Case Study

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Model for Integrative Psychotherapy in a Patient with Pain: A Clinical Case

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Abstract

The Pain Multidisciplinary Unit of the Centro Hospitalar Lisboa Norte, Hospital de Santa Maria, has a multi-disciplinary approach to the problem of pain, in which psychotherapeutic intervention plays a complementary role to the care given to patients, with the purpose of teaching them strategies that can help them better cope with their pain and reorganize themselves within their limitations. This article aims to show the psycho-therapeutic work that has been carried out, as well as its relevant moments (crisis containment, returning the synthesis of the problem, formulating the therapeutic contract, evaluation of the subject's internal dynamics, developing the therapeutic alliance, constant tweaking of the therapeutic relation, growing autonomous, and finalizing the therapeutic relation) with a clinical case as an example.

Keywords: Pain psychology; Integrative psychotherapeutic intervention; Relevant moments

Introduction

Following the multidisciplinary intervention implemented by the Pain Multidisciplinary Unit of the Hospital de Santa Maria (HSM), we present a description of a clinical case, which exemplifies the benefits of psychological intervention in the problematic of pain, being fundamental to the psychic re-adaptation/re-organization of these patients to a new reality, where they learn to live with pain, and, in some circumstances, to overcome that state. The psychology of pain aims to de-center from pain, re-learn to live under the new condition, as well as potentiate the therapeutic adherence and/or coadjuvate other complementary interventions. The psychologist is therefore working on questions, conflicts, and emotional disorders, relegating pain to the background. It's a process in which patients who can only see how pain has changed their lives can mourn and project themselves in the future. Considering the known epidemiological data and the, almost unanimous acceptance of the importance of psychological factors in the problematic of pain in general, it is fundamental that the psychology intervention, as well as the investigation, not of isolated factors or interventions, but of the individual as a whole should be expanded. In this perspective, the choice was made for a kind of integrative intervention, which uses data from the Object Relations Theory as well as cognitive behavioral techniques, like, for instance reformulation of distorted thoughts and the promotion of adaptive thoughts [1-6].

According to Branco Vasco, the psychotherapeutic model should be integrative, based on the integration of techniques, coming from different psychotherapeutic orientations. It should be a model centered on the person, thus selecting the most appropriate techniques for each patient, conciliating with contributions from other theoretical orientations, in particular, from the experiential/emotional and interpersonal/relational perspectives.

The clinical case before you, has this psychotherapeutic approach in consideration, which lasted for six months.

The subject is a 30-year-old female, who we shall refer to as Ana (fictitious name). At the Pain Multidisciplinary Unit, she had a multidisciplinary follow-up in with the participation of the assisting doctor, the psychologist, and anesthesiologist and specialist in medical acupuncture.

Case Study

Ana does several sports activities. In June 2012 she has the first episode of pain, with spontaneous trauma, while running, in the right sacroiliac region. She showed a pronounced edema, with injectable drug in the right gluteus during treatment with anti-inflammatory. Since then, she had neuropathic pain, which improved after pharmacological treatment. She still has pain, which she describes as a burning sensation. She identifies basal pain 4, with intermittent peaks of 8. It interferes with her walking and worsens when she stays sitting down for a long time. The pain is relieved by applying ice.

From December 2013, she starts complaining about nausea and daily vomiting, frequent arthralgias, and getting tired for little to no reason. Aiming to rule out any autoimmune disease, General and Family Medicine reference the patient to the Rheumatology Service, where, after complementary exams no relevant changes are identified [7-9].

Multidisciplinary intervention is decided by the team, in Vue of the patient's weak adherence to the traditional

pharmacological therapy. As a result, she starts being treated with acupuncture and is referenced for psychotherapy. When the patient starts the psychotherapeutic treatment, this is her clinical history:

- or without organic cause, detected when she was 15, and the family moved to the Alentejo region.
- First anxiety episode at 21 with "nervous breakdown".
- Depressive episode at 24 caused by a heartbreak.
- Anxiety episodes at 29, with psychiatric follow-up.

