BEHAVORIAL HEALTH DEPARTMENT – PRIMARY CARE CENTER AND FIREWEED
TREATMENT GUIDELINES FOR

CHRONIC PAIN / SOMATOFORMS

Revised By: Alex Orten, MD; Bob Chaney, PHD; Denise Dillard, PHD; Geri Chaney, MS, LPC; Joanette Sorkin, MD; Shelly Biss, MSW

CBG Approval Date: 11/21/2005
PIC Approval Date: 02/02/2006

Executive Summary

Introduction and statement of Intent

This treatment guideline is intended to assist clinicians in the Behavioral Health department in treatment planning and service delivery for patients with Somatization Disorder, Conversion Disorder and Hypochondraisis. It may also assist clinicians treating patients who have psychological problems associated with an identified medical problem. The treatment guideline is not intended to cover every aspect of clinical practice, but to focus specifically on the treatment models and modalities that clinicians in our outpatient treatment setting could provide. These guidelines were developed through a process of literature review and discussion amongst clinicians in the Behavioral Health department and represent a consensus recommendation for service provision for this disorder. The guideline is intended to inform both clinical and administrative practices with the explicit goals of outlining treatment that is: Effective, Efficient, Culturally Relevant, Acceptable to clinicians, program managers, and patients

Definition of disorder

Somatization Disorder: 300.81: History of multiple physical system complaints that cannot be fully explained in a medical way. Somatization disorder consists of a history of multiple medically unexplained physical symptoms that occur over a period of several years.

Conversion Disorder: 300.81: Motor or sensory function problems strongly associated with a stressor and cannot be fully explained by medical investigation. The predominant symptom in conversion disorder is a medically unexplained impairment of motor of sensory function that is suggestive of a neurological or medical illness.

Hypochondrasis: 300.70: Preoccupation with disease and misinterpretations of bodily sensations that cannot find evidence in medical investigation. The essential feature of hypochondriasis is a fear or conviction of having a serious illness despite receiving

Chronic Pain: Any of a number of pain problems associated with either/both psychological or physical/medical conditions. Most similar disorder to chronic pain Chronic fatigue and fibromyalgia

General Goals of treatment

As with treatment of all psychiatric illnesses, the goals of treatment are to reduce or eliminate symptoms and to restore function.

For somatoform disorders and chronic pain disorders this means patients will focus less on somatic concerns and experience significantly less distress and social occupational impairment. In addition it is expected that treatment and liaison with the patient's primary care provider will result in more appropriate utilization of medical resources. This could include reducing the number of unnecessary visits, lab tests and medication prescriptions.

Summary of 1st, 2nd and 3rd line treatment

If general medical condition has not been ruled out, refer to family medicine clinic for thorough physical examination and general health education. Consultation and liaison with primary care clinician is especially important in the treatment of patients with somatoform and chronic pain disorders given the high utilization of medical services exhibited by such patients.

It is not uncommon for these patients to undergo the same medical procedures multiple times by multiple providers. The mental health provider can be instrumental in encouraging coordination of services and consistent follow up with the same primary care provider when at all possible. In addition to consult and liaison functions, the mental health service may provide as 1st line direct service, group therapy for skill building and psychoeducation to better understand and manage their symptoms. Many patients may benefit from brief individual therapy prior to referral for group treatment. Additionally if group therapy focused on the treatment of somatoform disorders / chronic pain disorders is not available, consider individual therapy as outlined later to be 1st line treatment modality.

Antidepressant medications and non-addictive anti-anxiety medications may prove useful adjunctive therapies as these conditions often co-occur with somatoform / chronic pain disorders.

Approaches to patients who do not respond to initial treatment

Patients with somatoform disorders are often reluctant initially to consider psychological factors as a cause for their somatic symptoms. Also primary care clinicians are sometimes uncertain how to effectively refer such patients to a mental health provider. Care must be taken to assure the patient that their symptoms are not deemed feigned or made up. Feigned symptoms occur in the context of different disorders namely malingering or factitious disorders. Patients with somatoform disorders or chronic pain disorders are much more likely to respond favorable to the notion that their symptoms are real and distressing whether they originate centrally or peripherally. Such patients will often readily acknowledge that psychological factors such as “stress” or depression and anxiety may make their physical symptoms worse and negatively effect treatment. This will often pave the way for a smooth referral to mental health evaluation.

Within the team approach to treating patients with somatoform and chronic pain disorders, primary care providers may benefit from reminders that these patients will be well served if objective findings greater than subjective patient reports guide the choice of which, if any, procedures or medications to recommend. Avoiding unnecessary invasive procedures and medications may well avoid introducing unnecessary side effects and iatrogenic general medical conditions.

