

Bare psykisk?

Psykologi og smerte – før og nå.

NOSF - 9. Januar 2014

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Psykologspesialist
Seksjon smertebehandling og palliasjon
Haukeland Universitetssykehus

somatisering
personlighet
stress og mestring
uløste konflikter
malingering
forsterknings-
betingelser
personlighetstrekk
seksualitet

Melzack Wall
Turk Breivik
Butler Fordyce
Bonica Loeser
Livingston

1993



2014

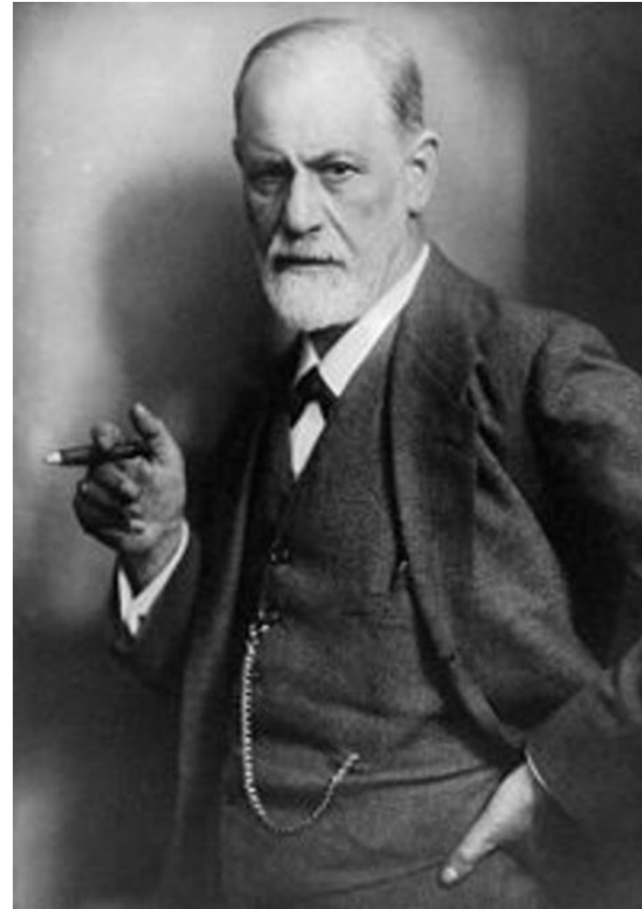
Lavterskel invasive tiltak
Pasientbestemt «Carve Out»
Bio-meididsnsk/
unidisiplinær

Tilbud – utredning,
behandling/rehabilitering
Spesialiserte tiltak, trygge rammer
Tilgjengelige kompetente
tverrfaglige klinikker
Samarbeid – bruker – klinikk

SMERTE – BARE PSYKISK?

Sigmund Freud – hysterie, smerte

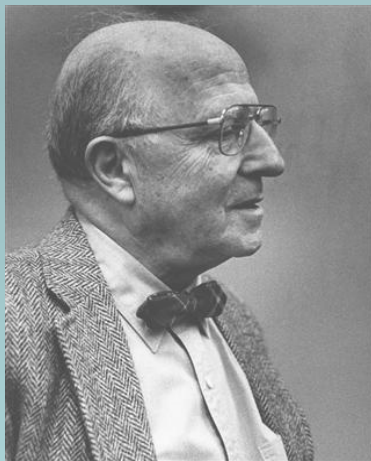
- Uløste konflikter, ikke-akseptable seksuelle lyster, tap, ikke uttalte emosjonelle reaksjoner ... osv.
- Uttrykkes gjennom fysiologiske mekanismer – konversjon.
- Utgangspunkt i personen



“Psychogenic” Pain and the Pain-Prone Patient*

GEORGE L. ENGEL, M.D.

Rochester, New York



have a peripheral lesion. Such descriptions reflect the characteristics of the individual and if he is suffering from a peripheral lesion, the disordered patterns arising from it are subjected to the most complex psychic distortion and elaboration so that at times the peripheral qualities may be totally obscured.

This now brings us to another who are the

The Pain-Prone Patients. For the most part these patients repeatedly or chronically suffer from one or another painful disability, sometimes with and sometimes without any recognizable peripheral change. There are also patients who

ICD-10: F45.4 Vedvarende somatoform smertelidelse

- «Den dominerende plagen er vedvarende, alvorlig og plagsom smerte, som ikke kan forklares fullstendig med en fysiologisk prosess eller en somatisk lidelse, og som inntreffer i forbindelse med følelsesmessige konflikter eller psykososiale problemer som er så omfattende at de må oppfattes som hovedårsak. Resultatet er vanligvis en markert økning i støtte og oppmerksomhet, enten personlig eller medisinsk.»

MEDISINSKE RØTTER

Smerte og medisin

- Smerte symptom på underliggende sykdom → Behandling av sykdommen.
- 1817 – morfin som sovemiddel, ca. 1850 analgetikum
- ca 1850: Eter-anestesi i bruk
- 1884 – Koller – kokain som lokalbedøvelse
- 1887 – Phenacetin, feber → smerte. Bivirkninger
- 1899 – Aspirin
- 1899 – spinal anestesi
- 1920-tallet: alkohol-blokader
- 1932 – petidin mot spasmer, senere smerter
- 1937 – Metadon – og flere andre opioider
- 1956 – paracet (phenacetin-metabolitt)

- 1936 – Rovenstine – nerveblokkade-klinikk
- 1946 – Beecher. Fravær av smerte hos skadde soldater.
- 1946 – Livingston – University of Oregon – fysiologiske og psykologiske aspekter ved smerte
- 1946 – Bonica – smerteklinikk Tacoma
- 1973 – opiat-reseptor oppdaget
- Utvikling av en rekke intervensjoner: blokader, TENS, ryggmargsstimulator, nye medikamenter, operative inngrep,



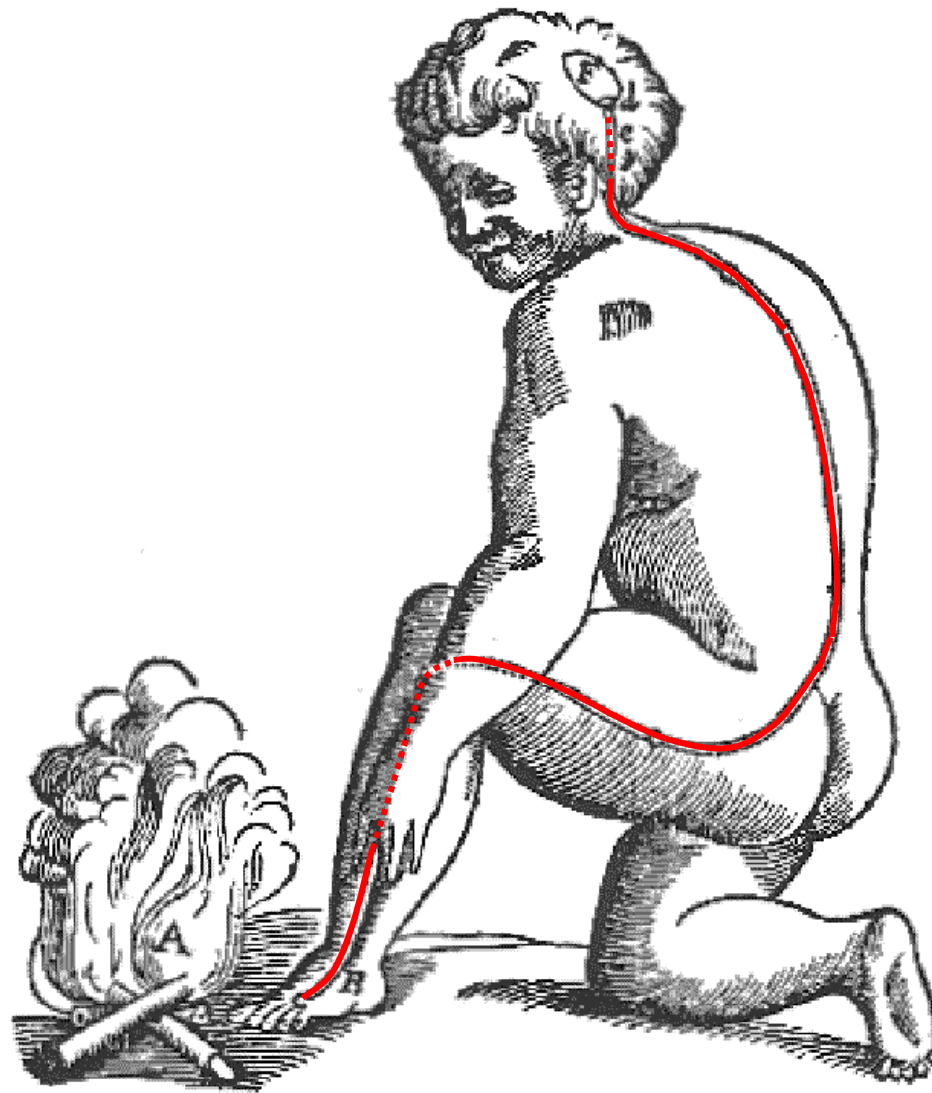
- Bonica – Tacoma 1946 – smerteklinikk
- 1960: University of Washington (klinikk mandag, tverrfaglig møte fredag)
- 1959 – Fordyce, rehab.med.
- 1973 - Bonica symposium Issaquah
- 1974 – IASP
- 1975 – PAIN
- 1983 Bonica → Loeser + Fordyce = MPC
- Vekst antall smerteklinikker, USA spesielt

