based pain
- No medications are prescribed for pain
- Initial screening by Rheumatology and/or PM&R
  - Diagnosis of exclusion
  - Review work up to date

While waiting to begin program:

- Encouraged to participate in daily physical activity
- Go to/remain in school
  - No accommodations provided prior to start of program
- Continue with any psychological support already in place
During the Program:

- Must attend all sessions
- 2 & 4 week check in with physician
- Coordination of home instruction or excused from school
- At completion expected to return to school
- CBT frequently continues after 4 week program
- Goal is improvement of function NOT resolution of pain

Occupational Therapy:

- Desensitization
  - Heat, cold, smooth, rough
  - Daily home exercises
  - Activities of Daily Living
  - Upper Extremity Involvement
  - Yoga

Aquatic Therapy:

- Additional Modality for desensitization
- Warm Water Therapeutic
  - Sore muscles
  - Moving body
- Like/Dislike
  - Body image

The Role of Physical Therapy with the AMPS Population in the Outpatient Setting

Kristyn Holc PT, DPT
Objectives

- Understand how to provide a thorough physical therapy evaluation for a patient seeking treatment through the AMPS outpatient program
- Understand the components and goals for each week during the 4 week intensive program
- Understand the role of desensitization and how it is implemented during treatment sessions

General Overview

- Patient Population:
  - 12-18 years of age
  - Not attending school or ½ days only
- Therapy for AMPS Patients
  - 2 hours 4 days/week
    - 1 hour Group Training
    - 1 hour Physical Therapy
  - 5th day
    - Aquatic therapy/Occupational Therapy/Group Counseling session

Evaluation

- Subjective – history from patient and/or guardian
  - Insidious onset
  - Minor injury > 1 yr old
  - Rule out other diagnoses
  - Previous therapy?
- Objective – functional assessment (timed)
  - 1 lap equivalent to 100 yds
  - 10 squats
  - 10 push ups
  - 10 sit-ups
  - 10 TRX rows
- Assessment
- Pain

Expectations

- 100% attendance
- Do your best
- Learning the difference between pain and soreness
- Managing the pain
Week 1
- Introduction to exercise
- Discharge any assistive devices
- Education – pain vs. muscle soreness/fatigue
- Initiate homework
- Share individual goals with group
- Initiate manual therapy

Week 2
- Boot camp style
- Learning to work as a team
- Learning to encourage others
- Education on active vs. passive recovery
- Self-desensitization

Desensitization
- Goal: to decrease or normalize how sensitive a specific area is to stimuli
- Allodynia vs. hyperalgesia
- Both the physical therapist and the patient will perform desensitization

Week 3
- 100% effort with each exercise
- Reinforcement of good form
- Beginning to provide input with workouts
- Desensitization
Week 4

- Patient should be independent in all exercises
- Patients are leading workouts together
- Review goals from Initial Evaluation
- Home Exercise Program
- Perform baseline assessment and compare times from initial evaluation

Results

- 28 participants
  - 4 did not finish the 4 week program
  - 1 completed the 4 weeks but regressed and was referred to inpatient program
  - 23 completed program successfully and returned to school full time
  - 82% success rate

Challenges

- Return to school but unable to sustain momentum
- Stop completing HEP
- Psychological component

We must bridge the gap between the program and reintegration into daily life

Current Research

- Dr. David Sherry (CHOP) – Inpatient Rehab Program
  - Intense PT and OT 5-6 hours/day
  - One-on-one therapy
  - Desensitization
  - Average duration: 3-4 weeks
- “Pain is like a prison, sometimes all you need is a prison break.”

References

AMPLIFIED MUSCULOSKELTAL PAIN SYNDROME

COGNITIVE BEHAVIORAL THERAPY
Stacy Alper, LCSW
Goryeb Children’s Hospital
October 14, 2017

Cognitive Behavioral Therapy
& The Role of Psychotherapy in the AMPS program

- Help to Reengage in Life
- Improve quality of life
- Provide Education
- Explore emotions
- Explore any Resistance
- Teach Coping Skills
- Provide Support and Reassurance
- Build Confidence and Reinforce Strengths
SAM

Thought: My back hurts so much more. There is no way I can do this. I spend part of the physical therapy session in the bathroom crying. They don’t understand. I spend most of my time in bed. How do they expect me to run, and do planks and stuff. I can’t do this, I don’t want to do this. Nothing is going to help.

