CBT Helps Patients Regain Lives, Despite Pain

Opioid therapy offers only partial relief, and even surgery often fails to alleviate symptoms.

BY BETSY BATES
Los Angeles Bureau

PALM SPRINGS, CALIF. — Physicians who doubt that chronic pain patients need and deserve cognitive-behavioral therapy as an adjunct to other treatments need to take an honest look at how well modern medicine treats pain, Dennis C. Turk, Ph.D., said at the annual meeting of the American Academy of Pain Medicine.

Opioids reduce severe, chronic pain by only about a third. Moreover, up to 50% of patients discontinue opioid therapy because of a lack of efficacy or because of side effects.

At the end of interventional pain trials, the vast majority of patients have improved so little they would still qualify for a new trial. Even surgical procedures that sever neurologic pathways believed to be responsible for a patient's pain often fail to alleviate the symptoms.

"Our best efforts still by and large don't cure people," said Dr. Turk, professor of anesthesiology at the University of Washington, Seattle.

Pain is real, but it is a subjective perception "resulting from the transduction, transmission, and modulation of sensory input filtered through a person's genetic composition and prior learning history and modulated further by [the person's] current physiological status, idiosyncratic appraisals, expectations, current mood state, and sociocultural environment," he said. In other words, "that arm or neck or shoulder is attached to a human being with a social context and with a history."

Underlying physical pain are emotional responses: fear, uncertainty, demoralization, and worry about the future. A family is involved, suffering as well.

Offering or referring patients for cognitive-behavioral therapy (CBT) acknowledges that pain may not be curable in every patient and that life must go on around it. It also gives patients credit for being capable of actively processing information and learning adaptive ways of thinking, feeling, and behaving, Dr. Turk said.

The exact CBT technique used is less important than the characteristics of the approach in general, according to Dr. Turk. All CBT should be:

- Problem oriented.
- Time limited.
- Educational.
- Collaborative (between patient and provider, perhaps family members as well).
- Practical, using clinic and home exercises to consolidate skills and identify problem areas.
- Anticipatory of setbacks and lapses and able to teach patients to deal with these.

In the context of pain, CBT can be particularly effective in helping patients reconceptualize their problems, making seemingly overwhelming hurdles become manageable.

It can help patients to believe they have the skills necessary to solve problems, transforming them from being passive and helpless to being "active, resourceful, competent," Dr. Turk said.

By utilizing real examples in a patient's life, CBT can help individuals recognize unhelpful thinking patterns such as overgeneralization, catastrophizing, seeing things in all-or-none terms, jumping to conclusions, selectively focusing on details rather than the big picture, and mind-reading the thoughts of others.

A CBT therapist then helps a patient learn to recognize problems associated with a life of pain and then propose his or her own adaptive solutions. Examples might include feeling bored and restless because of diminished activities, experiencing disharmony in family members due to altered roles, or suffering diminished self-esteem when a patient in chronic pain can no longer work.

A good CBT therapist guides the patient to set realistic solutions approached with step-by-step goals, practiced in sessions and during homework sessions tracked with diaries and charts.

Dr. Turk said he makes success highly attainable from session to session. For example, if increased mobility is a goal and the patient already believes he can walk 1 block, he sets the bar at walking 8/10 of a block every few days for the first week.

Monitoring, reinforcement, listening, and adapting to changing realities are all key to CBT success. Perhaps most important is the anticipation of nonadherence. Right from the start, a therapist can tell patients to expect flare-ups in pain and "slip-ups" in behavior, and a plan can be devised to deal with those situations before they occur.

To illustrate how CBT can work, Dr. Turk recounted the case of an elderly woman with chronic neck pain so severe that her husband retired from his job to care for her. During CBT she identified inactivity as a problem and set a goal of beginning to cook again. A plan was established for her to prepare one meal a day.

During her next visit, the patient's checklist revealed that she had not kept her goal. It seems her husband became nervous when she would begin to cook, telling her she should rest because she "didn't look too good." He would then prepare the meal.

In this case, moving forward with the CBT plan first required a "husbandectomy," in which the husband was encouraged to attend some activities at a nearby senior center so that his wife could begin to regain her self-esteem and meet her self-defined goals. ■

The 10 Rules of CBT Adherence

1. Anticipate nonadherence.
2. Consider the prescribed regimen from the patient's perspective.
3. Foster a collaborative relationship based on negotiation.
4. Prepare for flare-ups.
5. Customize treatment.
6. Enlist family support.
7. Provide a system of continuity and accessibility.
8. Make use of other health care providers (such as occupational or physical therapists) as well as community resources.
9. Repeat, repeat, repeat everything.
10. Don't give up! Pain specialists represent Ellis Island or Lourdes to chronic pain patients. If they were easy patients, "they wouldn't be seeing you."

Source: Dr. Turk

Psychiatric Disorder Rate High Among Regular Opioid Users

BY MIRIAM E. TUCKER
Senior Writer

VANCOUVER, B.C. — Psychiatric disorders are common among people taking opioid medications, Mark D. Sullivan, M.D., reported at the annual meeting of the American Psychosomatic Society.

Common psychiatric disorders were present in 45% of opioid users and 12% of nonusers.

DR. SULLIVAN

Data from the first population-based investigation of psychiatric comorbidity among patients receiving regularly prescribed opioid medication suggest that common depressive or anxiety disorders may pose a greater clinical problem among candidates for chronic opioid therapy than does substance abuse, said Dr. Sullivan of the department of psychiatry at the University of Washington, Seattle.

Moreover, the findings also point to unmet needs for mental health care among patients routinely receiving prescribed opioids. "We need to carefully assess and treat mood and anxiety disorders in patients who are candidates for chronic opioid therapy," Dr. Sullivan said.

Among 9,279 respondents to a nationwide telephone survey conducted in 1997-1998, 2.7% (252) reported regular use of prescribed opioids "at least several times a week for a month or more." All respondents were assessed for common psychiatric disorders with the World Health Organization's Composite International Diagnostic Interview (CIDI) and for substance abuse via an adaptation of the CIDI for drugs and Alcohol Use Disorders Identification Test (AUDIT) for alcohol.

Common psychiatric disorders were present in 45% of the opioid users, compared with just 12% of the nonusers. Most common was major depressive disorder, in 29% vs. 9%, followed by panic disorder, in 18% vs. 3%.

Problem drug use was also more common among the regular opioid users (7% vs. 2%), but the proportions reporting problem drinking did not differ (7% vs. 6.5%), Dr. Sullivan reported.

Prior to adjustment for various demographic factors, patients with a mood or anxiety disorder were six times more likely than those without to be regular opioid users. When looking at the effects of individual psychiatric disorders, those with panic disorder were seven times more likely to receive opioids, while patients with depression, dysthymia, or problem drug use were approximately four times more likely to receive opioids.

And even after adjusting for significant demographic and clinical predictors of regular opioid use—including age, education, income, work disability, self-rated health, and chronic back pain and headaches—patients with a common psychiatric disorder were still more than three times as likely as those without psychiatric diagnoses to receive regular opioids, Dr. Sullivan said. ■

"I can prescribe some happiness or we can sweat through the details."