Having mentioned that this psychotherapeutic intervention follows the integrative model paradigm, we'll be looking at the relevant moments that each patient goes through:

Crisis contention

The patients that come to the psychologist's office for the first time in the Pain Multidisciplinary Unit in general, arrive in a crisis situation, and the fundamental is to be available to listen to what he/she has to say, to take in the problematic, the complaints, and to try and give back words that make them feel accompanied. It's important that they know that, for a time frame to be defined, they can have someone that listens, understands them, and help them find strategies to reduce their suffering. In other words, to understand their beliefs. regarding the disease and its symptoms, so that they can produce coping strategies to reach a balance that will allow them to live with the reality of the disease, in counterpoint to the image they had of themselves prior to its emergency [10,11].

Returning the synthesis of the problematic

When the patient is feeling more peaceful, less plaintive and tense, summarize all the core problematic, and give it back, so that we can make sure we're in sync and that the patient will leave the therapeutic space more appeased, safe, and understood, if possible. Which is what promotes the creation of a therapeutic relation.

Formulation of the therapeutic contract

It's important that it's done in the first session, where we explain the setting (length, periodicity, time, and place of the psychotherapy, and all that takes place in a process, setting the duration of the psychotherapy), talking about the rules of ethic, explaining that it's a trust relationship, of mutual seriousness and sincerity. It's a verbal compromise, in which both the psychologist and the patient agree to meet their obligations.

Internal dynamic evaluation of the subject

In order to perform a therapeutic intervention, we need to know how the customer interacts e reacts to the rest (personal personality organization level, defensive stiles and relational patterns).

Developing the therapeutic alliance

Progresses along the sessions; if the patient comes consecutively to first three sessions, we can say the therapeutic alliance is set.

Constant fine-tuning of the therapeutic relation

According to the rhythm and the emerging conflicts that keep coming up during the psychotherapeutic process, that force us to make constant adjustments to the techniques.

Growing autonomy and closure of the therapeutic relation: as the patient progresses in the psychotherapy, achieving the desired goals, there's a decrease in the periodicity of the sessions, always explaining to the patient that this is a natural consequence of his/her evolution, we move on to follow-up sessions until we conclude the psychotherapeutic process, letting the patient know that he/she will be able to progress on his/her own.

There was a previous psychological evaluation in order to objectify pain and understand the patient's subjective part so that we can intervene and choose the most adequate strategies.

Next, we'll take a look at the case, where these relevant moments will be operationalized.

In the first session, Ana points out the problematics/complaints that have been bothering her the most. She says that at that time in her life, she has been very anxious, "it seems that everything has been going wrong". I've had a great deal of pain in my joints, besides this pain in my hip", a constraint that the patient considers to be disturbing her functional side, given that she's unable to perform certain tasks conveniently, that she's forced to be on medical leave, and inhibited from practicing several sports, as she used to. These limitations and the fact that she was staying longer alone at home, meant that, as she says "…I feel more and more anxious, and the anxiety makes me feel insecure and afraid to fail – sometimes, the sadness keeps me from concentrating. The nights are terrible. It's when I'm getting ready to go to bed that I start getting nauseas and vomit, lately followed by panic attacks. These symptoms are more frequent and difficult to control. At other times, I wake up during the night with my pajamas all wet. I can't explain why, but it's as if I had been very frightened or anxious. I'm exhausted and desperate. I don't know what to do…". I heard her attentively and let her share all her complaints. When she became less tense, and more appeased I told her: The situation you're going through is very difficult. I understand why this is causing you such malaise". I tried to understand a little better some details; in that session I tried to do crisis containment, returning the synthesis of the problematic, and formulate the therapeutic contract [12,13].

She starts the second session by talking about her mother, of how she identifies with her as a person, that she has the same profession, the same personality, way of being, sense of

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humor, and of her autoimmune disease (ankylosing spondylitis). She points out that her mother also suffered from recurring depressions. That's when she says she's waiting for an appointment at the Instituto Português de Reumatologia (Portuguese Rheumatology Institute) to do the tests that can rule out the diagnostic. She says she's been rather anxious and afraid that she may have the same disease, saying she has a great deal of pain in the hip and joints and that she's still unable to go to work, and despite her attempts, she's still unable to play sports. She's very worried because of the memories she has of the limitations her mother had to endure, as she cared for her during the last years of her life and draws an analogy with her current situation - "there's a suspicion about this diagnostic, and the fact that I have pain in my joints and a malaise in my stomach may be symptoms". As she was very tense and anxious, I started using coping strategies to approximate and promote acceptance of the change in social role, from caretaker to patient10. Evaluation of the internal Dynamics of the patient. The session went by and Ana was becoming more appeased, less tense. At the end of the session, I said: "You told me that you have the same profession as your mother, that you are very much like her, in terms of personality, and way of being. Do you expect to inherit her disease as well, since you're so much like her, having the same disease seems to be what's missing to be like her, after all, you're so much alike". She stared at me for a while and said: "I never thought about that" - Confrontation with the interpretation.