In this liaison role the mental health provider can also discuss the potential benefits of regular, brief reassurance visits to the PCP. At such monthly or bi weekly visits a patient can be reassured that their brief physical exam revealed no abnormalities and vital signs are within normal limits. Such investment of a few minutes a month may decrease patient and provider frustration.

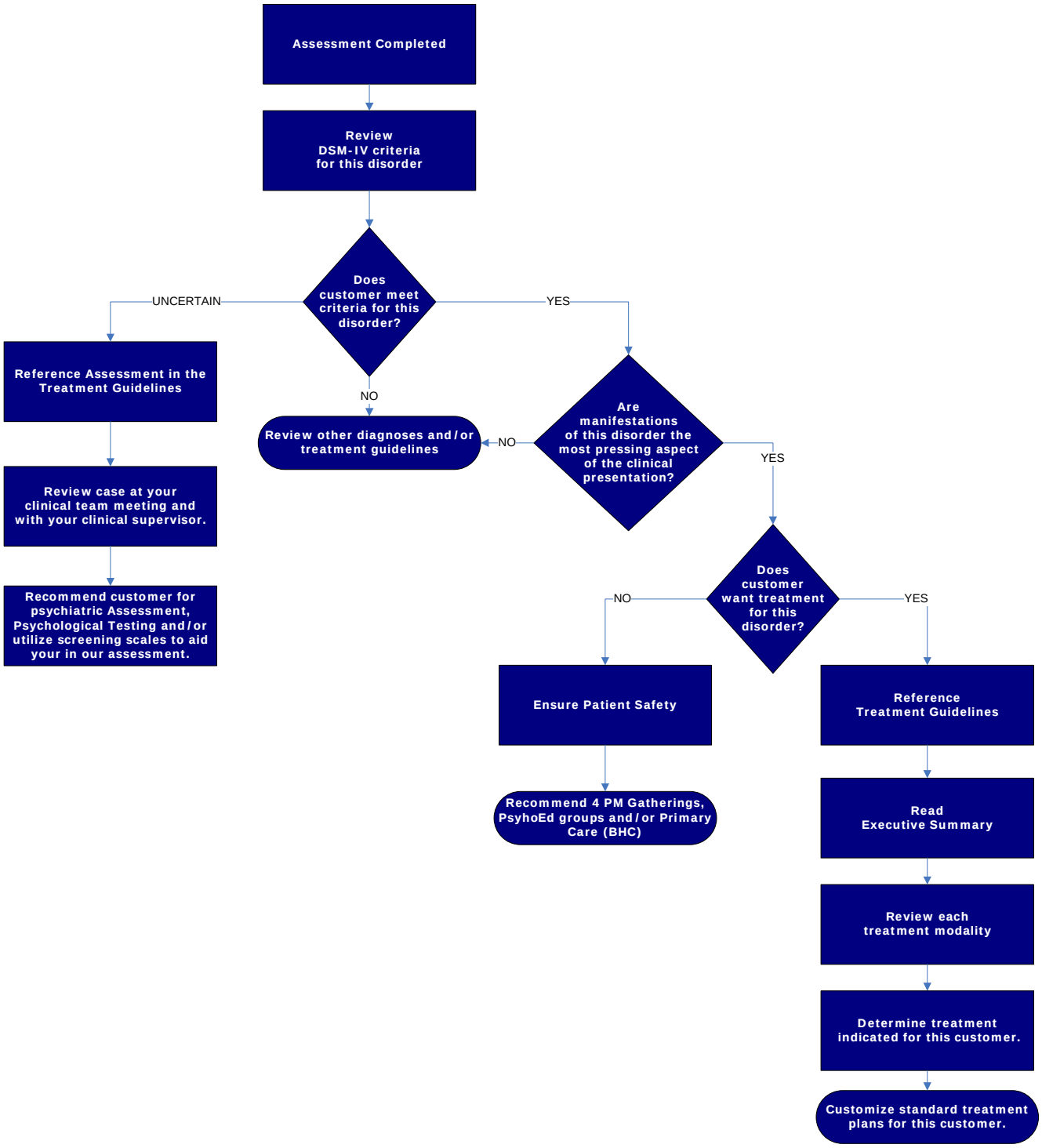
Clinical and demographic issues that influence treatment planning

There is no data to support or refute group therapy as a primary modality of administering psychoeducational, cognitive-behavioral or other psychotherapeutic treatments. Some patients with significant reservation about mental health treatment may best be served with a brief course of individual therapy at the onset of mental health care. This may increase the likelihood of successful referral for group therapy in those patients.