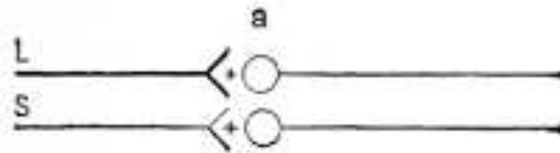


MODELLER

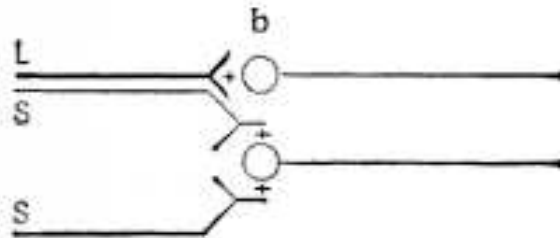
“That there is something basically at fault about the nervous system of certain of the individuals affected, is probable.

Some are insurance problems.
Others have grudges against the world, or are perhaps stupid, or even criminal”

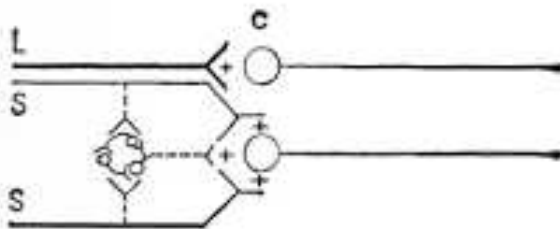




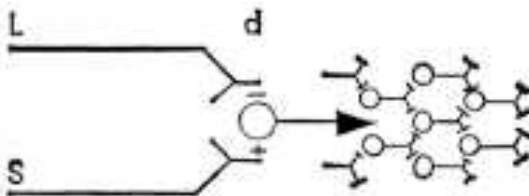
19thC: Von Frey's specificity theory: large and small fibres transmit touch and pain specifically, to specific touch or pain centres in the brain



19thC: Goldscheider's Summation theory: small fibres converge onto a dorsal horn cell, and touch is carried on large fibres



1943: Livingston's reverberatory circuit model: dorsal horn cell bombarded by self-exciting neuron circuit transmits abnormally patterned volleys to brain



1959: Noordenbos' sensory interaction theory: large fibres inhibit, small ones excite central transmission neurons; comprises multi-synaptic afferent system.



