Their pain is real – and for patients with mystery illnesses, help is coming from an unexpected source

'It's all in your head' isn't something many patients love to hear, but for some of those with the least understood and most expensive ailments, it may be true – and a made-in-Canada approach is uncovering new evidence to back that up

ERIN ANDERSSEN ›

INCLUDES CORRECTION
PUBLISHED DECEMBER 8, 2018

For more than a decade, Kim Hawes of Dartmouth, N.S., suffered from chemical sensitivity, agoraphobia, anxiety and depression, and no doctor could tell her why. Her condition resolved and she was able to return to work after undergoing an innovative form of talk therapy with psychiatrist Allan Abbass, whose methods suggest that unexplained physical symptoms can be caused by unresolved emotional trauma.

DARREN CALABRESE/THE GLOBE AND MAIL

At his psychiatric clinic at QEII Health Sciences Centre in Halifax, Allan Abbass is showing video clips of his therapy sessions.

A man arrives via wheelchair, dragging frozen feet the last few steps, leaning heavily on a cane. He takes a seat, talks to Dr. Abbass. When he leaves, he carries his cane under his arm.

A pixie-haired woman who has not spoken for a month sits before him in another clip. She's been seen by a team of doctors, who found nothing. By the end of the first session, she speaks, in full, clear sentences.

A middle-aged office manager with an uncontrollable tremor is being considered for brain surgery; 90 minutes of therapy later, she triumphantly waves a stapler in the air, her tremor gone.

Dr. Abbass knows how it sounds. He's used to skeptics, at least until he rolls the tape.

But these aren't miracles, he says. This is science.

Dr. Abbass, middle, reviews video of therapy sessions with colleagues Angela Cooper, left, and Joel Town. He specializes in an innovative form of talk therapy called Intensive Short-Term Dynamic Psychotherapy.

DARREN CALABRESE/THE GLOBE AND MAIL

The people Dr. Abbass and his small team see are some of the most expensive in the health care system, and often among the longest suffering. Research suggests they account for up to half of all visits to family doctors and about 15 per cent of specialist appointments, reporting ailments that are often surprisingly common, such as migraines, lower back pain and upset stomach, but that can't be traced to a medical cause. In the worst cases, they return again and again, haunting waiting rooms and emergency departments, enduring rounds of tests and intrusive examinations that come back negative. As employees, they rack up sick days. Many end up on long-term disability. They are often unfairly suspected of faking. But their pain is real, says Dr. Abbass. It's just been caused, or made worse, by psychological factors.

Dr. Abbass, the head of Dalhousie University's Centre for Emotions and Health, treats patients with these unexplained medical symptoms, a phenomenon also known as somatoform disorder, with an innovative form of talk therapy that's producing impressive results. Called Intensive Short-Term Dynamic Psychotherapy, or ISTDP, the psychological approach deals with unconscious negative emotions – often guilt or anger linked to an emotional trauma suffered years or decades earlier – which have manifested as a physical symptom. Once the devastating event is addressed, the unexplained symptom can disappear or be significantly reduced, Dr. Abbass says, in as many as three-quarters of patients. In some cases, all it takes is a handful of sessions.

Dr. Abbass and other health care professionals who've studied ISTDP say the approach, which is now being tested more extensively through pilot projects in Nova Scotia, could save the health care system many millions of dollars – to say nothing of easing suffering for the up to 25 per cent of patients who may be affected by medically unexplained symptoms. One example, says Dr. Abbass, can be seen with irritable bowel syndrome, a diagnosis that can have a psychological cause. According to a recent presentation he made to the Nova Scotia government, the 40,000 Nova Scotians alone with this condition bill roughly $160-million a year in direct health care costs and disability payments.

Dr. Abbass has a growing stack of research to support his case. In studies, ISTDP has been found to reduce hospital stays, emergency room visits and doctors' appointments. One study, published in the Journal of Psychiatric Research in 2015, which followed roughly 890 Nova Scotians with psychiatric or medically unexplained symptoms over three years, reported an average savings in health care bills of $12,628 for each patient who underwent ISTDP compared to a control group of patients who didn't. The average cost for ISTDP treatment for the patients in the study was $708. A similar study showed that 56 per cent of patients on medical leave who received the therapy returned to their jobs – saving millions of dollars in disability payments.

The therapy is getting attention in other parts of Canada and internationally. John Ogrodniczuk, the director of the University of British Columbia Psychotherapy Program, who has worked with Dr. Abbass, calls his approach “a model to follow,” one that “holds tremendous promise” for hard-to-treat patients. In Britain, psychologist Leo Russell, a former student who now practices ISTDP and heads a public clinic that specializes in treating somatoform patients, says the research by Dr. Abbass presents “an excellent solution to an unenviable problem of our time; how to get more for less.”

Dr. Abbass’s work could help countless people. But more broadly, it challenges the way society – and the medical system – have traditionally separated physical symptoms from mental illness and emotions, dividing what the body feels from what the mind thinks. So stomach pain gets treated in one building, and anxiety in another, and surgeons don’t regularly consult with psychiatrists. The notion that stress can make us physically sick is hardly new. But if a patient is told that the pain they feel is “all in their head,” they’d probably be insulted.