Comorbidity is common with somatoform and chronic pain disorders. Most common comorbid diagnosis include depressive disorders, anxiety disorders and personality disorders. Antidepressants and non addictive antianxiety medications may be useful adjunctive treatments. Given the chronic nature of these illnesses it is recommended that prescribers use caution in prescribing psychotropic agents with the potential to cause dependence.

While data are not available on the prevalence of Somatoform and Chronic Pain disorders specifically in the Alaska Native population, clinical experience suggests it is at least as prevalent as in the general population. The unique history of Alaska Native peoples, variation in levels of acculturation, and frequent differences in cultural background between patients and clinicians create unique challenges to providing effective, efficient and relevant care in our treatment setting. Although they may lack the formal evaluation and empirical validation of other treatment models, concurrent referral to a talking circle or a traditional healer may be appropriate for some patients.

Flow Diagram



Assessment

The Diagnostic Testing team will be reviewing and commenting on the Psychological Testing column for every disorder.

	Psychiatric Assessment	Psychological Testing	Screening/Scales
Indications	▪ Diagnostic dilemma or clarification of co-morbidity ▪ Symptoms that have not improved with standard interventions ▪ Patient or guardian requests a second opinion or wishes to consider pharmacologic intervention. ▪ Family medicine provider wishes to consider pharmacologic intervention	▪ Diagnostic clarification following assessment by MD or ANP. ▪ Question only answerable by psychological testing ▪ Appropriate physical assessment completed	• Establish baseline and/or monitor treatment effectiveness • Clarify symptoms
Contraindications	▪ Diagnosed severe cognitive disorder or developmental delay and collateral source not available ▪ Consent not available (if patient has guardian)	▪ Extremely dangerous to self and/or others ▪ Untreated psychosis ▪ Initial evaluation / assessment is not done ▪ Referral question not answerable and/or not clear ▪ Any physical causes of the disorder have not been ruled out ▪ Attention span inadequate ▪ School or other source has already conducted psychological testing within the last year ▪ Severely depressed	▪ Limited English proficiency. ▪ Attention span inadequate ▪ Lack of cooperation
Structure	In patients with cognitive impairment who cannot give adequate history, parent or guardian with knowledge of the patient's history must be available for assessment.	▪ Depends on the referral question	▪ Self-administered for adults and adolescents ▪ Completed by Parent and/or care giver for children or incompetent adults. ▪ Consider using one of the screening or scales referred in Appendix E.

Modalities & Treatment Models

Group Therapy

INDICATIONS	CONTRAINDICATIONS	RELATIVE CONTRAINDICATIONS
▪ Customer is 3 years old or older ▪ Mild to moderate severity ▪ Able to tolerate affect without behavior destructive to group ▪ Sufficient verbal and/or cognitive ability to benefit from treatment ▪ For customers under 18 years old, parental education and involvement is predictive of good outcome and should be integrated whenever possible.	▪ Dangerousness to self or others ▪ Sexually acting out behaviors ▪ Court ordered treatment with no buy in from child and/or guardian ▪ Child abuse investigation incomplete ▪ Severe untreated hyperactivity ▪ Untreated Psychosis or mania ▪ History of chronic or extreme disruptive behavior in groups ▪ Untreated substance dependence ▪ Acute intoxication or withdrawal from alcohol or other substances	• Diagnosis social phobia (May need individual therapy for group preparation) • Relatives or significant others in the same group (unless it is a family group and/or couples group) • Meets CMI or SED criteria without receiving rehab services • Lack of commitment from customer and if customer not competent, lack of commitment from parent and/or legal guardian

STRUCTURE

- Groups will be facilitated by a Master's Level Therapist and Case Manager
- For 17 years old and below, some age grouping recommended
- For 18 years old and above consider adult services

Duration	60 to 90 minutes for 10 to 15 weeks
Frequency	Once a week
Size	▪ 3 to 9 years old 4 customers per provider ▪ 10 years old and over 8 to 10 customers per provider
Open vs. Closed	Open or Closed with windows

TREATMENT MODEL

- Patient Education
- Biofeedback
- Relaxation training
- Operant Treatment
- Social and assertiveness skills training
- Imagery and hypnosis
- Habit reversal
- Worldview shaping
- Progressive Muscle Relaxation