pe: adapted from p. 163, Melzack & Wall, Challenge of



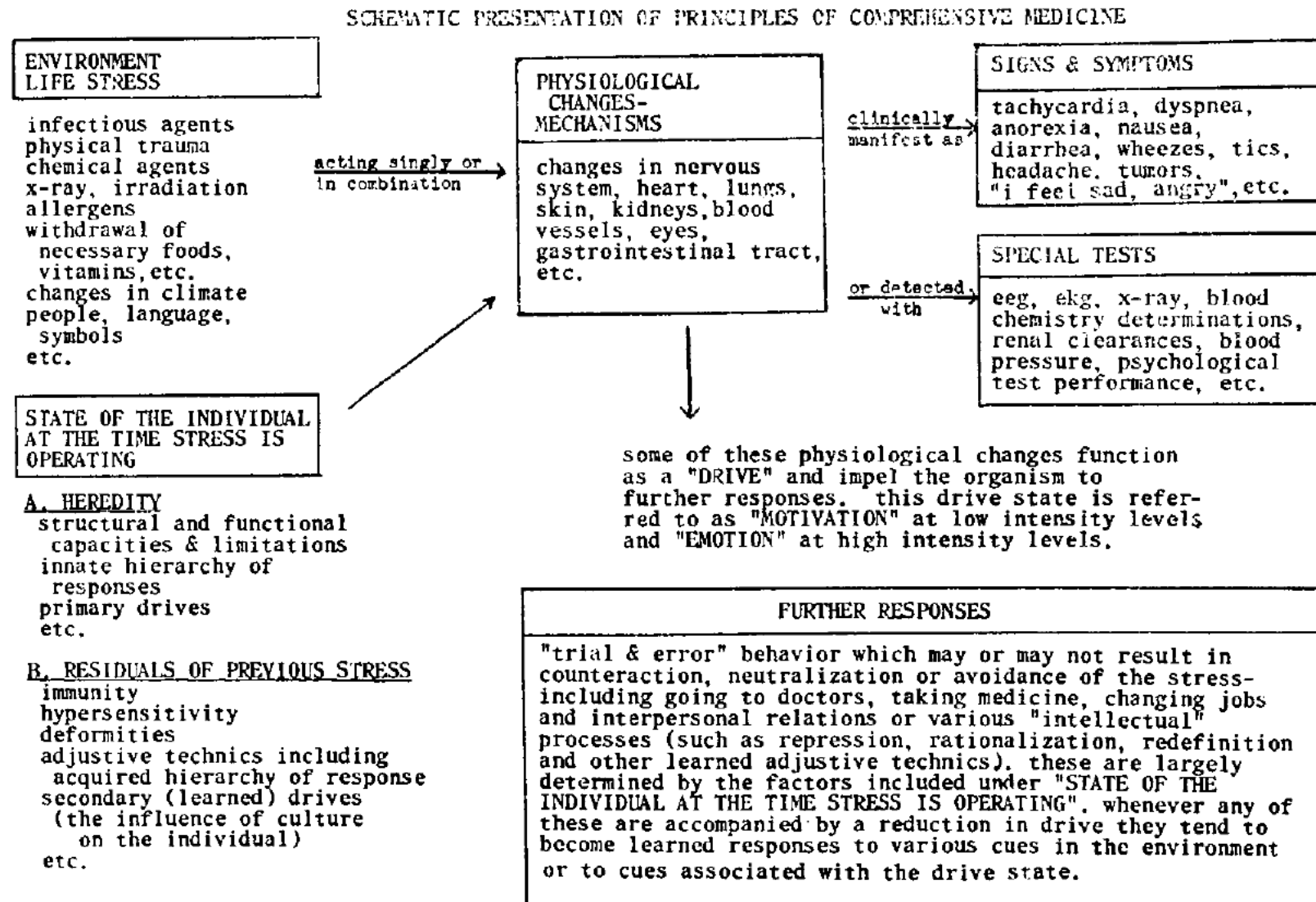


FIGURE 1

Pat's drawing in an early draft sent to Ron

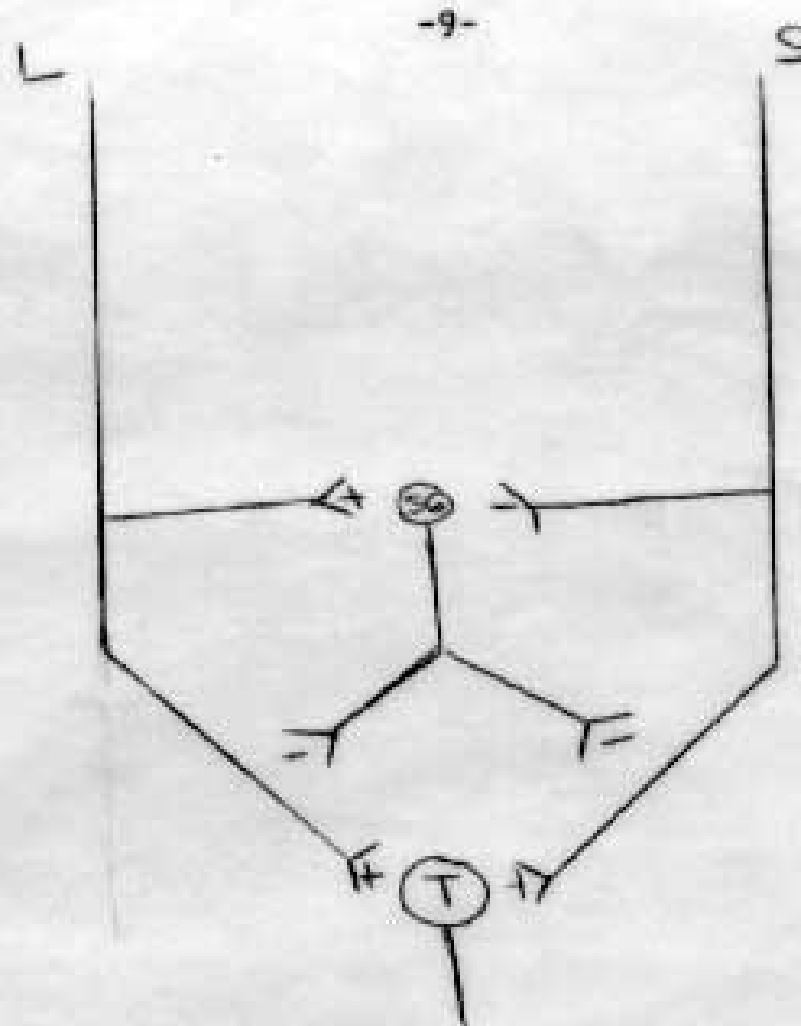
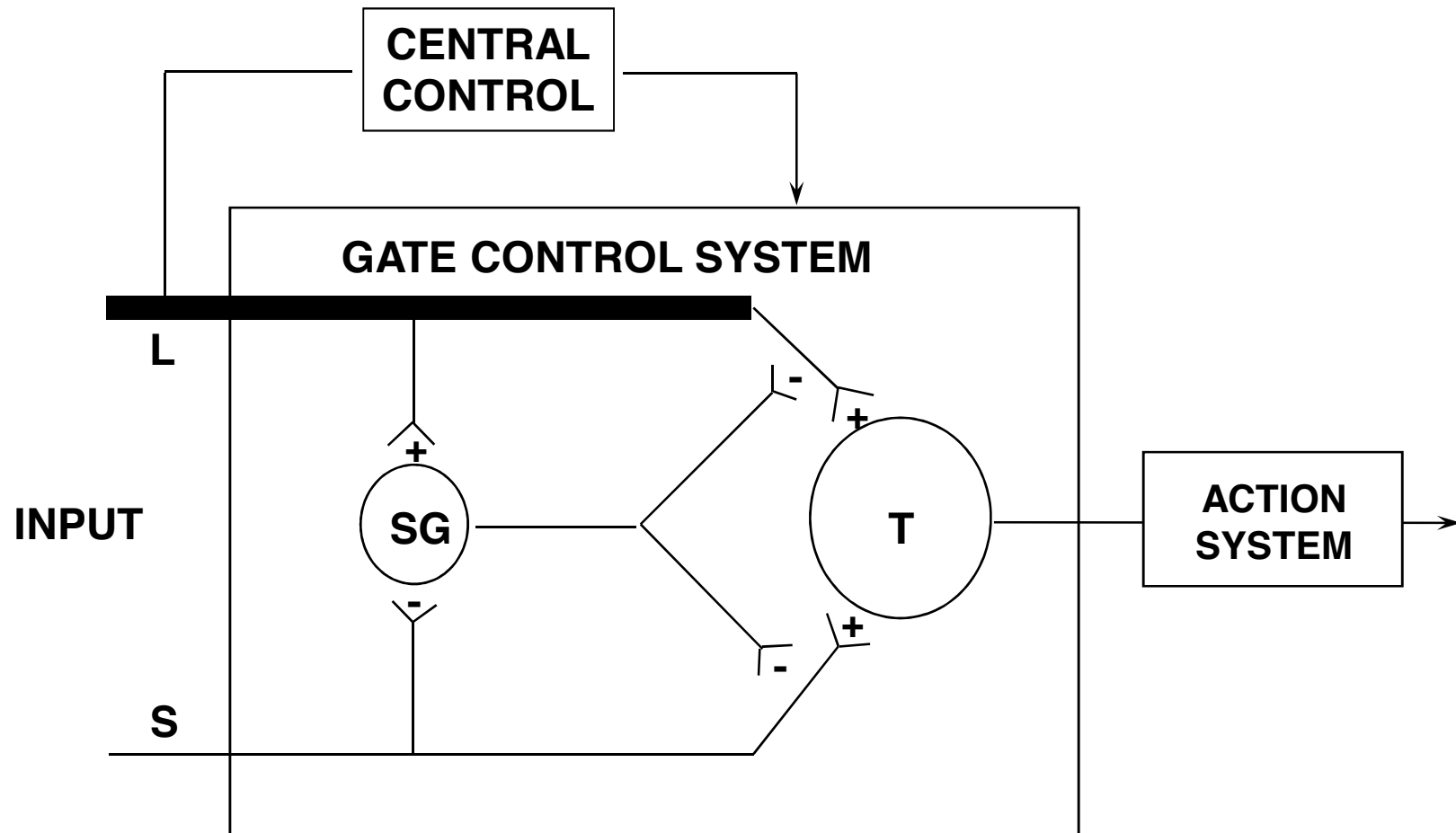


Diagram one

Greatly a simplified diagram of presynaptic control mechanism. Large diameter afferent fibers (L) excite both substantia gelatinosa cells (SG) and the



- | | |
|--|-------------------------------|
| L - Large-diameter ($A\beta$ -fibre) | T - Transmission cells |
| S - Small-diameter($A\delta$ - og C-fibre) | + - Excitation |
| SG - Substansia gelatinosa | - - Inhibition |