Feeling: Sad, frustrated, depressed, anxious, hopeless

Behavior: Doesn’t finish the program

SAM #2

Thought: My back does hurt more but I haven’t been exercising like this in a long time. I know now the pain is not dangerous and it won’t be dangerous for me to continue to do the exercises. This is not easy but I want to get better, I believe exercising and using the skills I have been learning will help me. I have done hard things before, I can do it again.

Feelings: hopeful, a bit frustrated with pain but motivated

Behavior: Does the workouts, talks about frustrations, using coping skills like abdominal breathing, changing any unhelpful thoughts, spending time with friends, playing guitar when she can.

Automatic Negative Thoughts

- Catastrophizing: Believing something is the worst it could possibly be.
- Should statements: Thinking in terms of how things, should, must out to be
- All or Nothing Thinking: Seeing things as “either-or” or “right or wrong” instead of in terms of degree
- Jumping to conclusions: Making negative conclusions of events that are not based on fact
- Emotional Reasoning: Believing how you feel reflects how things really are.
- Disqualifying the Positive: Focusing on only the bad and discounting the good

Visual Imagery

- Visual imagery involves creating a detailed mental image of a place where you feel at peace.
- A place where you feel free to relax and let go of all tension and anxiety.
- Soothing, peaceful images can slow your pulse and breathing and lower your blood pressure. They also trigger the release of endorphins. Endorphins interact with the receptors in your brain that reduce your perception of pain. Endorphins also trigger a positive feeling in the body.

STRESSORS

1. Psychological Consequences of Having Severe Pain
2. Family
3. School
4. Friendships
5. Social media
6. Activities
COPING BEHAVIORS

1. DISTRACTION TECHNIQUES
2. PRACTICE RELAXATION/MEDITATION
3. SELF TALK
4. EXERCISE
5. ACTIVITIES AND HOBBIES
6. SPEND TIME WITH FRIENDS AND FAMILY
7. GET PROPER REST

RAISING PAIN TOLERANCE

- ABDOMINAL BREATHING
- PROGRESSIVE MUSCLE RELAXATION
- MEDITATION
- VISUAL IMAGERY
- PAIN IMAGERY

Abdominal Breathing Better Known As “Belly Breathing”

1. Abdominal breathing exercise directions:
   a. Place one hand, palm side down, on your chest. Place the other hand, palm side down, on your stomach. Breathe slowly through your nose to a count of 3 or 4. Notice the motion of each hand. When you breathe in, does the hand on your chest move out or in? How much? When you breathe out, does the hand on your abdomen move out or in? How much?
2. Repeat three or four times.
3. Alternatives:
   a. As you inhale, imagine a healing color spreading throughout your body and as you exhale, imagine the color fading away.
   b. As you inhale, imagine a word that you want to bring into your body. As you exhale, imagine a word that you want to release from your body.
   c. As you inhale, imagine a word or phrase that you want to bring into your body. As you exhale, imagine a word or phrase that you want to release from your body.

Abdominal Breathing can help you achieve a state of relaxation because it has both sedative (physiologically calming) and meditative (mentally calming) effects.

How Meditation can help Reduce Pain

2. Meditation teaches the ability to more effectively handle distress and regulate emotions, and overall can improve coping skills that can lead to better pain management (Rosenzweig et al. 2010, Wachholtz & Pargament 2005)
3. Meditation can provide natural pain relief
4. Meditation can also provide a distraction from pain (Morone et al. 2008).
How Meditation can Help Reduce Pain

5. A meditative state can allow a person to achieve detached observation, in which the physical sensations are separated from the emotional and cognitive experiences of pain (Morone et al. 2008).

6. Changes in thinking allow the pain experience to be less distressing.

7. Structural changes in the brain and nervous system occur as a result of meditation as well (Salomons & Kucyi 2011).

Pain and healing imagery exercises

- **Healing imagery:** As always find a quiet comfortable place to sit or lie down and start your deep breathing. Then imagine yourself healthy and without symptoms. Imagine the positive energy flowing throughout your body producing joyful moods and physical well-being. Next imagine your body mending and healing itself.

- **Pain control imagery:** This imagery is designed to control pain through various imagery methods. First find a quiet relaxed space. Then start your relaxation breathing. Close your eyes when ready. Start by imagining in your mind an image of what you perceive the pain to look like, and then change this image into something that is manageable and not so frightening; something you feel confident about and can control. Explore this image for about 10 minutes. Then coming back to your safe place. When you are ready you can become aware of your surroundings and go about your daily life.