Individual Therapy

INDICATIONS	CONTRAINDICATIONS	RELATIVE CONTRAINDICATIONS
• Group therapy contraindicated • Sufficient verbal and/or cognitive ability to benefit from treatment • Moderate to Severe severity • Unable to tolerate affect without behavior destructive to group ▪ Customer is 3 years old or older • Recent sexual, physical, abuse and/or neglect • For customers under 18 years old, parental education and involvement is predictive of good outcome and should be integrated whenever possible.	▪ Imminent dangerousness to self or others ▪ Lack of commitment or engagement from customer and if customer not competent, lack of commitment from parent and/or legal guardian ▪ Court ordered treatment with no buy in from child and/or guardian ▪ Child abuse investigation incomplete ▪ Untreated Psychosis or mania ▪ Acute intoxication or withdrawal from alcohol or other substances	

STRUCTURE

Duration	60 minutes
Frequency	▪ Weekly or Twice a Month ▪ Up to 8 sessions for treatment

TREATMENT MODEL

For customer with Somatoform disorder consider more frequent brief sessions and coordinate care with family medicine providers.

- Patient Education
- Biofeedback
- Relaxation training
- Operant Treatment
- Social and assertiveness skills training
- Imagery and hypnosis
- Habit Reversal
- Worldview shaping
- Progressive Muscle Relaxation

Family Therapy / Couples Therapy

INDICATIONS	CONTRAINDICATIONS	RELATIVE CONTRAINDICATIONS
▪ First line of treatment for 0 to 5 year old ▪ Disorder is impacting the family and/or relationship ▪ Family dynamic exacerbating or triggering symptoms ▪ Sufficient verbal and/or cognitive ability to benefit from treatment ▪ No buy-in to group and/or individual therapy ▪ For customers under 18 years old, parental education and involvement is predictive of good outcome and should be integrated whenever possible. ▪ Concurrent with group and/or individual treatment for children or adults with severe mental illness	▪ Imminent dangerousness to self or others ▪ Court ordered treatment with no buy in from child and/or guardian ▪ Child abuse investigation incomplete ▪ Current Domestic violence or abuse of child ▪ Custody dispute ▪ Untreated Psychosis ▪ Acute intoxication or withdrawal from alcohol or other substances	▪ Lack of commitment from customer and if customer not competent, lack of commitment from parent and/or legal guardian

STRUCTURE

Duration	60 minutes
Frequency	▪ Weekly or Twice a Month ▪ Up to 8 sessions for treatment

TREATMENT MODEL

For customers with Somatoform disorder consider more frequent brief sessions and coordinate care with family medicine providers.

Consider teaching family members and/or the customer these skills to assist with treatment.

- Patient Education
- Biofeedback
- Relaxation training
- Operant Treatment
- Social and assertiveness skills training
- Guided Imagery and hypnosis
- Habit Reversal
- Worldview shaping
- Progressive Muscle Relaxation

The family may also benefit from gaining awareness of how each family member as well as the family system can reduce stress.

Individual Medication Management

INDICATIONS	CONTRAINDICATIONS	RELATIVE CONTRAINDICATIONS
▪ Parent and/or legal guardian consent ▪ Current biopsychosocial intake or psychiatric assessment is available. ▪ Recommended concurrent with psychotherapy and/or psychoeducation	▪ Refuses Medication Management ▪ Acute intoxication or withdrawal from alcohol or other substances	▪ Documented history of medication non-compliance ▪ Disorder is caused by an untreated physiological disorder. ▪ Benzodiazepines should be used with caution in patients with a history of substance abuse and dependence. ▪ In general, Benzodiazepines should be used cautiously in customer with somatoforms disorders.

Somatofrms

SSRI and SNRI are often useful adjuncts in the treatment of somatoforms.
TCA and MAOI antidepressant medications may be useful considerations as well.

Second generation anti-psychotics may have a role in certain customers with somatoform disorders.

Chronic Pain, Fibromyalgia and Chronic Fatigue Syndrome

SNRI, TCA, anti-depressants are often helpful in the management of chronic pain. Depression often co-occurs with chronic and these anti depressants may have analgesic affect as well.

SSRI have not been as affective in the management of chronic pain.

Opiates are often used in the management of chronic pain through their primary care provider. The addictive potential of these medications may require multidisciplanry intervention.

Anticonvulsants (such as Gabapentin and Tegretol) can be helpful in certain chronic pain conditions.

STRUCTURE

Duration	30 minutes
Frequency	Monthly

TREATMENT MODEL

Recommended concurrent with psychotherapy and/or psychoeducation.

Group Medication Management

Need for parent and/or guardian presence makes group medication management impractical for customers 0 to 18 years old.