She comes in the office sounding less mournful, and after sitting down, starts the third session saying: "Do you believe I spent the whole week without panic attacks, more peaceful? It was good for me to listen to what you told me about my mother's inheritance". Establishing the therapeutic relationship. In terms of complaints, she mentions that there was a decrease in the level of pain in general, that she played some sports this week, mentioning two Yoga classes, although she still feels frustrated for not being able to play other sports. Until then she had never spoken about her father, nor any other member of the family. I asked her if she was an only child. She replied that she has a twin sister from her father's second relationship and four from the first. She stays silent for a while and says that it's not at all pleasant for her to talk about her father, that she even finds him repulsive, saying she finds him ill-intentioned with the others. That's when she addresses the heavy family history, where there's domestic violence. She says that they grew up watching their mother being mistreated and failing to defend herself, and according to her, that's the way she had to protect her daughters, because then, the mistreatment wouldn't extend to them. - Relational structure. I commented: "Among all the confusion in your life, since you were a child, watching your father hitting your mother, watching her suffer... ", she interrupted me and said: "My mother didn't suffer. At least, she wouldn't show it. She was always in a good mood"; I resumed: "…watching your father having this sort of behavior, how did you handle the fear? ", she replied she had no fear. I asked if she was scared when she saw her father being aggressive. She says: "In those cases I was scared, but I wasn't aware of it. I think sports were my escape. Evaluation of the patient's internal dynamics, constant fine-tuning of the therapeutic relation. We remain in silence for a few moments, resuming the story of an afternoon when the mother had gone out and the daughters had come back from high school, he set fire to the house and left, leaving them alone. She says that since then, she started to have a great deal of fear and insecurity. She comments, "now that I mention it, I think it was in this situation that I felt my first panic attack".

Intermediate session – After 4 months of psychotherapy, Ana arrives at the office in a fast pace, apologizing for the being late. She says: "I took longer to finish a report and I'm a little late. You know, I have been thinking a lot about everything that we've been talking about and now that I feel less pain, that the tests of the Instituto Português de Reumatologia's diagnostic came out negative, that I'm back to work, I have some news: yesterday, I started surfing again, for the first time. I'm starting to feel that I want to go out with my friends again and I managed to rent the house I used to live in. I moved to an apartment in the same building as my twin sister". There was silence for a while, and she went on: "Although I'm feeling more peaceful, I'm a little worried, because I'll have to take a long trip by airplane, and I fear my pain and anxiety may worsen". Constant fine-tuning of the therapeutic relationship.

I asked her how that could happen, since she'd kept herself in a stable condition, with controlled pain, and that she had learned coping strategies to help her in extreme situations. She agreed with me, and said that breathing slowly and deeply, listening to her heartbeat, controlling her pulse, as well as diverting thoughts away from the pin/discomfort, and thinking about how much she likes to travel, really are strategies that help her control the anxiety and pain. It was agreed that day to change periodicity to once every fortnight. Growing autonomization.

Last session: Six months after the beginning of this process, the day comes when the therapeutic relation comes to an end. Ana had resumed her professional activity. Had a much more active social life and had begun an affective relationship three months ago. "… Apart from the decrease in physical discomfort, I also feel there was an internal change. I feel more secure, more peaceful. Now I can sleep without problems, and I never suffered further anxiety and panic attacks". She made a brief silence and asked: "Do you remember that session when you told me that I wanted to keep caring for a mother that has died, when she didn't even want that when she was alive, letting herself be mistreated by her husband". I told her yes. She proceeded: "I often remember this sentence from you. I was always a caregiver, and when I came to this Unit, it was very difficult for me to become the one to be cared for. And I think that for some time, I didn't want it either. That sentence made that 'click', and I understood that I didn't want to be like her. That's when I accepted and changed my role". Another silent moment, and she went on: "It seems that my life is making sense again, in these six months, this space was important so that I could stop to think, feel and reorganize

myself. Today I'm certain that I'm leaving here stronger" - Finalizing the therapeutic relationship.