Progressive Muscle Relaxation Script

- Let us start by focusing your forehead; move your forehead a little more, a little more and then let go and relax your forehead. Relax until it becomes your head.
- Now focus your heart area, including opening your eyes and relaxing your eyes, and your mouth. Feel the temperatures, then let all the tension go and relax your face. Notice the sensations you are having in your face. What temperature do you feel… Do you feel warm or cool? Are your eyes heavy or light? Are they moving or似乎 you are a combination of both. Are your eyebrows raised?
- Focus your brow; close your eyes. With your index finger and your eyes closed, imagine your eyes. The temperatures are different in each eye.
- Focus your face; make sure you move your face gently to help the pain. Notice how your face feels.
- Focus your shoulders; bring your shoulder up to your ears and hold, hold, hold, and RELAX! What do you feel now? Are you starting to feel some and other parts?
- Focus your neck; imagine your neck gently pulling your head up to your hands.
- Focus your arms; imagine your arms gently pulling your hands up to your shoulders.
- Focus your chest; notice any sensations in your chest, and then relax.
- Focus your ribs; notice any sensations in your ribs, and then relax.
- Focus your stomach; notice any sensations in your stomach, and then relax.
- Focus your legs; notice any sensations in your legs, and then relax.
- Focus your feet; notice any sensations in your feet, and then relax.
- Finally, let us focus all the muscles we did together: your forehead, your face, your shoulders, your arms, and hands, and your stomach and legs, and your feet. Tighten these emotions (1, 2, 3 and RELAX). Notice how your muscles feel in your body-relaxing? Not all your tension flows away out of the body?

PARENT GROUP

- Focus less on pain “Don’t ask about pain”
- Reinforce functioning
- Defining the family other than pain and illness
- Spend time together with your significant other and or friends
- Support
Art Therapy in the AMPS Program

What is Art Therapy?

- Art Therapy is an integrative mental health and human services profession that enriches the lives of individuals, families, and communities through active art-making, creative process, applied psychological theory, and human experience with a psychotherapeutic relationship. It is used to improve cognitive and sensory-motor functions, foster self-esteem and self-awareness, cultivate emotional resilience, promote insight, enhance social skills, reduce and resolve conflicts and distress. *(American Art Therapy Association, 2017)*.
- The art therapist may adopt various approaches to art therapy, depending on how appropriate the approach is for the specific population, such as cognitive behavioral, humanistic, trauma-informed, etc.

Who Can Practice Art Therapy?

- Only an art therapist can facilitate art therapy.
- Art therapists must have a Master’s degree in art therapy.
- Art therapists are licensed and registered [ATR-BC](https://www.arttherapy.org) or working towards licensure.
- NJ has recently passed the LPAT (Licensed Professional Art Therapist) license that should go into effect within the next 2 years.
- Art therapists have extensive training in:
  - Psychology
  - Counseling
  - Psychoeducation
  - Human development
  - Art mediums
  - Multicultural awareness
  - Eclectic approaches in therapy
Benefits of Art Making

Beyond Relaxation...

- It fulfills a natural need to be creative
  - We all have an innate need to be creative, and making art is a great way to get in touch with that creative side that we may have put away since childhood.

- It offers a non-verbal way to communicate
  - Drawing or creating art can be an great outlet for expression, especially things that you may find hard to verbalize.

- Helps address feelings of isolation
  - Art is something you can do with others, without even needing to talk; just the act of creating something together has been shown to be positive.

- Improved sense of control
  - If there are other areas in your life in which you feel out of control, having an activity that you are able to direct and control can be very helpful.

Advantages of Art

- Use the whole brain (left and right hemispheres)
- Think in images
- Externalize and objectify feelings
- Allow spatial communication
- Create a permanent, visual record
- Decrease defenses — “back door” approach

Autism and Art: a Therapeutic Tool

- Use of art to facilitate cognitive and behavioral change in individuals with autism
- Art therapy can help children with autism improve social skills, communication, and self-awareness

Art therapy spectrum

- Expressive Arts Therapy
- Art Therapy
- ArtTherapher

Art and music activities and the creative art therapies? (Healing Arts offers both)

- Arts and Music Activities
  - The goal of the meeting or activity is to complete the activity, engaging creativity, and encouraging the healing benefits of creativity and art.