8 April 1977, Volume 196, Number 4286

SCIENCE

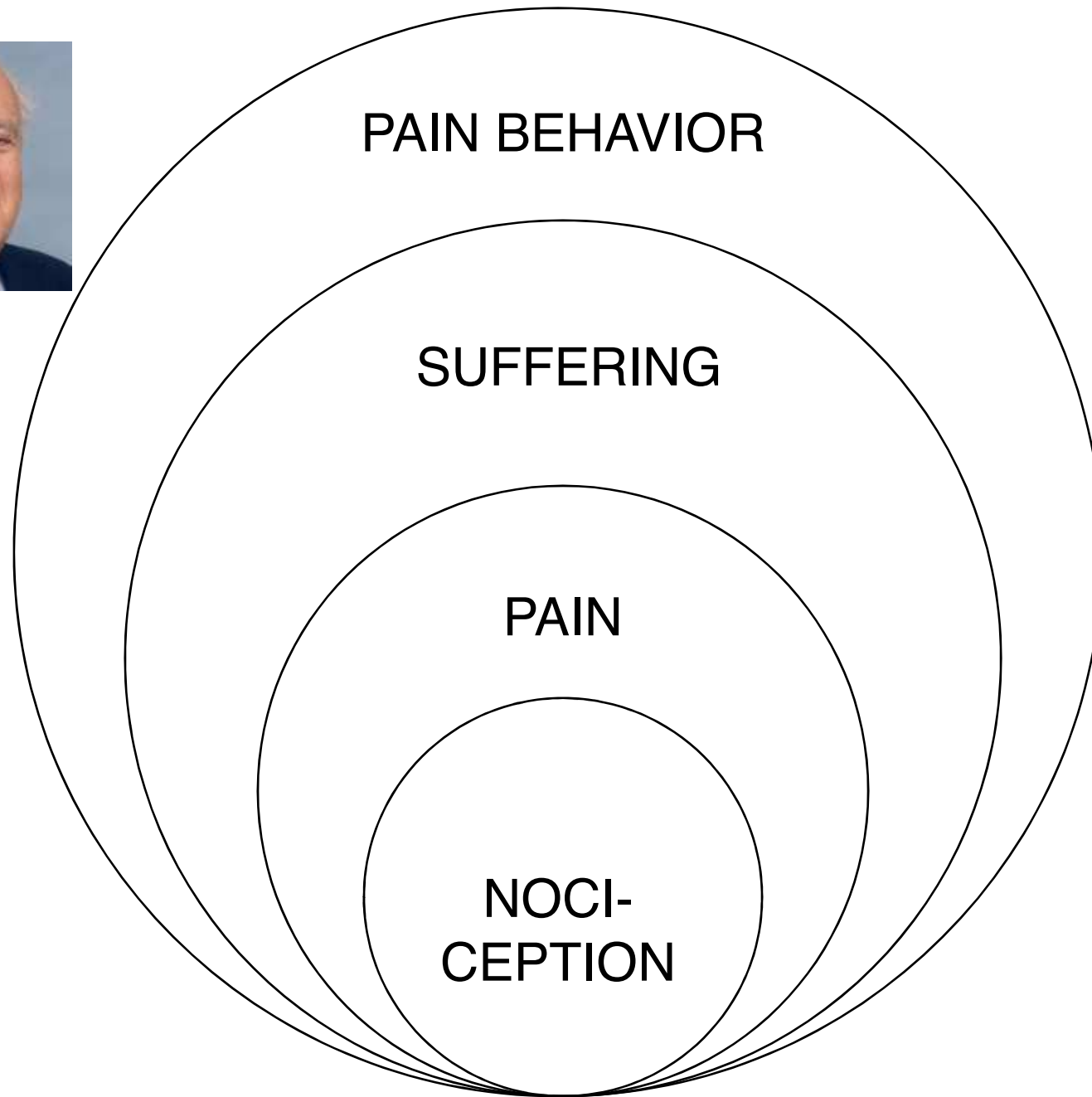
The Need for a New Medical Model: A Challenge for Biomedicine

George L. Engel

At a recent conference on psychiatric education, many psychiatrists seemed to

the physician is appropriate for their helping functions. Medicine's crisis

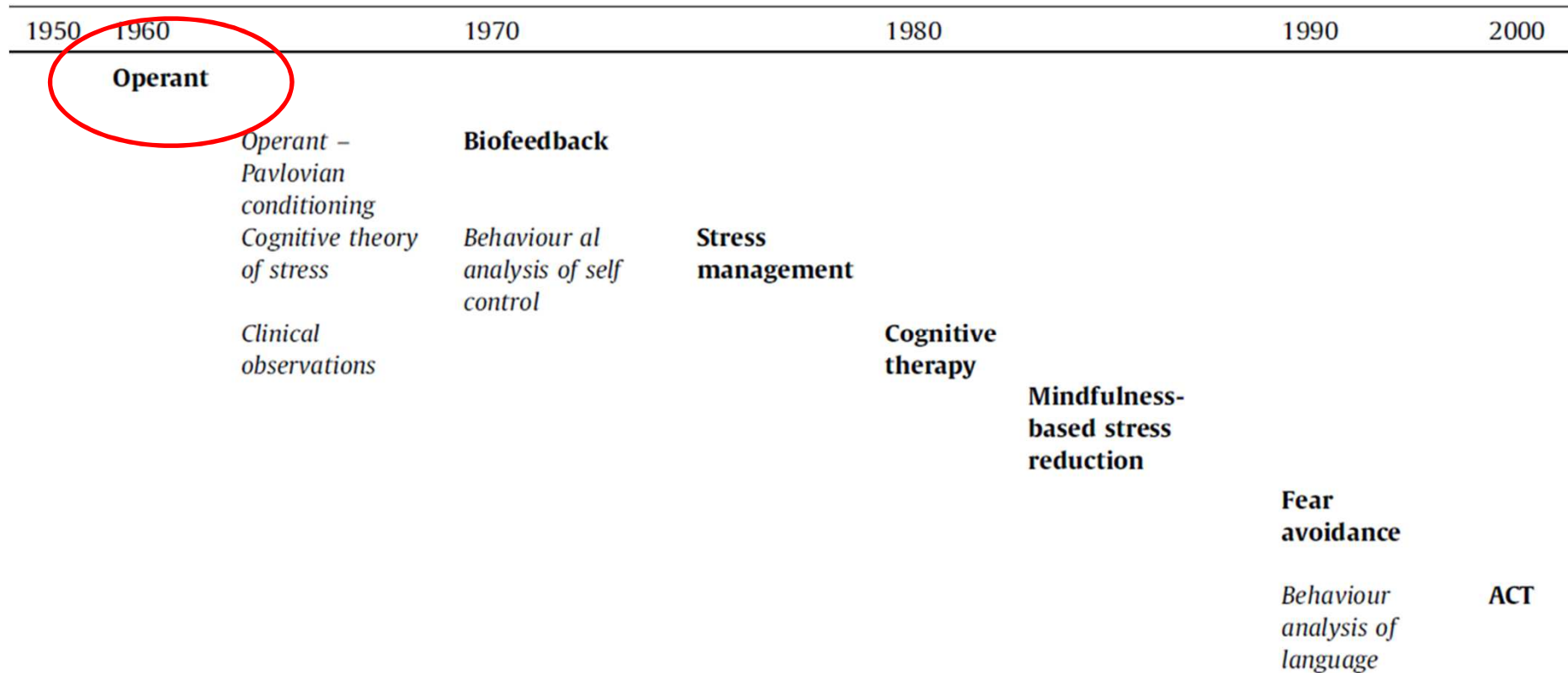
new discipline based on behavioral science. Henceforth medicine would be responsible for the treatment and cure of disease, while the new discipline would be concerned with the reeducation of people with "problems of living." Implicit in this argument is the premise that while the medical model constitutes a sound framework within which to understand and treat disease, it is not relevant to the behavioral and psychological problems classically deemed the domain of psychiatry. Disorders directly ascribable to brain disorder would be taken care of by neurologists, while psychiatry as such would disappear as a medical discipline.



PSYKOLOGIENS BIDRAG

Table 1

Schematic timeline outlining the development of CBT applied to the treatment of chronic pain.



Morley, S. (2011). "Efficacy and effectiveness of cognitive behaviour therapy for chronic pain: Progress and some challenges." Pain **152**(3 Suppl): S99-106.

Bill Fordyce

- *«All chronic pain has a behavioral component»*
- Fra personlighet, psykodynamikk og vevsskader – til observerbar atferd og samhandling.
- Smerteatferd - Operant betinging.