Yet if a bad day can cause a headache, why can’t many bad days cause more serious physical problems, even decades later?

Why, when we experience pain, does a tumour make more sense than a trauma?

Dr. Abbass calls his form of therapy 'tough coaching,' designed to stir up negative emotions and release them.

DARREN CALABRESE/THE GLOBE AND MAIL

Elizabeth Burns, 56, is one of the patients that Dr. Abbass shows on video. She arrives to her first therapy session in flowered pajamas, walking gingerly from the Halifax hospital room where she's been living for seven months. She's carrying a vomit tray. Weakened by malnutrition, her voice has withered to a whisper.

Her doctors booked the appointment with Dr. Abbass because they couldn't find a solution to her severe stomach problems – not even after poking and prodding by specialists, and a marathon of ultrasounds, CT scans and unsuccessful drug therapies.

When Ms. Burns learned they were sending her to see a shrink, she raged at them. She figured the doctors had given up, that they thought she was nuts. As if anyone, she says, could – or would – fake months of uncontrolled vomiting, stomach pain that felt worse than childbirth, and never being able to eat without a bucket at the ready.

On the video, she slumps wearily in her chair, greeting Dr. Abbass's silence with a hostile stare. As she explains later in an interview, running through her mind is this thought: "What the hell are you going to do for me?"

Years ago, working in family practice and emergency rooms in Nova Scotia, Dr. Abbass was asking himself the same question when confronted by patients like Ms. Burns. He would run the appropriate tests and come up empty.

"I didn't have a clue," he recalls. "But I knew something wasn't right."

In the fall of 1990, he took a year off to study at McGill University, where, by chance, he attended a presentation by a psychiatrist named Habib Davanloo, who had pioneered ISTDP two decades earlier and was demonstrating the results with patient videos. "I was shocked by what could happen in an hour or two of interviews," Dr. Abbass recalls.

"I was convinced this was something important." Two years later, he went on to complete a psychiatric residency, studying for a decade under Dr. Davanloo, who is now in his 90s and a professor emeritus.

The therapy is based on the idea that repressed negative emotions can emerge as physical symptoms, and that triggering, or releasing, those emotions can relieve them. Where cognitive behavioural therapy (CBT), for instance, focuses on changing thought patterns to alter behavior, ISTDP draws a client's attention to their physical responses to address unresolved feelings such as anger or guilt. One unique feature of the therapy is that sessions are videotaped so that therapists can review their work with colleagues and sometimes with patients themselves.

At the Halifax clinic, patients come for a single session, designed as a test to see if the therapy might work for them; on average, treatment lasts about seven appointments, although Dr. Abbass has treated his most serious cases for as many as 60 sessions.

True to its name, the sessions are intense: This is not warm and fuzzy therapy. Dr. Abbass calls it "tough coaching," or a "positive irritating process." In ISTDP, clinicians do not sit back, taking notes, posing occasional queries, while the patient takes the lead. They are active participants, asking questions and challenging answers.

Though towering at a lean six-foot-nine , Dr. Abbass has mastered shrinking in a chair, and posing dark questions with genial curiosity: "Did you feel so angry toward your [abusive] mother that you wanted to kill her? How did you want to kill her? What is your body doing right now, thinking about that?"

"The idea from the first session," he explains, "is to stir up emotions so that symptoms come and go – evidence that there's a psychological cause, and also, confirmation that doctors haven't missed a physical explanation." (Usually, by the time, they arrive in Dr. Abbass's clinic, every possibility has been explored, he says, but in rare cases, his team has sent patients back to the referring specialist, recommending more tests – one woman had a developing case of pneumonia, a male patient was found to have gallstones.)

Stir up emotions, says Dr. Abbass, and what you find, in as many as 95 per cent of his cases, is a childhood story, one that's been buried deep, carried like a malignant cell into adulthood, until it emerges as headaches or stomach pain or any number of physical ailments. The story could be abuse, abandonment or neglect. The death of a parent. A toxic divorce. Researchers call these "adverse childhood experiences," and more studies are linking early trauma to later-in-life problems, not only addiction and mental illness, but diabetes, heart disease and somatic or unexplained medical symptoms.

For some, the symptoms may appear after a sudden shock, and recent stressful event – walking in on a cheating spouse, for instance. Sometimes, says Dr. Abbass, the event isn't even negative – a big promotion or life change can also be a trigger. Depression and anxiety, or personality disorders, also play a significant role.

In the video examples, Dr. Abbass waits for the patients to metaphorically open a door – a reference, typically, to a difficult family member or painful past event – and then pushes them to express their fear or anger or guilt, drawing attention to the way they tense up or make a fist or take a big sigh. Indeed, on the videos, patients tended to bring up the trauma almost spontaneously, like a gasp after being under water too long. Even so, Dr. Abbass says, the patient will often deny feeling anything, until he points out their body's response. He might encourage them to imagine their rage being expressed by a third person, or even directed at him, their persistent interviewer. Some patients, he says, offer graphic descriptions of their pain – the sensation of a hand tightening on their neck or a knife stuck in their chest – and "you can predict what the rage is going to do."