INDICATIONS	CONTRAINDICATIONS	RELATIVE CONTRAINDICATIONS
▪ If symptoms stable and patient cannot return to primary care for maintenance treatment, group medication management may be considered. ▪ History of non-compliance ▪ Able to tolerate affect without behavior destructive to group ▪ Frequently misses scheduled appointments	▪ Acute dangerousness to self or others ▪ Untreated psychosis ▪ Sexually acting out behaviors ▪ No child care available ▪ Severe untreated hyperactivity	▪ Diagnosis social phobia (May need individual therapy for group preparation) ▪ Relatives or significant others in the same group (unless it is a family group and/or couples group) ▪ Meets CMI or SED criteria without receiving rehab services

STRUCTURE

Duration	▪ 90 minutes ▪ 8 to 12 weeks for customer over 17 years old
Frequency	Once a week
Size	8 to 10 customers per clinician
Open vs Closed	Open

Psychoeducational Groups

This modality can be extremely helpful for families of customers with substance abuse and/or a mental health disorder. Psychoeducation should be considered for the family even if the customer cannot participate.

INDICATIONS	CONTRAINDICATIONS	RELATIVE CONTRAINDICATIONS
▪ Sufficient verbal and/or cognitive ability to benefit from treatment ▪ Able to tolerate affect without behavior destructive to group ▪ Could benefit from skills development	▪ Dangerousness to self or others ▪ Sexually acting out behaviors ▪ Untreated Psychosis or mania ▪ History of chronic or extreme disruptive behavior in groups ▪ Untreated substance dependence ▪ Severe untreated hyperactivity	

STRUCTURE

Groups will be facilitated by 1 to 2 Case Managers.

Duration	60 to 90 minutes for up to 8 weeks
Frequency	Once a week
Open vs. Closed	Open

TREATMENT MODEL

For customers with Somatoform disorder consider more frequent brief sessions and coordinate care with family medicine providers.

Consider teaching family members and/or the customer these skills to assist with treatment.

- Patient Education
- Biofeedback (
- Relaxation training
- Operant Treatment
- Social and assertiveness skills training
- Guided Imagery and hypnosis
- Habit Reversal
- Worldview shaping
- Progressive Muscle Relaxation

Case Management

All Ages	
Assessment	▪ Collect psychosocial history ▪ Collect collateral history and/or past treatment records ▪ Obtain patient and/or guardian consent ▪ Liaison with outside agencies and/or link to community resources ▪ Administer standardized scales ▪ Lead orientation to services ▪ Review and/or conduct client initial screening and triage
Treatment	▪ Psychosocial education ▪ Maintain supportive contact ▪ Triage current clients in crisis ▪ Crisis management (e.g. triage, risk assessment, skills coaching, referrals when needed) ▪ Community liaison work and coordination of care ▪ Manage charts ▪ Provide aspects of treatment ▪ Assist with group preparation ▪ Draft treatment plans ▪ Follow-up when customer fails to keep appointments. ▪ Encourage medication and treatment compliance ▪ Maintain frequent supportive contact for customers who frequently present with mental health crisis.
Follow-up	▪ Liaison with outside agencies and primary care ▪ Link to community resources ▪ Gather and disseminate information from external referral sources

Referral

- Possible referral to outside support groups if available.
- Consider referral to SCF Health Education for chronic pain 1 and 2.
- Consider referral to SCF Traditional Healing and Complementary Medicine.
- Refer to social security office for disability evaluation when appropriate.

INDICATIONS

- Services needed are not available within the Behavioral Health department.
- Meets CMI criteria and not receiving rehab services
- Legal custody or other issues predominate
- Needed treatment is available elsewhere.

CONTRAINDICATIONS

Meets criteria for treatment within the Behavioral Health department system

Primary Care

INDICATIONS

- Refuses specialty mental health care or has not engaged in mental health care.
- Specialty Mental Health care not available
- Uncomplicated Medication Management
- Maintenance Medication Management