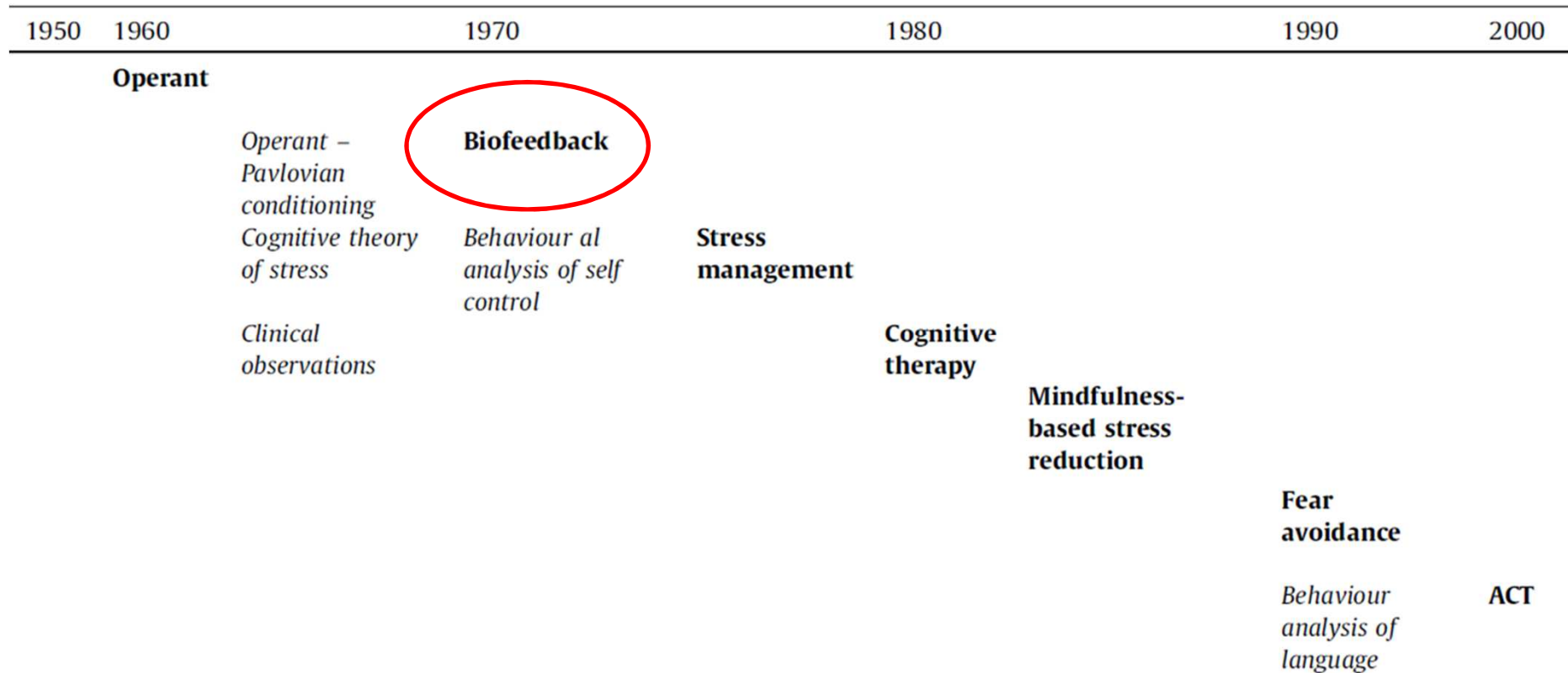
Smerteatferd



Konsekvenser

Table 1

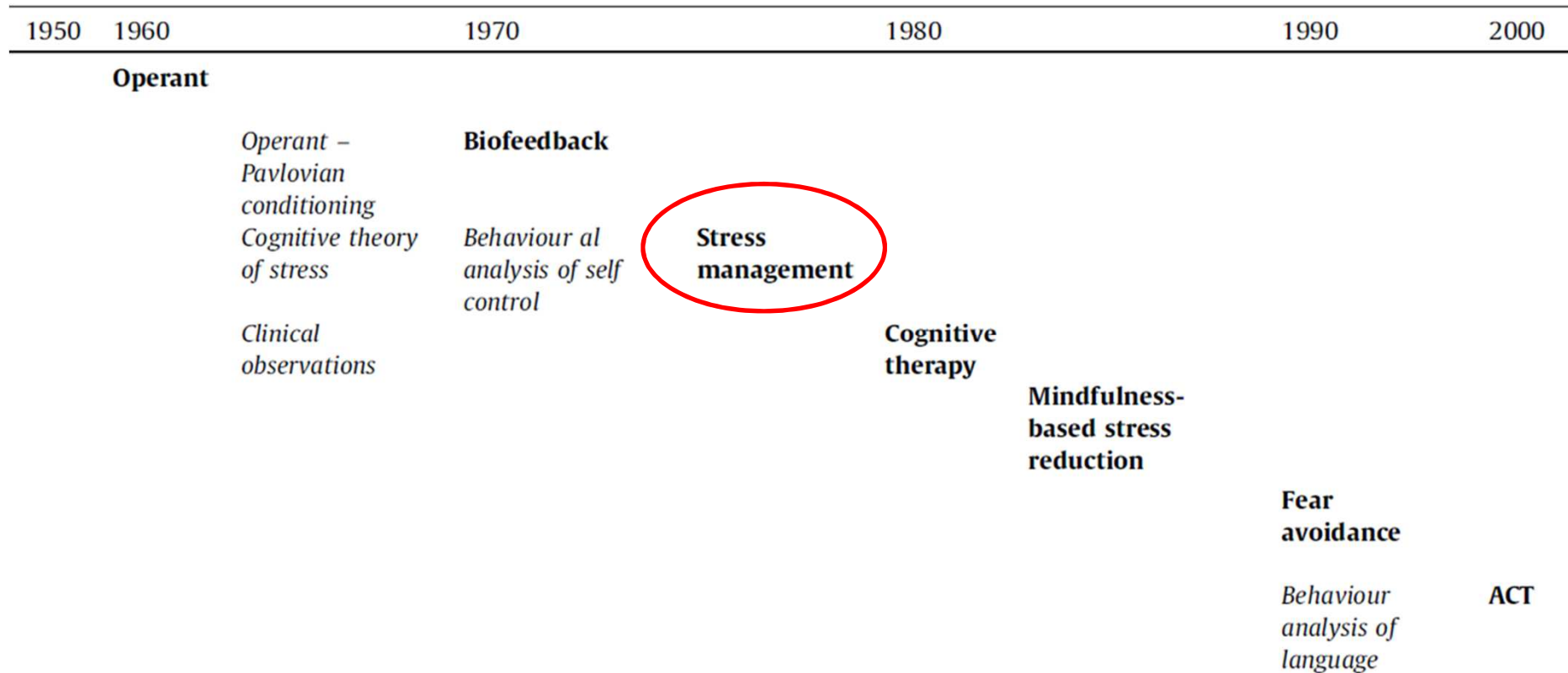
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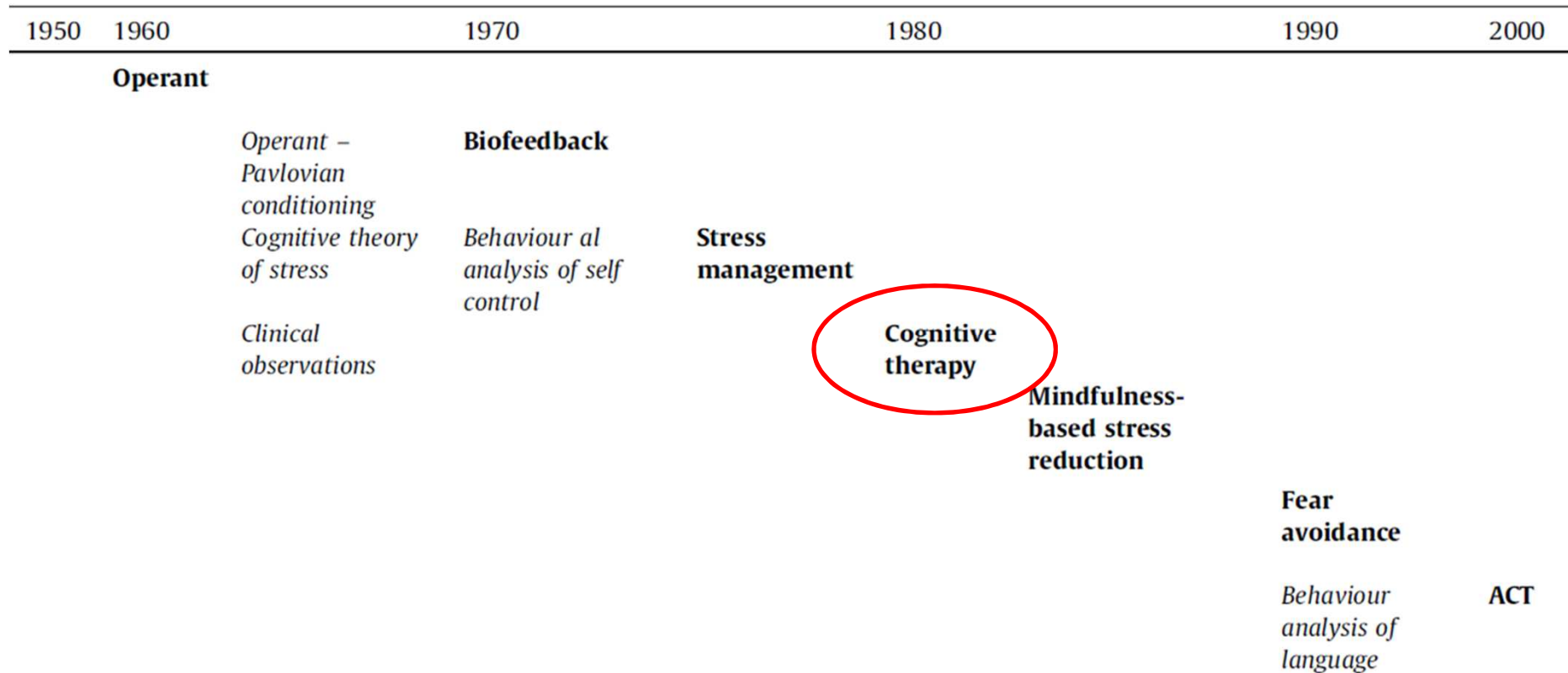
- Kognitive faktorer

