



Case Report

Interpreting Total Pain : A combination of Complementary and Pharmacological Therapy A clinical application

Endrizzi C^{1*}, Mediani TS², Di Pietrantonj C², Sacchi V², Barbaro R², Fumagalli P², Speranza L² and Battistin I²

¹Palliative care Service of Mede, Local Health Unit of Pavia (ASST-Pavia), Italy

²Medical statistician, Regional Epidemiology Unit, Piedmont, Local Unit Health ASL AL, Italy

Abstract

Background

The multidimensional nature of pain and the distress of severe pain all raise particular attention in clinicians addressing the suffering. The difficulty of pain management recognizes neglected factors as psychological distress.

Objective

To illustrate the application of imagery and complementary instruments (hypnosis, mindfulness, art and movement therapy) as a way to interpret deep and unconscious contents behind the pain.

Analysis

In the clinical case, clinicians use the information collected during the sessions of expressive psychotherapy and the complementary approaches to reshape the pharmacological therapy and to manage the pain. During the sessions the patient draws about her biographical experiences, memories, images that contribute to the understanding of suffering and help her turning on creative resources stucked by the fixed thoughts of pain.

Conclusion

The application of these instruments provides opportunities for understanding the suffering and above all for limiting the excessive use of pharmacological therapy.

*Corresponding author: Endrizzi C, Palliative Care Service, ASST-Pavia, via dei Mille 23, 27035 Mede, Mede (PV), Italy, Tel: + 0039 384 808320, E-mail: hospice_mede@asst-pavia.it

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Introduction

Palliative and integrative medicine work in synergy; the core principles of palliative care meet the same goals of integrative oncology such as interdisciplinary person-centered care to enhance quality of life and reduce suffering [1]. Therefore complementary and integrative medicine are actually an important component of supportive cancer care [2], and may be potentially addressed to all patients with non oncological diagnosis in palliative care.

Mind-body interventions are practices that focus on the interaction between brain, body, mind and behaviour with the intent of using mind to alter physical function and promoting overall health [3]. Hypnosis has documented efficacy in a variety of conditions, as a means to control pain [4,5], pain-related anxiety [6], expressive therapies as art therapy, music therapy and movement therapy allow an increase in self-awareness, facilitate coping with symptoms, alleviate stress and encourage life-affirming pleasure of making creative experiences; there is growing evidence that body-mind therapies and arts therapy can contribute on reduction of pain [7-10]. Koch distinguishes five mechanisms through which creative art therapies and movement therapy work: hedonism, aesthetic experience, non-verbal meaning-making, enactive transitional space (experiencing activity, agency, constructive resources, rituals) and creation (generativity, productivity). Other more specific therapeutic mechanisms are connected to techniques of dance-movement therapy such as mirroring, movement analysis, meditative techniques, imaginative techniques, introspection and focusing [11].

In the debate concerning the clinical application of placebo for mitigating symptoms and the ethical feasibility of placebo administration, the American Pain Society recommends caution against the use of placebo to assess the nature of pain [11], placebo infact should not be used to invalidate a patient's pain complaint. A survey by Chen and Johnson [12], found that 27% of patients deemed it appropriate to use diagnostic placebo. Placebo analgesia is a well understood model of placebo effect with studies showing that placebo responders experience on average a 5 point (on a 10 point Numerical Rating Scale) reduction in pain [13]. Regarding an ethical standpoint, Kisaalita and Robinson findings [14], support that there are significant differences in the context of placebo administration, but that individuals are rather 'pragmatic' in their determination of placebo acceptability of pain. Particularly the change of resulting condition plays a role in placebo acceptability [15]. An improved condition goes along with less feeling of deception, more trust and less negative mood, than an unchanged condition or a worsened condition [15].

Case description

This case is about an 84-year-old woman with loco regional relapse of a breast cancer (G3 T2 N1 Mx): she was operated two years earlier and underwent postoperative radiotherapy as well, with no

