THE PSYCHIATRIST'S TOOLBOX

We Must Reclaim Our Specialty

A friend of mine, a 42-year-old woman, called me a few weeks ago and asked about some lower back pain she was experiencing. She had no history of arthritis or rheumatism, had suffered no recent back injuries, had not physically exerted herself, and is in good health.

She reported that, while sitting with a financial counselor, planning her son's college expenses, the counselor raised the issue of her retirement. My friend remembers saying, "I don't have anything but a small 401 something or other." The next morning, she could hardly get out of bed because of excruciating lower back pain. The pain didn't leave her fully for at least 2 days.

BY ROBERT T. LONDON, M.D.

You don't have to be a psychiatrist to diagnose the cause-and-effect relationship between the stress and tension generated from the fear that she might be going through middle age and on to old age without a proper way of financially caring for herself later on.

Some of the fine orthopedic and neurosurgeons I've known over the years could assess this in a moment or two and solve a patient's problem quickly, or if the problem ran a bit deeper, make a referral to a psychiatrist. In the name of good medical care, they would do an examination and order an MRI scan first. Then they'd make the referral—hopefully to a psychiatrist doing some form of behavior modification or cognitive therapy.

Lower back pain, medical and surgical sources show, is one of the most common causes of lost work days and disability. Often, the pain arises from an emotional stressor or set of stressors, possibly an emotional trigger point from a previous injury. In the case of my well-adjusted friend, the cause was pure stress. She is now fine.

Sometimes, though, the stressors are not immediate—arising instead out of long-established life patterns of rage, frustration, guilt, emotional insecurity, or ongoing fear, as various psychotherapeutic theories have suggested. Whatever the cause, the reeducation and relearning processes offered by a psychological intervention should be among the first lines of treatment when organic causes have been ruled out. But the acupuncturists, chiropractors, biofeedback experts, hypnotists, and massage therapists seem to get the referrals first. So I ask: Why?

The reason is simple. The predominance of psychoanalytically oriented therapy as a treatment has seriously slowed the progress of various other psychological modalities of psychiatric/psychological care and prevented them from finding a place in the treatment of psychosomatic illnesses.

For many years, theoretical constructs of trying to work out the unconscious conflicts that generated these symptoms were the emphasis in the treatment. In other words, understanding and resolving the conflict, if possible, was the treatment.

As other modalities, such as biofeedback, acupuncture, hypnosis, massage therapy, and chiropractic practice developed, they offered relief of the symptoms. Such results were a joy to referring physicians who wanted to refer their patients for relief, not necessarily understanding. To make matters more complicated, the psychoanalytically oriented world of therapy even negated treatments that removed symptoms. They suggested that symptoms, if psychological in nature, would then occur elsewhere (symptom substitution) if removed.

There are, however, theories centering on how the brain and the autonomic nervous system process information, and I believe some of these have great merit in working with psychosomatic illness if used differently from the psychoanalytical, conflict-resolution type model that works on transferences, suppressions, and repressions.

In the older theories of Dr. Franz Alexander and Dr. Helen Flanders Dunbar, aggressive and anxious thoughts and excessive worry, respectively, both lead to stress and tension, which can lead to muscle spasms and pain. By integrating learning theory—not psychoanalytic theory—in the form of behavior modification or the various forms of cognitive restructuring, to educate and challenge what's happening to the patient in the form of the psychophysiological illness, the theories become more viable, practical, and economical. In addition, positive results are obtained.

Perhaps the best part is that these results occur without using years of therapy and with fewer gadgets, scalpels, or acupuncture needles. It's not that the gadgets, feedback, and needles don't work. Often they do, but good, current, noninvasive relearning psychotherapy does just as well.

Unfortunately, psychotherapy seems to be last on the list, which doesn't give us much of a chance. So many times the referring physicians, not knowing newer techniques of psychiatric/psychological treatments, will suggest psychiatric intervention, but not in a very encouraging or supportive way.

In the early and mid-20th century, many referrals were made to psychiatrists and psychologists for psychosomatic problems, without much success. The patients remained in therapy for years, with maybe some understanding of their problem but with limited clinical change. When the gadgets, massages, acupuncture, biofeedback, and chiropractic came along, they led to positive, reasonably quick results, compared with psychoanalytically oriented therapy. Furthermore, insurance often covers the techniques involving gadgets and needles, and the short-term behavioral/cognitive approaches as well.