CONTRAINDICATIONS

Higher intensity services needed to ensure safety to patient or others

Appendix A: Glossary

Term or Acronym	Term Definition
Acute Intoxication	A reversible substance-specific syndrome due to recent ingestion of (or exposure to) a substance. Clinically significant maladaptive behavior or psychological changes that are due to the effect of the substance on the central nervous system and develop during or shortly after use of the substance. (Adapted from DSM-IV)
Acute Withdrawal	A substance-specific syndrome due to the cessation of (or reduction in) substance use that has been heavy and prolonged. (Adapted from DSM-IV)
CBT	Cognitive Behavioral Therapy
Closed Group	Customers may enter only at initial formation of group.
Closed Group with Windows	Customer enrollment available intermittently
Eclipse	Overshadow, for example, when the symptoms and dysfunction related to one disorder overshadow another making treatment of one more pressing.
Exposure Therapy	Exposure therapy (Haug et al, 2003) with or without response inhibition is most cited as effective for specific phobia, obsessive compulsive disorder and PTSD. Generally, these run 10 -12 sessions with each session targeting a specific skill, exposure level and cognitive reframing. Manuals are available to guide clinical work.
Intervention	Any thoughtful action taken by a clinician or customer with the purpose of addressing a perceived problem or therapeutic goal
IPT	Interpersonal Therapy
NOS	Not Otherwise Specified
Open Group	Participants can enter at any time.
PDD	Pervasive Developmental Disorder
Play Therapy	Play therapy is a form of psychotherapy for children who have been traumatized. It encourages children to explore their emotions and conflicts through play, rather than verbal expression.
Psychiatric Assessment	Formal assessment by a psychiatrist or ANP
Psychoeducation	teaching and training about the disease or problem for which the customer or family member is seeking treatment. Psychoeducation is frequently presumed to be part of all forms of assessment and treatment, yet additional interventions that emphasize education about an illness are often shown to improve outcomes over treatment as usual. Psychoeducation can be incorporated into many treatments, but can be viewed as an intervention in its own right and can be delivered by non-professional staff such as case managers or health educators.
Psychological Testing	Formal psychological assessment which includes clinical interview and appropriate tests conducted by a psychologist and/or psychometrician. This testing is standardized and normed.
Screening/Scales	Brief, easily administered screening and scales which do not require advance training to interpret.
Social Rhythm Therapy	A structured psychotherapy combining elements of behavioral therapy and psychoeducation and shown to reduce rates of relapse and rehospitalization in bipolar disorder

Term or Acronym	Term Definition
Structural Family Therapy (SFT)	Structural Family Therapy is model of treatment in which a family is viewed as a system with interdependent parts. In this treatment model, the family system is understood in terms of the repetitive patterns of interaction between the parts. From such a perspective, the goal of structural family therapy is to identify maladaptive or ineffective patterns of interactions, then alter them to improve functioning of the subparts and the whole.
TBI	Traumatic Brain Injury
Treatment Modality	For purposes of this guideline, we have defined "modality" as the structure in which the customer receives treatment, for example, individual psychotherapy, group psychotherapy, or psychoeducation.
Treatment Model	For purposes of this guideline, we have defined the "model" of care as the underlying theoretical approach to clinical intervention, for example, Cognitive Behavioral Therapy, Insight Oriented Therapy, Interpersonal Therapy.
Untreated Psychosis	For the purposes of this treatment guideline, we define untreated psychosis as psychotic symptoms that are prominent, disruptive in some way, and for which the customer is not accepting or engaging in care that would mitigate such symptoms. The diagnosis of a psychotic disorder, or the presence of psychotic symptoms at some point in the course of illness or treatment should not be a barrier to participation in treatment that might be helpful. However, nor should a customer with a significant psychotic disorder be treated with some forms of psychotherapy from which they are not likely to benefit. Clinical judgment will be needed in selecting appropriate treatment for each customer.
Untreated Substance Dependence	Because "dual diagnosis" is the norm, rather than the exception in behavioral health settings, customers with substance abuse problems should not be excluded, a priori, from participation in treatment for other mental health conditions. However, the impact of their substance use on their capacity to participate in treatment must be assessed on an ongoing basis. Customers with current substance dependence may not be appropriate candidates for some forms of treatment.

Appendix B: Literature Summary

Evidence Based Clinical Guidelines
Southcentral Foundation Research Project
Summary Sheet
Somatic Disorders and Chronic Pain

Diagnosis: This is broad category of diagnoses and problems. The intention is too either work with individuals that lack a definitive physical etiology of their physical symptoms or work adjunctively with individuals that suffer with chronic pain and increased severity due to psychological factors.

300.81: Somatization Disorder: History of multiple physical system complaints that can not be fully explained in a medical way.

300.81 Conversion Disorder: Motor or sensory function problems strongly associated with a stressor and can not be fully explained by medical investigation

300.70 Hypochondriasis: Preoccupation with disease and misinterpretations of bodily sensations that can not find evidence in medical investigation.

Pain Disorders: Any of a number of pain problems associated with either/both psychological or physical/medical conditions.