indications to hormonotherapy. Her progress was complicated by venous thrombosis involving basilic, axillary and subclavian veins; she was than anticoagulated. From the beginning she experienced a mixed type pain: nociceptive somatic with neuropathic sensitization, associated with tissue edema, skin inflammation, allodynia and paresthesia. As time passed, she developed cutaneous anesthesia and flaccidity. Pain treatment was complex (opioids and adjuvants) and PRN medications were often needed (acetaminophen 1 g and morphine 5 mg BD). There was an associated altered state of mind with anhedonia, crying, social retirement. The patient refused any further oncologic therapy; she was admitted to Hospice for pain control, planning a further transfer to a Residential Care Facility once stabilized. The patient maintained a good performance status with a Karnofsky Grade of 40 (ECOG Grade 3), Palliative Prognostic Index [15], 3, 5 (survival more than 6 week). At admission she underwent a social and psychological assessment: hypoacusis made it difficult for her to run a conversation. Her husband died two years earlier, she had an alive daughter whilst her eldest daughter died in 1993 for HIV. The patient was a reserved person, a loner, not open to socialization; she always depended on her husband's authority and had little initiative; her family unit included two nieces (daughters of her alive daughter), a brother (who represented an important role model, linked to a happy time of her life) and her sister-in-law. The patient embraced the proposal of an expressive psychotherapy integrated with art and dance therapy, done by touch massage, synchrony between movement and breathing together with free association in the verbalization phase that accompanied the experience. The patient, who was right-handed, was stimulated to draw the pain itself: on the paper she drew an arm-contoured stretched shape represented as a bird; she then drew another stretched shape, a second bird and a two-year-old boy holding a ball with a string. The session allowed an intimate talk where the patient recalled the memory of the deceased daughter and of her helplessness against her drug abuse. The patient looked at her painful arm, a "dead arm" and shook her head as for resigned impotence. After the session the patient felt some relief and had the sensation of an inner movement of her fingers, without a physical movement visible. The therapist reported the session content to the team with the hypothesis of an old emotional pain fixed in the painful arm. Two other expressive psychotherapy sessions followed, with the possibility of accessing the patient's memories and confirming a probable psychogenic component within her pain associated with an organic cause. Thus, the team decided to try to treat the patient's requests of painkillers with placebo, which was actually effective. The patient, invited to draw during the psychotherapy sessions, started to draw autonomously by painting pre-printed shapes with different subjects (flowers, cartoons) living a new childlike dimension. The recruitment of creative resources introduced a new period (starting from the third week of hospitalization) in which the patient was concentrated on drawing that acted as a pain diverter. The patient underwent hypnosis sections as well (two sessions on the fourth and fifth week of hospitalization) introducing the hypnotic image of the balloon going up to the sky; during the hypnotic state she made small movements with her left thumb, reporting paresthesia and "flashes". Out of the hypnotic state she was surprised to see her arm was still there. The sessions lead to relaxation and distancing from the emotional aspect of the pain in her arm. During the following hypnosis sections, together with the positive image of the balloon taking the pain away, the technique of the "magic box" was added; it consists of putting the pain or its causes into a trunk, and placing it at increasing distance from yourself until it disappears to the metaphoric horizon. The patient, during her long stay, activated a

communication with her painful arm, tailoring it, scolding it and behaving as a mother with her child. The patient didn't tolerate the brace prescribed by the physiatrist and preferred keeping her arm on her lap, as a baby. After a congruous period of observation and treatments, including a physiotherapy series, the patient was transferred from the Hospice after four months of stay. [16,17]

Discussion

The expressive psychotherapy sessions integrated with art and movement psychotherapy allowed a deep analysis of the patient's emotional past, exploring the origin of her pain and helping to speculate about the connection of the organic pain with the life experience background. It was hypothesized that the "dead arm" recalled the impotence and the daughter's death. In the ideal and imagined vital motivation, represented by the arm holding a balloon, by the arm simulating a child to be cared of or scolded, by the childhood memories with the elderly brother, the impotent arm was subject to a regression to childhood which stimulated a new vitality and a return to life and socializing (with the Hospice team as well as with her family). It was chosen not to go on with psychotherapy with more evolved coping goals, but to do just what was necessary for pain management. The hypnosis sections offered a way to relax and a higher emotional serenity, stimulated patient's agency and her real possibility of improving her situation. The complementary tools in general allowed a reduction in medications requirements, a discrimination of the pain's psychogenic component permitting an ethical use of placebo; moreover, they allowed a modulation of the antidepressant therapy to finally optimize pain management.

The clinical description also proposes the use of analgesic placebo for reducing on-demand therapy while adjusting fixed time therapy. In this case the reason for placebo use was to avoid the iatrogenic effects of medications. The real patient suffering was not denied. Patient's age, the frequency of her requests, the multiple etiological components of pain and the pathology progression, even without short-term poor prognosis, requested particular caution in dosage and drugs formulation choice and excluded other strategies such as palliative sedation. On the effectiveness point of view there is not a big difference between the use of on demand therapy and placebo. In table 1 we shows that the reduction of NRS (numerical rating scale for intensity of pain) is statistically significant after pharmacological therapy and after placebo (5%). In both cases the reduction is comparable (-5.4); baseline values of NRS are also similar (6.3 before the pharmacological therapy; 5.6 before the placebo). The valuation of psychological attitude and biographical experiences through the complementary approach sessions suggested the use of analgesic placebo in addition to fixed time therapy.

	NRS	NRS After Therapy	Mean Difference	Lower Limit CI 95%	Upper Limit CI 95%
Mean	6.33	0.93	-5.41	-6.09	-4.73
SD	1.4936	1.2380	1.7155		
Sample size 27					
Mean	5.56	0.19	-5.36	-5.65	-5.07
SD	1.1325	0.7491	0.8669		
Sample size 36					

Table 1 : Pain intensity reduction: comparison of episodes treated with drug therapy and treated with placebo.

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