- Francis Keefe, Judith Turner, Mark Jensen, Joan Romano, Dennis Turk ...
- **Kontrollplassering** (Rotter, 1954). Indre, ytre, tilfeldig.
- **Mestring** (Lazarus & Folkman, 1984). Prosessorientert, kontekstuel, deskriptivt (ikke «god» eller «dårlig»). Problemfokuser, emosjonelt fokusert.
- **Smertemestring**: aktiv (målrettet instrumentell handling) og passiv (tilbaketrekking)
- **Verstefallstenking** (Ellis 1962) anta stadig verre utkomme av en spesifikk bekymring

- **Mestringstro (self-efficacy):** (Bandura 1977).
Vurdering av ens evne til å gjennomføre en spesifikk atferd
- **Opplevd kontroll** (Thompson 1981, Bowers 1968).
- **Distraksjonsteknikker** (f.eks. Pearce 1983):
Oppmerksomhet mot noe annet enn plage.

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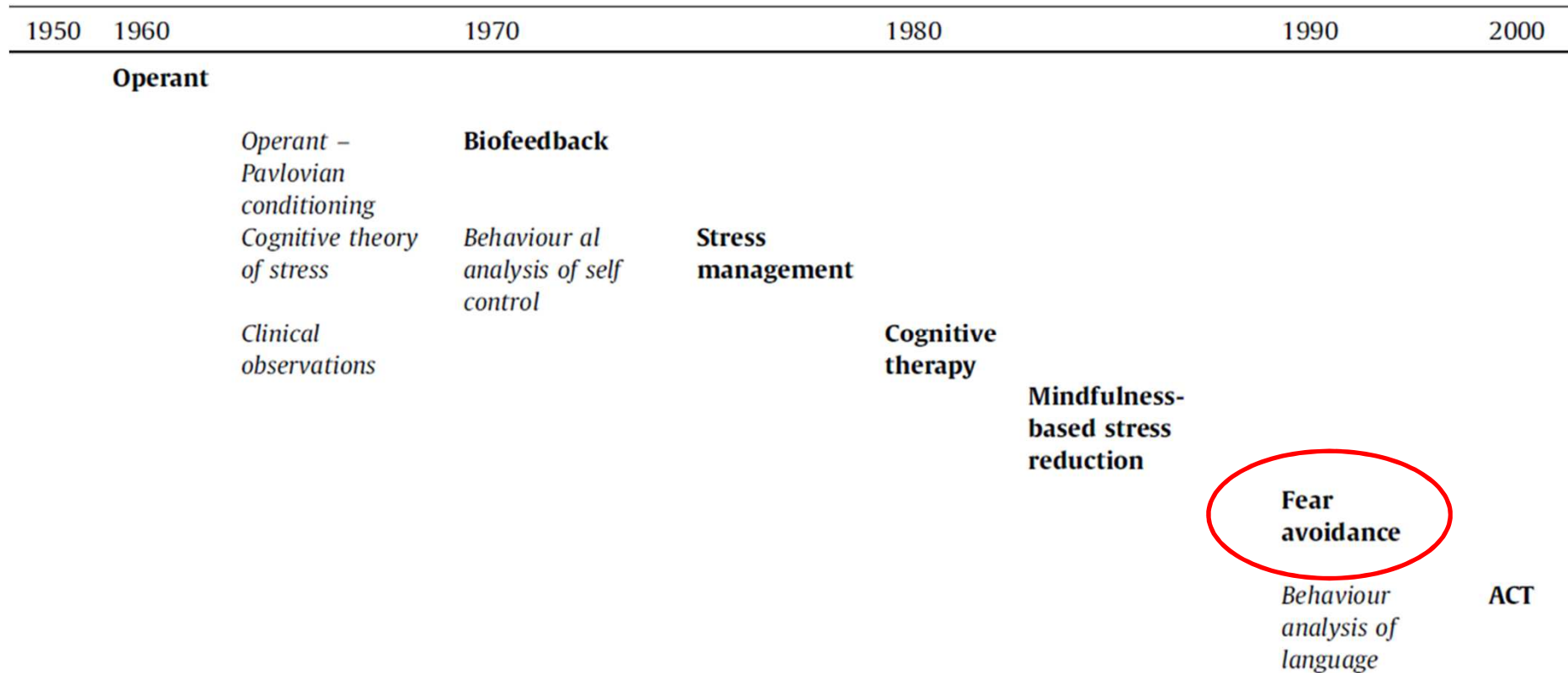
Morley, S. (2011). "Efficacy and effectiveness of cognitive behaviour therapy for chronic pain: Progress and some challenges." Pain **152**(3 Suppl): S99-106.

CBT – cognitive behavioral therapy

- «affect and behavior are largely determined by the way in which the individual construes the world»
- «therapy is designed to help the patient identify, reality-test, and correct maladaptive, distorted conceptualizations and dysfunctional beliefs» (Turk et al. 1983, s. 4).

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«Fear avoidance»

Johan Vlaeyen, J. de Jong, S. Linton m.fl.