General Information: Somataform disorders are difficult to diagnosis or miss depending on the context of the assessment and the instruments used. The general fact is that behavioral health interventions have a generally positive outcome when applied to either the real disorder or the psychological engaged disorders. Turk (2002) suggests that the deepening understanding of the process of pain and sources of suffering obscures the distinction between the psychological and physical. In fact, the social and cultural meaning of the pain or suffering is reported to strongly influence the outcome of any intervention. The consensus is that the process of listening, investigating and showing empathy are very therapeutic.

Group Therapy and Somatic Disorders: No specific group information was reviewed in the evidence based practices and empirically supported interventions. It is by extension that the CBT could be done in a group format. The dynamics of these disorders lend themselves to mutual support, education and cognitive behavioral group interventions.

Professional Status in Pain Disorders: Simon (2001) is clear that mental health professionals that have some understanding of physiological disorders that might manifest with psychological correlates and psychogenic disorders or psychological created problems can and should be central in the management of these populations. He notes that group and individual CBT and other techniques (biofeedback, relaxation, worldview shaping) are tools that mental health can bring to the team.

Brief Therapy Models and Somatic Disorders: Barsky, 2004, noted that six sessions of CBT for Hypochondriasis patients produced strong outcomes. The Evidence Based Mental Health review of this article noted that the structure and predictability of the interventions and the showing of empathy and support were important contributor to the outcome. Likewise, Looper (2002) outlined the evidence to support the use of Cognitive Behavioral Therapy with this category of client. The treatment were generally 12 weeks and focused on feedback loops, sensory interpretation and reassurance of health following thorough medical evaluations. Morley (1999) reviewed the evidence for CBT for chronic pain patients and concluded that it is quite effective. Although the intensity of the pain was decreased through relaxation training, biofeedback, cognitive reframing, the CBT method was superior. This follows Chapman (2004) when he outlined that meaningfully, worldview, cognitive catastrophic thinking and sensorial miscuing are addressed in therapy with pain patients (psychogenic and physical) that pain decreases, quality of life improves and daily functioning increases.

The fact that the physical and psychological as well as the social and worldview cannot be disengaged in a meaningful way in the current thinking, Turk (2002) and Simons (2001) posit that psychology in general can

work consistently and productively with a team and primary care in the support of these populations. Monsen (2000) noted that Psychodynamic Body Therapy, a form of CBT demonstrated adjunctive benefits in a cohort of chronic pain patients. It focused on affect regulation through cognitive processing, tolerance and re-organizing their interpretations.

Pharmacological Interventions: Many reviews noted that antidepressants help reduce pain in psychogenic pain, somatoform, chronic illnesses, chronic pain, Fibromyalgia and neuropathic pain. See: Fishbain (1998); Gill (1998); Sammons (2004)

Manuals: None noted.

Literature Summary References:

Barsky, A.J., Ahern, D. K., Cognitive Behavior Therapy for Hypochondriasis: A randomized controlled trial. *JAMA, 2004, Vol. 291, No. 12 1464-1470*

Chapman, C. R., Pain and Co-Occurring Disorders: A Mind-Body Perspective. Pain and Psychological Pathology Conference April 2004, Wasilla Ak.

Fishbain, D.A., Cutler, R.B., Rosomoff, H.L., Rosomoff, R.S., Do antidepressants have an analgesic effect in psychogenic pain and somatoform pain disorder? A meta-analysis. Psychosomatic Medicine. Vol. 60, Issue 4. 503-509

Gill, D., Hatcher, S., A systematic review of the treatment of depression with antidepressant drug in patients who also have a physical illness. Cochrane Review, 1998

Looper, K.J., Kirmayer, L. J., Behavioral Medicine approaches to Somatoform Disorders. *Journal of Consulting and Clinical Psychology. 2002. Vol. 70, No. 3, 810-827*

Monsen, K., Monsen, J.T., Chronic Pain and Psychodynamic Body Therapy, A controlled outcome study. *Psychotherapy. 2000. Vol. 31, No. 3. 257-269*

Morley, A., Eccleston, C., Williams, A., Systematic review and meta-analysis of randomized controlled trails of cognitive behavioral therapy and behavior therapy for chronic pain in adults, excluding headaches. *Pain. 1999, Vol. 80, 1-13*

Sammons, M.T., Pharmacological Management of Chronic Pain: I. Fibromyalgia and Neuropathic pain. *Professional Psychology: Research and Practice. 2004, Vol. 35, No. 2, 206-210*

Simon, E.P., Folen, R. A., The role of the psychologist on the multidisciplinary pain management team. Professional Psychology: Research and Practice. 2001. Vol. 32, no. 2, 125-134

Turk, D. C., Okifur, A., Psychological Factors in Chronic Pain, Evolution and Revolution. *Journal of Consulting and Clinical Psychology. 2002. Vol. 70, No. 3, 678-690*

Appendix C: References

1 Grinstead, Stephen F. and Terence T. Gorski. “Addiction-free pain management: relapse prevention counseling workbook”. 1997. (FYI: I got reproduction rights from the author for the clinic on file).