- Art and Music Therapy: Creative Arts Therapies
  - It’s only therapy when it’s facilitated by an art or music therapist!
  - The Creative Arts Therapies are mental health professions practiced by registered art or music therapists who use art and music as the modality to reach specific therapeutic goals.
What is therapeutic art?

“Therapeutic”, NOT therapy.

- Therapeutic art does not = art therapy
- Does not need to be facilitated by an art therapist
- Art created by oneself
- No set goal

“Therapeutic”, NOT therapy.

Art as therapy vs. Art psychotherapy

- Healing comes from the act of creating art rather than focusing on the final art product
- Process oriented
- Facilitated by art therapist

- A combination of art making, final product, and therapeutic dialog
- To gain a greater understanding of one’s own conscious and unconscious thoughts
- Product oriented
- Facilitated by an art therapist

When to refer to an art therapist?

- If you would like further information about the therapeutic uses of art
- If you would like more information from a professional who has specialized in art therapy
- If the client/patient...
  - is emotionally blocked.
  - overly intellectualized.
  - expresses himself/herself more easily through visual images.
  - experiences intense affect during or after an art process.
  - has preverbal trauma.
  - has unresolved trauma, grief, or difficulty making a developmental transition.
  - artwork is disturbing to you or if you have questions on how to respond to it.

Art Therapy in AMPS

- The goals of art therapy within the AMPS Program is to provide a safe place for pre-teens/teens to explore and express their feelings using visual media, to employ art making as a coping tool to deal with their pain, to increase self-esteem, and to cultivate identities beyond their pain.
- Art Therapist worked with the AMPS staff to help monitor and inform changes in patient cognition, behavior and motivation; offer insight into the child’s creative process and ability to cope
Art Therapy with AMPS patients

• Brief therapy – building trust/rapport
• Balance between structure and freedom
• Focus on art as therapy with some processing at the end of group

• Themes explored through art directive during the four weeks:
  • Creating a vision board
  • Identifying goals and motivations for change
  • Constructing a feeling mask (two weeks)
  • Identifying, expressing, and containing emotions
  • Reframing a pain scribble
  • Fostering resilience through cognitive restructuring of pain

Vision Boards

RW, Age 16
HF, Age 18
TVW, Age 16

Mask Making

GO, Age 15
RW, Age 16

Reframed Pain Scribble

RW, Age 16
Challenges with the AMPS Population
Coordination of Multidisciplinary Care

Getting Started

Once a patient has been identified as a candidate for the AMPS program by one of our physicians, they are referred to me for details about the program. I have a packet of information that I send out to them that includes detailed instructions for admission to the program. It has been our experience that this population is often very interested in the program in theory but when they are faced with the reality of a 4 week commitment to daily appointments at multiple facilities, the interest wanes.

Paperwork

- An overview of AMPS in layman’s terms
- Instructional “checklist” on how to get started in the program
- Insurance worksheet for the CBT services
- Release of Medical Information – needed for us to communicate with schools
- Instructions on how to complete the release of medical info form
Building the AMPS program

- Our program is housed at 3 different locations, making it necessary for patients who do not drive to have transportation Monday – Friday.
- Our program is not bundled with the insurance company so each therapy service is billed individually – uses up the sessions/calendar year quickly.
- Art and Music therapy added with money donated through the Atlantic Health Foundation.
- Some of the facilities have parking fees.
- Rules about how much access parents should have during therapy sessions.

When do we say “enough is enough” to patients not compliant with the program

- One of our biggest challenges is determining when to discharge a patient from care who is non-compliant with appointments.
- Missed appointments have an impact on the other participants yet we understand that it is most often the level of parental commitment that leads to absences.
- Parents often have their own mental health issues that get in the way of patient participation.

Visions for the future

- Work with insurance companies to bundle the therapy services so it becomes a program fee vs. individual therapy session fees.
- Find a single facility that can accommodate all the therapy services included in the program.
- Offer an after school program so that patients that are still attending school do not have to be pulled out for 4 weeks.
- Offer family therapy services.
- Post program services to keep patients from relapsing.

Final Thoughts

- Very Complex Population
- Functional improvement is goal not pain control
- Physical and psychological approach
- Some patients just will not be ready
- Will not reach/help everyone
- Therapy is just the beginning
Thank you!

Questions & Answer