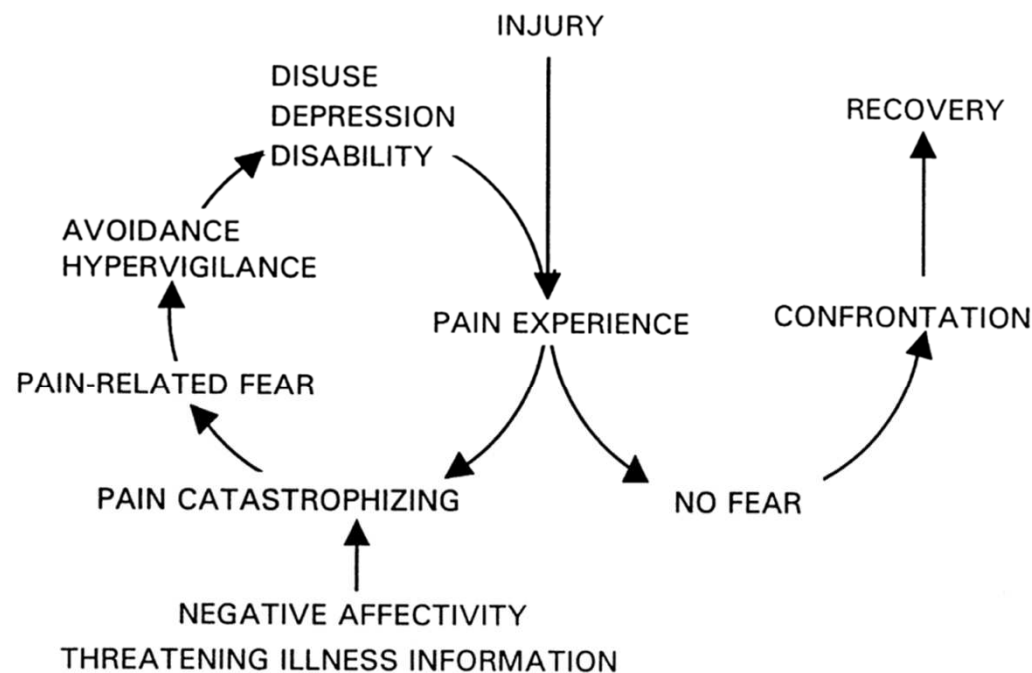
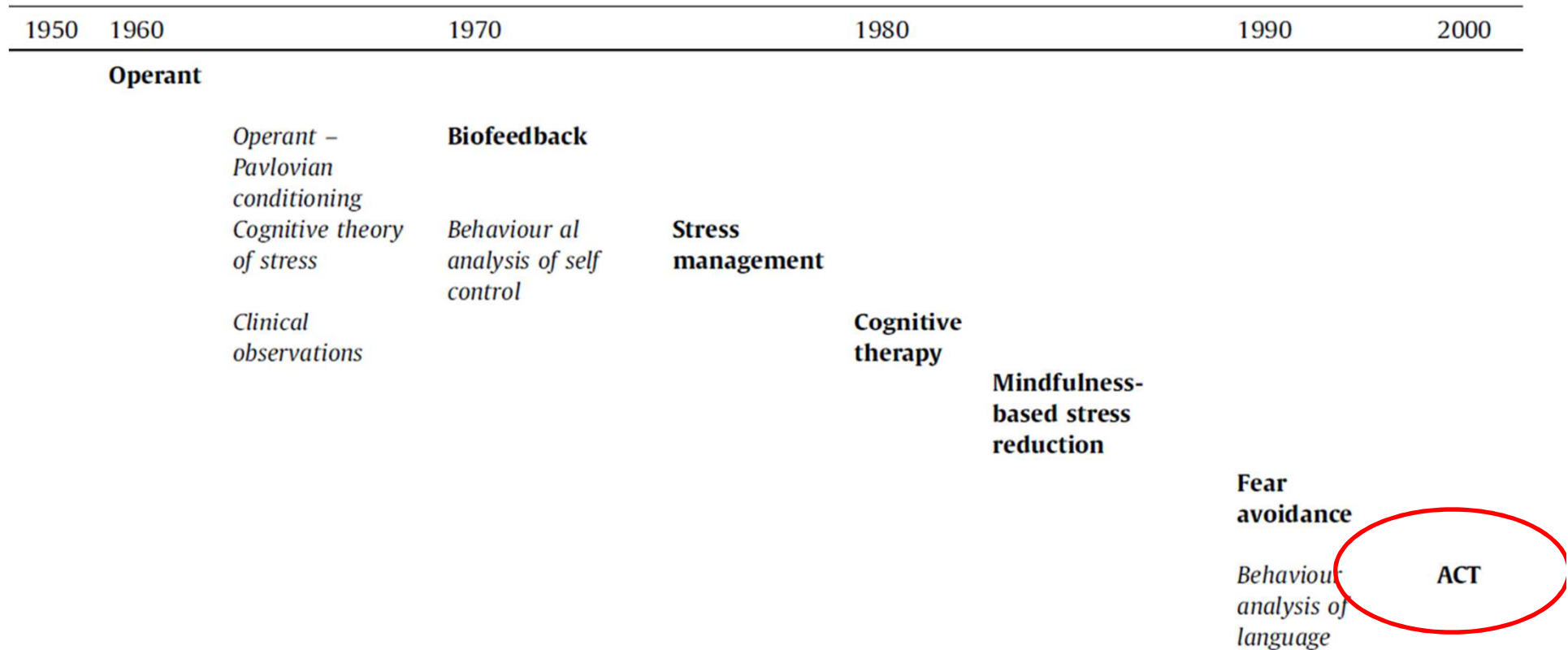


Fig. 2. The 'fear'-avoidance model. If pain, possibly caused by an injury, is

Vlaeyen, J. W. and S. J. Linton (2000). "Fear-avoidance and its consequences in chronic musculoskeletal pain: a state of the art." Pain 85(3): 317-332.

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Verdi og akseptering: ACT

- Steven Hayes. Lance McCracken. JoAnn Dahl
- Mindfulness, akseptering, verdibasert valg.
- Ikke kontroller tanker, følelser, minner osv – men forhold deg til dem som de er – og forhold deg til viktige verdier og mål.
- Fremme psykologisk fleksibilitet

CBT 1990

«Other psychological techniques of controlling pain that have been proposed included relaxation and a variety of cognitive-behavioral procedures, but these did not gain widespread acceptance and application» (Bonica, 1990, s.12)

Bonica (1990) – i The management of pain (2. ed.), vol I, s. 12.

CBT 1999

- *“Published randomized controlled trials provide good evidence for the effectiveness of cognitive behavioural therapy and behaviour therapy for chronic pain in adults”.*

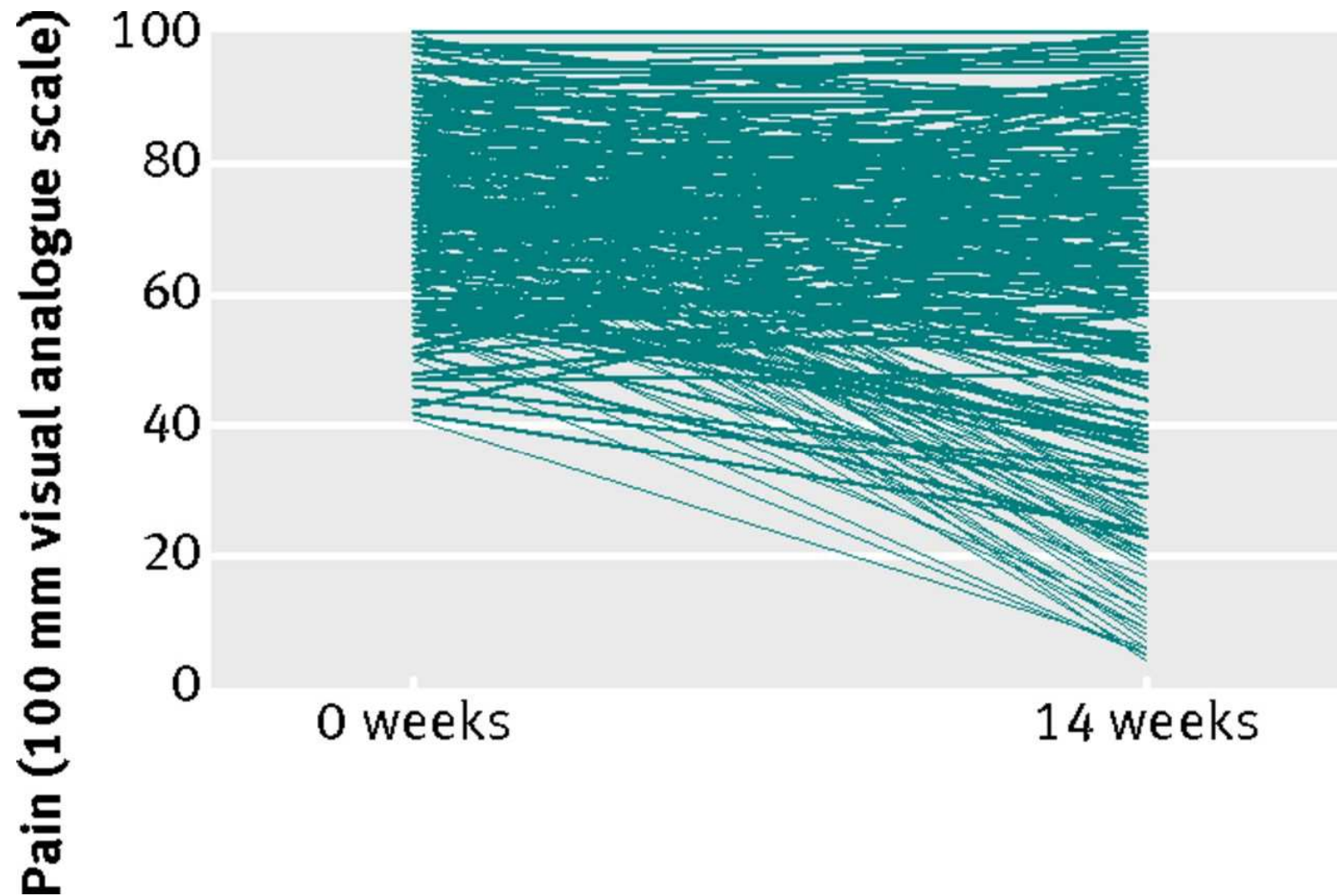
Morley, S., et al. (1999). "Systematic review and meta-analysis of randomized controlled trials of cognitive behaviour therapy and behaviour therapy for chronic pain in adults, excluding headache." *Pain* 80(1-2): 1-13.