Appendix D: Sample Treatment Plans

Treatment Plan for Somatoform, Conversion disorder, Hypochondrasis, and Chronic Pain

Problems:

- Preoccupation with some imagined defect in appearance or excessive concern regarding a small physical abnormality.
- A physical malady caused by a psychosocial stressor triggering a psychological conflict.
- Preoccupation with the fear of having a serious physical disease without any medical basis for concern.
- A multitude of physical complaints that have no organic foundation and have caused the patient to change his/her life (e.g., seeing physicians often, taking prescriptions, and withdrawing from responsibilities).
- Preoccupation with chronic pain grossly beyond what is expected for a physical malady or in spite of no known organic cause.
- One or more physical complaints (usually vague) that have no known organic basis, or the complaining and impairment in life functioning are in excess of what is expected.
- Preoccupation with pain in one or more anatomical sites with both psychological factors and a medical condition as a basis for the pain.

Goals:

1. Reduce frequency of physical complaints and improve the level of independent functioning.
2. Reduce verbalizations focusing on pain while increasing productive activities.
3. Accept body appearance as normal even with insignificant flaws.
4. Accept self as relatively healthy with no known medical illness.
5. Improve physical functioning due to development of adequate coping mechanism for stress management.

Objectives:

1. Verbalize negative feelings regarding body and discuss self-prediction of catastrophized consequences of perceived body abnormality.
2. Discuss causes for emotional stress in life that underlie the focus on physical complaints.
3. Verbalized the secondary gain that results from physical complaints.
4. Verbalize an understanding of a relationship between emotional conflict and physical complaints.
5. Identify causes for anger. Express angry feelings assertively and directly.
6. List pleasurable and constructive activities that can serve as a diversion from self-preoccupation.
7. Increase social and productive activities rather than being preoccupied with self and physical complaints.
8. Identify family patterns that exist around exaggerated focus on physical maladies.
9. Identify causes for feelings of low self-esteem and inadequacy based in early family history.
10. Identify the connection between negative body image and general low self-esteem.
11. Verbalize acceptance of body as normal in function and appearance.
12. Implement the use of relaxation skills to reduce tension in response to stress.
13. Increase daily exercise regimen to reduce tension in response to stress.
14. Report on instances of taking active control over environmental events versus passively reacting like a victim.
15. Set aside a specific, limited time each day to focus on, talk about, and journal details of physical complaints.
16. Implement a self-punishment technique to reduce the focus on physical symptoms.
17. List coping behaviors that will be implemented when physical symptoms appear.
18. Poll family and friends regarding their concern about patient's physical complaints.
19. Decrease physical complaints, doctor visits, and reliance on medication while increasing verbal assessment of self as able to function normally and productively.
20. Engage in normal responsibilities vocationally and socially without complaints or withdrawal into avoidance using physical problem as excuse.
21. Accept referral to a pain clinic to learn pain management techniques.

Interventions:

- Referral for medical stabilization and more intensive inpatient or residential psychiatric treatment.
- Individual, group, couple, and/or family therapy
    - Psychoeducation
    - Biofeedback
    - Relaxation training
    - Operant treatment
    - Social and assertiveness skills training
    - Imagery and hypnosis
    - Habit reversal
    - Worldview shaping
    - Progressive muscle relaxation
- Medication Management
    - Individual
    - Group
    - SSRI, SNRI, TACA, MAOI
- Nutritional counseling and dietary education

Treatment Plan for Chronic Pain and Somatoform Disorders

Problem #1:
Chronic Pain and Somatoform Disorders

Goal:
Reduce pain and improve functioning in spite of any residual pain.

Objectives:

1. Customer will identify how chronic pain has impacted daily life
2. Customer will acquire and utilize necessary pain management skills
3. Customer will develop skills to manage pain in order to maximize daily functioning and returb to productive employment
4. Lessen daily suffering
5. Customer will gain control again over his/her life.
6. Customer will find relief from pain and build renewed contentment and joy in pe4rfomring activities of every day life.