

Interdisciplinary Rehabilitative Treatment for Prolonged Chronic Pain:

The Critical Role of Integrated
Cognitive Behavioural Therapy

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The Concept

A careful integration of medical science (including psychiatry) with behavioural science to insure that the strengths of both the medical model and the cognitive-behavioural are brought to bear on treatment and do not conflict and thus undermine each other.

The Model

Simultaneous and integrated interdisciplinary assessment and treatment¹;

Significant reliance upon behavioural medicine field therapist working with the patient in his/her own environment¹

¹ see Marlin et. al. (1998) and Cott et. al. 1990

The Model

Utilization of Disease-Illness₁ Distinction and recognition that disease is but one determinant of illness.

Recognition that non-disease determinants of illness are as valid, real and powerful as disease determinants.

¹see Mechanic (1961) and Cott et al (1990)

The Outcome Data

Of 89 treated patients who had been off work, on disability an average of 61.5 months (range 28 to 216); 58 (65%) reached a level of function that they were employable, and sustained that level during the 6 months of follow-up after disability benefits ended.

The other 31 remained on disability benefits.

When active treatment ended:

of the 58 successful patients:

29 were working, full-time

2 were working part-time

18 were actively seeking work, and

9 had elected to retire or retrain

Demographics

All had a diagnosis of Chronic Pain Syndrome;

72% had one or more additional diagnosis(es);

Mean age: 44 years

Percent male: 31%

Mean duration of treatment: 47 weeks

Details of the Interdisciplinary Model

The Role of the General Internist

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The All-Important Interview

Building rapport and trust;

Patient's account of issues/difficulties;

Outlining “the big picture”; getting a sense of priority;

Order:

- Priority list of difficulties

- Systems Review

- Past Health

- Current/Past Drug Therapy

- Social/Family History

Some Interesting Questions

What do you think is wrong with you?

Do you have any hidden fears/worries about your health?

Are you happy with your medical care to date?

Are there any things that I have not asked you about that you think we should hear from you?

Physical Examination

Often necessary to have a general overview

May require referral to specific specialist

Repeated examinations may be necessary in exceptional cases to reassure both patient and physician

Assessment of Definable Disease/Pathology

Interview

Examination

Review of previous consultations/investigations

Is the patient under optimal medical management?

Are there contra-indications to increased physical activity?

Does the definable disease/pathology alone establish any irreducible limitations to function?

Are there any medical issues that could undermine the psychological or behavioural intervention?

Why a General Internist?

Medically Unexplained Symptoms By Specialty

Rheumatology	Fibromyalgia
Infectious Disease	Chronic Fatigue Syndrome
Gastroenterology	Irritable Bowel Syndrome
Neurology	Chronic Headaches
Cardiology	Noncardiac Chest Pain
Urology	Irritable Bladder Syndrome
Gynecology	Chronic Pelvic Pain
Allergy	Multiple Chemical Sensitivity Sick Building Syndrome
Oral Surgery	TMJ Syndrome

Ten Commandments

1. Complete clinical overview is the starting point.
2. Do not make derogatory comments to the patient such as “it’s all in your head”.
3. Do not engage in arguments with the patient over their diagnostic beliefs.
4. Be prepared to discuss current popular and fad diagnoses such as twentieth century disease, chronic candidiasis, etc.

Ten Commandments

5. Avoid multiple referrals and self-referrals to self-appointed gurus on the disease-of-the-month as they reinforce the patient's belief that his physical symptoms are due to a physical illness that has so far defied diagnosis.
6. Avoid lengthy, repeated and extensive investigations as they may create "an illness maintenance system" that reinforce the patient's beliefs.

Ten Commandments

7. Do not forget the importance of reassurance.
8. Don't denigrate the efforts of others unless it is clearly harmful.
9. Don't get into arguments about the value of various herbal preparations etc. unless they are clearly harmful.

Ten Commandments

10. Keep an open mind. Remember the epitaph on the ‘psychosomatic’s’ gravestone:

“See, I told you I was sick!”

The Role of Psychiatry

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Psychiatrist

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**Are there any clear DSM-IV
Axis I disorders?**

If so are they under optimal
pharmacological
management?

**Are There Other Symptoms
That Meds Might Help?**

Potentially Pharmacologically Responsive Symptoms

Pain

Sleep disturbance

Fatigue, decreased energy

Executive dysfunction – concentration,
memory, difficulties multitasking

Dysphoria esp. in context of past
personal or family hx of depression

Pharmacotherapy

Pharmacotherapy is done in the background of the primary treatment modality (CBT; activation)

Psychopharmacology

Pain:

Non-narcotics from the “psychiatry family”:

tricyclics (amitriptyline, nortriptyline)

venlafaxine

gabapentin

pregabalin

Psychopharmacology

Sleep disturbance:

sedative antidepressants (mirtazepine, trazodone, doxepin, amitriptyline);

hypnotics – zopiclone;

benzodiazepines;

sedating 2nd generation/atypical antipsychotics

Psychopharmacology

Fatigue:

psychostimulant e.g. methylphenidate,
dextroamphetamine;

modafanil may be very helpful;

bupropion

Psychopharmacology

Anxiety

SSRIs;

SNRIs;

benzodiazepines;

2nd Generation/Atypical
Antipsychotics.

Is any of the current
pharmacotherapy
contraindicated from either a
psychiatric or psychological
standpoint?

Do No Harm

The majority of patients assessed are already on antidepressants and/or have had adequate drug trials.

If the diagnosis is depressive disorder, NOS and further drug treatment is unlikely to be of benefit then the role of the psychiatrist is often to reinforce that **NO** further drug interventions are indicated.

Do No Harm

Excessive drug treatment is not helpful:

- Reinforces a 'medical' model of illness;

- Encourages abdicating personal responsibility;

- Reinforces patient passivity and 'waiting' for improvement to occur;

- Undermines the cognitive-behavioural model

The Role of the Psychologist

Assessment

Evaluation of cognitive and emotional functioning;

Identify psychological and behavioural factors contributing to discomfort and disability (beliefs, habits, fears, external stressors, characterological features, operant and Pavlovian variables, family and social factors, workplace.....)

Treatment

Primarily Cognitive-Behavioural
Treatment:

Asmundson et. al.

Gatchel and Turk

Craig

McCracken

Gheldof et. al.

Meichenbaum

Fordyce

Linton et. al.

Vlaeyen et. al.

Treatment

Intensive (3 hrs once or twice per week);

Individualized (start where they are at, finish where they want to be);

In their environment (home, community, work);

Gradual and therefore lengthy (6 to 12 months);

Treatment

Comprehensive (pain management; activation; exercise; scheduling; sleep hygiene; medication change/reduction; family therapy; parenting; vocational assistance.....);

Collaborative (other health-care providers, family, employer, insurer.....)

The Cases

Ms. A.

Ms. A.

46 years of age, off-work 9 years, airline customer service agent, chronic pain syndrome, major depressive disorder, generalized anxiety disorder, panic disorder, borderline personality disorder, significant use (and misuse) of opioids and benzodiazepines;

The Cases

Ms. B.

Ms. B.

50 years of age; off-work 8 years; manager of public relations international firm; history of breast cancer, post-mastectomy pain syndrome; on modest dose of methadone (15 mg, t.i.d.) but measurable cognitive impairment; major depressive disorder.