WOW. Contemporary nonpsychiatric physicians don't really know about the shorter-term treatments for many mental disorders, let alone the psychosomatic ones. Organized psychiatry has not exactly led the way in educating nonpsychiatric physicians in the newer techniques or in creating an educational matrix in which training programs go beyond teaching newer cognitive/behavioral techniques by making sure that trainees know how to use them. Almost everyone with whom I speak in psychiatry and psychology these days knows about cognitive-behavioral therapy, behavior modification, or dialectical behavioral therapy, but when asked to treat a person in any of these modalities, the response too often is "It's too hard" or "I don't have time."

Don't have time? These approaches work relatively quickly and are rewarding. The traditional psychotherapeutic techniques do not appear to offer positive results in these psychophysiological problems. Oftentimes, many patients simply drop out of long-term therapy ("Placing Short-Term Therapy First," The Psychiatrist's Toolbox, October 2005, p. 28).

Some years ago, a neurosurgeon referred a patient who had been operated on twice for a structural back injury secondary to a high school football injury. His pain continued, and surgery, although successful, was no longer indicated.

The patient, a 40-year-old executive, recalled his rather stern, controlling, domineering father. Furthermore, the pain was exacerbated when this executive had to deal with controlling figures in the workplace. After I talked with the patient, it became clear that he had disappointed his father because the injury had prevented him from playing college football.

I used an educational psychotherapeutic approach with this patient. Within 12 weeks, he learned to make the connection and to challenge his symbolic, unwitting thinking related to authoritarian figures, and he became essentially pain free. In the process of relearning (using the learning component of my learning, philosophizing, and action method), I integrated the ideas of Dr. Alexander and Dr. Dunbar to further teach and illustrate psychic processing in relation to physical symptoms.

We in psychiatry can reclaim much of the talk therapy and expand our treatments if we focus on learning and behavior modification techniques, which allow us to offer methods to alter thoughts that lead to behavioral problems—and unwanted physical symptoms.

Let me know what you think about treating psychosomatic illness, and I'll try to pass your thoughts along to my readers. ■

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Oral Appliances a Top Option for Mild to Moderate Apnea

BY KATE JOHNSON
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MONTREAL — Oral appliances are equally effective as continuous positive airway pressure therapy in patients with mild to moderate obstructive sleep apnea, but not in those with severe disease, according to a randomized trial.

"We've now shown clearly that oral appliances are a viable option that can be considered alongside CPAP [continuous positive airway pressure] therapy in mild to moderate cases," Dr. Aarnoud Hoekema said in an interview. "Oral appliances are still a subject of much debate. In some clinics, they are used as secondary therapy only when CPAP therapy fails. Other clinics might use them only in patients with mild sleep apnea."

His study, which he presented at the Eighth World Congress on Sleep Apnea, randomized 103 patients with obstructive sleep apnea to either CPAP (52) or oral appliance therapy (51).

Treatment effectiveness was evaluated by polysomnography after 8 weeks, and was defined as either a reduction in the apnea-hypopnea index (AHI) to below 5, or an AHI reduction to below 20 if this represented at least a 50% reduction in AHI and also rendered the patient symptom free.

A total of 50 patients were classified as having mild to moderate sleep apnea, defined as an AHI of between 5 and 30, while the remaining 53 patients had severe disease, with an AHI of more than 30, reported Dr. Hoekema, who is a dentist and research associate in the department of oral and maxillofacial surgery and maxillofacial prosthetics at Groningen University Hospital in Groningen, the Netherlands.

Overall, the study found that treatment was effective for most patients in both the oral appliance (76.5%) and the CPAP (82.7%) groups. In this comparison of the groups, oral appliance therapy met the predefined criterion for noninferiority, Dr. Hoekema said. But when the results were subanalyzed based on the severity of sleep apnea, oral appliance therapy was inferior in patients with severe disease, resulting in a 69% success rate, compared with 85% for CPAP. In the subgroup of patients with mild to moderate disease, oral appliance therapy was not inferior, with an 84% success rate, compared with an 80% success rate among patients using CPAP.

In mild to moderate patients, it might make sense to consider oral appliances first, he said. ■