CBT 2013

- *«... current meta-analyses indicate that psychological treatments are likely to be effective. However, as more studies are produced and added to meta-analyses, the results are effectively being diluted by the addition of poorly conceived, conducted, and reported trials.»*

Morley, S., et al. (2013). "Examining the evidence about psychological treatments for chronic pain: time for a paradigm shift?" *Pain* 154(10): 1929-1931.

Fig 1 Individual changes in pain over 14 weeks of treatment with pregabalin 450 mg in 200 patients with fibromyalgia.



Moore A et al. BMJ 2013;346:bmj.f2690

ANALYSIS

Expect analgesic failure; pursue analgesic success

Most analgesic drugs work well but in only a small percentage of people. **Andrew Moore and colleagues** argue that we need to move away from a focus on average response and seek out what works for each patient

Andrew Moore *professor*¹, Sheena Derry *senior research officer*¹, Christopher Eccleston *professor*², Eija Kalso *professor*³

... failure, assessing pain, and understanding options for stopping and switching. For the drug industry, regulators, and researchers this means casting aside our slavish reliance on the average, and asking what works for whom in what circumstance, recognising that population improvements in overall effect will require access to numerous treatment options to achieve pain relief for the individual.

**2014 – ENIGHET OM GOD
SMERTEBEHANDLING?**

FØR ← → NÅ

Spesifisitetsteori/dualisme ← → Biopsykososial modell

«Objektive funn» ← → Subjektiv plage

Hvile ← → Aktivitet

Smertefrihet ← → Funksjon og livskvalitet

Passiv pasient ← → Aktiv, samarbeidende

Tverrfaglig innsats, normalisering, aktivitet, funksjon

Relieving PAIN in America

**A Blueprint for Transforming Prevention,
Care, Education, and Research**

Committee on Advancing Pain Research, Care, and Education

Board on Health Sciences Policy

INSTITUTE OF MEDICINE
OF THE NATIONAL ACADEMIES

and cognitive context in which pain occurs, and cultural and social factors.

Because pain often produces psychological and cognitive effects—anxiety, depression, and anger among them—interdisciplinary, biopsychosocial approaches are the most promising for treating patients with persistent pain. But



Effective Health Care Program

Technical Brief
Number 8

Multidisciplinary Pain Programs for Chronic Noncancer Pain



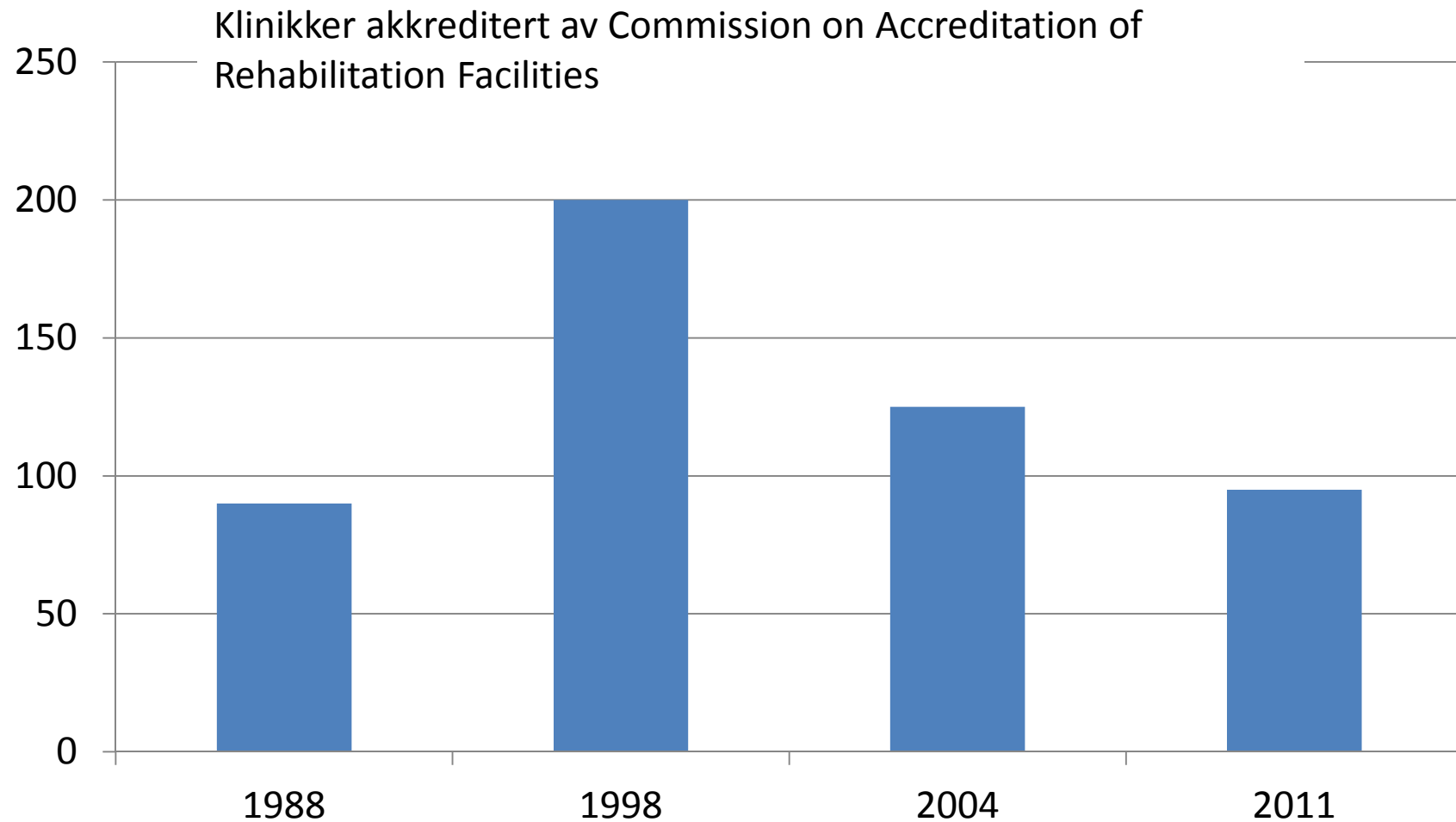
Agency for Healthcare Research and Quality
Advancing Excellence in Health Care • www.ahrq.gov

... reported qualitative evidence for MPPs effectiveness compared to standard treatment and non-MPP treatment for patients with chronic back pain, fibromyalgia and mixed chronic pain.

However, the review also noted the generally low quality of the available studies for review.

2011₄₂

Tverrfaglige smerteklinikker, USA



Kilder: Loeser, J. D. (2005). Multidisciplinary pain Management. The paths of pain 1975-2005. Merskey H, Loeser JD and Dubner R. Seattle, USA, IASP Press: 503-512.

Jeffery, M. M., et al. (2011). AHRQ Comparative Effectiveness Reviews. Multidisciplinary Pain Programs for Chronic Noncancer Pain.

1. Organisering:

disciplinary collaboration versus discipline-segmented organization of major medical centers

2. Finanisering:

collaborative care versus the fee-for-service model of healthcare payments

3. Behandlingsmodell:

rehabilitative treatment versus the curative medical model of treatment

Meldrum, M. (2007). Brief history of multidisciplinary management of chronic pain. Chronic Pain Management: Guidelines for Multidisciplinary Program Development. ME. Schatman and A. Campbell. New York, Informa healthcare: 1-13.

1. Pasient – ønsker kurativ medisinsk innsats
 - Tro på effektiv medisinske tiltak/fokus vekk fra eget ansvar
2. Tilbydere – stimulert av et mulig marked
 - Private klinikker, invasive tiltak
3. Økonomiske insentiver – outsourcing
 - pengene følger pasienten/fritt behandlingsvalg

Fare for

- Psykologi – som ikke ser system og somatikk
- Somatikk – som overfokuserer på biomedisinske forhold.
- Fysioterapeuter – passiv behandling, og glemmer aktivitet og funksjon

Vi trenger

- Kunnskap om tverrfaglighet – blant helsearbeidere og pasienter
- Utvikle helsepsykologi som klinisk område i Norge (spesialitet, i grunnutdanning, og arbeidsplasser)
- Gode kår for tverrfaglige smerteklinikker
- Forsiktighet – invasive prosedyrer og medikamentell behandling av smerte