

THE PSYCHIATRIST'S TOOLBOX

Psychiatry and Medicine Working Together

A recent column I read in *CLINICAL PSYCHIATRY NEWS* ("Bouncing Back From Serious Illness," April 2005, p. 98) took me back to therapy groups I ran for cancer patients in the 1970s with Dr. Edward Amorosi, a hematologist/oncologist at New York University Medical Center.

I remembered many of the issues members of those cancer groups had to face while they were receiving chemotherapy or had recently finished a course of it ("Concept Worth Another Try," May 2003, p. 13). Sometimes, the patient's dignity was shattered. At other times, the patient felt hopeless and experienced decreased self-esteem, in addition to anger and a sense of despair.

The groups worked well. Dr. Amorosi participated in some sessions by adding an educational piece about cancer, and did so in a way that made patients feel comfortable: He didn't wear a white coat, and he loosened his tie.

We addressed some of the intellectual constructs surrounding the illness and explored ways in which patients could "bounce back." The techniques used were wide ranging; no particular format of group therapy dominated.

Those groups ran almost weekly for about 5 years, not including holidays and summer breaks. As time passed, the patients' need to address specific problems of pain control emerged more and more, as

did phobic responses that led to their avoiding, or wanting to avoid, chemotherapy. Learning to control nausea and vomiting during chemotherapy emerged as a major concern.

Over time, global questions—such as, Why did this happen to me?—lessened, as did some emotional expression. Among those patients who attended over a period of time, the group's focus shifted to discussions about specific ways to cope with some of the symptoms noted earlier.



BY ROBERT T. LONDON, M.D.

In those early days of my career, I was in the process of developing my learning, philosophizing, and action (LPA) treatment of specific habits, anxieties, problems of pain control, and phobic responses through my work at NYU Medical Center/Bellevue Hospital, where I was directing the short-term psychotherapy program. We

were using behavior modification and cognitive approaches, as well as hypnotic strategies, to address a myriad of psychiatric and medical problems.

At the time, I used several techniques with imagery to treat headaches. Migraine sufferers often report nausea as part of the symptom complex of their vascular headaches. So when chemotherapy patients in the group were concerned about nausea and vomiting, it was natural to offer a strategy similar to one I had used for the treatment of nausea related to migraine and vascular headache.

Using the Hypnotic Induction Profile as

developed by Herbert Spiegel, M.D. (in "Trance and Treatment: Clinical Uses of Hypnosis" [New York: Basic Books, 1978] by Herbert Spiegel, M.D., and David Spiegel, M.D.), I measured the hypnotizability of the patient before I embarked on a strategy to help control nausea with—or with less—medication. Those who were in the mid to high range of hypnotizability were good candidates for the same strategy I had used in vascular headache sufferers. I did not offer this procedure to minimally hypnotizable patients who did not think they would benefit from this approach. Instead, I found other avenues of referral, such as biofeedback, for those patients.

The technique was straightforward. After teaching a patient how to induce relaxation using the hypnotic induction described earlier, the conceptual image of "cold" was used to cool, chill, and even freeze the air that the patient breathed.

The learning and philosophizing phases of this technique were explored in the group setting, but we entered into the action phase of LPA straightaway: The patient would sit comfortably in a chair, using a simple, rapid technique of relaxation/hypnosis.

When this state was achieved after 2-3 minutes, the patient was taught to imagine wearing an ice-cold helmet, or opening a freezer door and being hit with a blast of ice-cold air.

Then—to continue the imagery—I told the patient to breathe in that cold, cold air, thereby cooling and chilling the food pipe (esophagus) as the cold emanated from the imaginary helmet or freezer. The cooling

and chilling would lead to a sense of numbness not only of the esophagus but also of the stomach.

These chilling and numbing sensations could then have the effect of controlling or stopping the nausea. I used a full hour to teach this method, allowing patients, of course, to make any modification that would improve the strategy. I always encouraged patients to practice this technique for a few minutes at least 10 times per day to ensure that they would know what to do if they became nauseated after chemotherapy.