The intervention of psychology on the area of pain, putting it into perspective based on the behavioral and psychophysiological concepts, have contributed to a wider vision of this problematic and the emergency of innovative treatments based on the control of pain, considering that this should be seen as a complex response that integrates sensorial, emotional, affective, cognitive, and behavioral components that can be measured at a verbal-subjective level, behavioral-motor and physiological (8). Given that pain is better understood when the patient is seen from a biopsychosocial point of view, that is, pain emerges from the dynamic interaction between the physiological state, thoughts, emotions, subjective experience, sociocultural and family context, thus recognizing that it's a strongly subjective experience, and that the intervention, instead of the cure, is aiming at providing the most adequate techniques to each patient, in order to allow them to be autonomous in managing their pain2.

Resorting to the integrative model allows us to have a larger adequacy to the heterogenous population that the Pain Multidisciplinary Unit takes in, by joining different techniques for better adequacy to each patient.

The role of the psychologist in pain also contemplates performing psychological evaluation that allows collecting diversified and objective information about each patient. Besides pain, its impact on their lives is also evaluated so that we can potentiate the intervention, of which this clinical case is an example. This first evaluation is used as a starting point towards setting goals, and also as a way to monitor the effectiveness of the interventions [1].

Currently the multimodal intervention in pain, where psychology sets itself as a complementary technique, allows to effectively help the patient to feel a greater degree of control over pain, of re-balancing their life, improving the feeling of self-effectiveness [7].

Conclusion

Given the prevalence of pain in the general population, it's increasingly more pressing the development of investigation in the area of psychological evaluation of pain, as a starting point for any psychotherapeutic intervention. That investigation should translate in an increasingly effective intervention on pain, so as to minimize its impact, as well as its consequences, improving the quality of life of the patients. That's the objective of the technicians that make up the Pain Multidisciplinary Unit.

References

1. Moore R (2009) Biobehavioral Approaches to Pain. Springer Science. New York.
2. Roditi D, Robinson M (2011) The role of psychological interventions in the management of patients with chronic pain. Psychology Research and Behavior Management 2011;4: 41-9.
3. Bateman A, Brown D, Pedder J (2000) Princípios e práctica das Psicoterapias. Climepsi Editores, Lisboa.
4. Beck A, Newman C (2005) Cognitive therapy. In: Kaplan & Sadock's, Comprehensive textbook of psychiatry. 8th ed, Lippincott Williams & Wilkins, New York.
5. Breen J (2002) Transitions in the concept of chronic pain. Advances in Nursing Science 24: 48-59.
6. Greenberg J, Mitchell S (2003) Relações de Objecto na Teoria Psicanalítica. Climepsi Editores. Lisboa.
7. Fishman S, Ballantyne J, Rathmell J (2010) Bonica's Management of Pain. Lippincott Williams & Wilkins. Philadelphia.
8. Flor H, Turk D (2011) Chronic Pain: An Integrated Biobehavioral Approach. IASP Press.
9. Knapp P, Beck T (2008) Cognitive therapy: foundations, conceptual models, applications and research. Revista Brasileira de Psiquiatria 30: 54-64.
10. Moos R, Schaefer J (1984) The crises of physical illness: An overview and conceptual approach. In R. Moos (ed.) Coping with Physical Illness: New Perspectives. Nova Iorque, Plenum Press 2: 3-25.
11. Ogden J (2000) Psicologia da Saúde. (2ndEd.) Climepsi Editores, Lisboa.
12. Turk DC, Okifuji A (2002) Psychological factors in chronic pain: evolution and revolution. J Consulting Clin Psychol 70: 78-690.
13. Vasco AB (1992) Psicoterapeuta conhece-te a ti próprio: Características, crenças metateóricas, estilos terapêuticos e desenvolvimento epistemológico dos psicoterapeutas portugueses. Dissertação de doutoramento. Faculdade de Psicologia e de Ciências da Educação da Universidade de Lisboa.

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