For some patients, this hypnotic imagery method worked very well to help control nausea and the subsequent vomiting. Controlling vomiting once it had already begun was beyond the scope of our approach. Instead, our aim was for the patient to avoid vomiting in the first place or slow it down after it started, or even to reduce the patient's need for antiemetic medications. For some of the patients and for me, the results were pleasing.

As psychiatrists, we can offer these alternative mental processing techniques to help relieve some of the pain and suffering these cancer patients experience.

In future columns, I will discuss treatment strategies for pain and the phobic responses of this patient population. Let me know about your experiences treating the problems of cancer patients on chemotherapy, and I'll try to pass those ideas along to my readers. ■

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Somatization Scores May Predict Success of Outpatient Tx for Headache

BY COLIN NELSON
Contributing Writer

BOSTON — A test measuring somatization can predict which patients with chronic headaches will benefit from outpatient care and which ones won't—and will instead require intensive inpatient therapy, according to a new study.

The next step is to explore whether it is possible to calculate an exact cutoff score that would signal which patients should skip outpatient care and go directly to inpatient therapy, Dana Brendza, Psy.D., and associates suggested in a poster presented at the annual meeting of the American Pain Society.

Dr. Brendza and associates at the Cleveland Clinic studied the medical records of 213 patients enrolled in the multidisciplinary treatment program of an outpatient neurology headache clinic. Neurologists had referred the patients, predominantly white women aged 17-85, for psychological

evaluation. All patients filled out the 344-item Personality Assessment Inventory (PAI), a tool used for assessing personality and psychopathology.

As a group, the patients' scores on the Somatic Complaints subscale were significantly elevated (two standard deviations above normal). Individually, the scores of more than half (51.6%) were considered clinically elevated.

The researchers took a closer look at the patients who failed outpatient treatment and required referral to the inpatient pain program. Their scores on the Somatic Complaints scale were significantly higher than the scores of patients who did not fail outpatient therapy.

Elevated scores on another measure (the Physical Symptoms subscale of the Depression scale) showed they were also more likely to be tuned in to physical symptoms.

The findings are consistent with a common belief among chronic headache patients that their malady

is rooted in physical causes, not primarily psychological ones, coauthor Kathleen Ashton, Ph.D., explained in an interview.

The results also reinforce previous research suggesting that disability is often more intractable in headache patients who suffer from anxiety and mood disorders.

"The PAI Somatic Complaints scale may be useful in identifying patients who are most likely to be referred to an intensive, inpatient chronic pain treatment program after failure to improve in traditional outpatient treatment for their headache disorders," the researchers concluded.

In patients with high scores, "there is probably an underlying emotional component to this pain that's not being addressed in outpatient therapy," Dr. Ashton suggested. In addition, headache patients scoring lower on the Somatic Complaints scale are probably more amenable to psychological therapy, she said. ■

For Pain Relief, Look on Bright Side of Hospital

Spinal surgery patients exposed to increased sunlight in their hospital rooms used 22% less pain medication per hour than those not exposed to the additional sunlight, said Jeffrey M. Walch of the University of Pittsburgh and his colleagues.

In the prospective study, 44 patients were situated on the bright side and 45 patients on the dim side of the same hospital unit. Their mean age was 59 years, and the mean length of stay was 3.5 days (*Psychosom. Med.* 2005;67:156-63).

Patients on the bright side of the unit received 46% more natural light than the patients on the dim side. The colors of the hospital rooms and the patients' gowns were alike, so they were not

confounding factors.

Patients exposed to additional sunlight spent 21% less on pain medication, compared with the other patients. Upon discharge from the hospital, those patients who were from the bright side also reported significantly less perceived stress and slightly less pain, although the difference in reported pain was not statistically significant.

"An optimal therapeutic hospital design may maximize sunlight exposure for patients with high use of analgesic medication," Mr. Walch and his associates noted. A reduction in opioid use, they added, could improve the dose-dependent side effects common in postoperative patients.

—Heidi Splete