In one session, a 68-year-old patient refers to pain "like his head is being blown off"; as the session goes on, he angrily describes hating an abusive parent so much that as a child he wanted to shoot them in the head. By the eighth session, after four decades of unexplained pain, the patient reported being virtually symptom-free, says Dr. Abbass. "At the end of my life," the patient says on the tape, in his last session, "I am starting again."

In the diverse field of psychology, ISTDP does have critics. Alan Karbelnig, a psychologist in California who attended a conference in 2016 at which Dr. Abbass spoke and showed videos of his sessions, suggests that ISTDP "creates a bizarre, stressful environment for patients," in which they may to be too quick to please their therapist by providing the right answers.

Dr. Karbelnig specializes in psychoanalysis, a long-term, patient-led therapy that also explores links between the unconscious and the conscious, so his objections to a more forced, short-term approach are perhaps not surprising. But even fans of Dr. Abbass, point to some of its shortcomings.

"Inelegantly performed ISTDP can be a source of emotional harm," suggests Robert Tarzwell, a clinical assistant professor of psychiatry at UBC, who has conducted brain imaging research with Dr. Abbass, "whereas this is less likely with techniques such as CBT."

As well, unlike CBT, which can be practised from a manual, ISTDP takes longer to learn, with students under close supervision. In fact, Dr. Abbass currently trains clinicians around the world in the therapy, including in Britain, and in Norway, where therapists study for six years before being certified and where the publicly funded use of ISTDP is expanding for treatment-resistant psychiatric patients, including those with medically unexplained symptoms. (In Canada, although governments have been expanding access to talk therapy in the public system, more specialized treatments such as ISTDP aren't widely available, but there are practitioners scattered across the country, mostly in private practice.)

Other Canadian experts who treat somatoform disorders suggest patients need better access to a variety of options. The Health Psychology Clinic at the Royal University Hospital in Saskatoon, for instance, treats people with unexplained symptoms with a less-intensive version of ISTDP therapy. At UBC's Neuropsychiatry Clinic, patients with medically unexplained symptoms are offered physio or occupational therapy, as well as counselling and medication, depending on their situation. (Two of the clinic's neuropsychiatrists, Anton Scamvougeras and Andrew Howard, published a book this fall calling for more resources and physician education for these patients.)

ISTDP, as with any treatment, isn't a solution for everyone – as Dr. Abbass readily admits. Not everyone gets better, and in many of his patients, symptoms improve but still linger.

And he acknowledges the concerns about ISTDP – when he first watched the video as a student, he too was convinced the therapist was "attacking the patient." But clinicians are trained to push, he says, only as far as the patient will allow.

He also points out that, unlike the closed-door approach of many therapies that still rely largely on a clinician's own notes and subjective conclusions, the videotaping, patient feedback surveys and peer-review aspects of ISTDP create a level of supervision that safeguards patients and catches off-track therapy quickly. The results, he argues, speak for themselves.

"This isn't the explanation for all human suffering," Dr. Abbass says. But for many patients "we can't just put a pill on it. It just doesn't work."

At the Halifax clinic where Dr. Abbass conducts therapy, average treatment lasts about seven appointments, although he has treated his most serious cases for as many as 60 sessions.

DARREN CALABRESE/THE GLOBE AND MAIL

A few years ago, Samuel Campbell was called to the emergency room at the QEII to see a woman complaining of stomach pain. She had been in three times in as many days, asking for morphine so insistently that the nurses believed she was exaggerating to get drugs.

When Dr. Campbell pulled back the curtain to examine her, he found her writhing in pain. The regular tests, however, had found nothing. But Dr. Campbell recalled a presentation he had just heard by a psychiatrist in the hospital, and so he asked her a new question: What was happening in her life?

She told him, in a flood of emotion, about her adult daughter who had moved back into her home to flee an abusive relationship. They didn't have much money, and she was worried about how to support her. Dr. Campbell listened, suggested her pain might be caused by stress, and proposed an appointment with Dr. Abbass.

When he came back, ready to give her a script to help with the pain, she declined. The pain, she told him, was gone.

But it was still real, says Dr. Campbell, the chief of the emergency and trauma centre. “People aren’t coming at six in the morning, and waiting six hours in emergency, because nothing is wrong with them.”

Their problems, however, don’t register on a traditional medical scan. According to Dr. Campbell, as many as 20 per cent of patients who come to emergency leave without a confirmed diagnosis. (On a medical chart, it’s often checked as NYD – not-yet diagnosed.) The doctor rules out a heart attack or a blood clot and sends them home. At other times, “we give it our best guess,” he says. Sometimes, that best guess sticks – what medical professionals call “diagnostic momentum” – and the patient leaves convinced that their problem has been solved, carrying a label back to their GP, and setting up a new round of unnecessary testing.

But there's good reason for this: Doctors are afraid to miss something. "The one thing in medicine you don't want to do is to tell people they have stress-related illness, and it turns out they have cancer," says Dr. Campbell.

The risk of moving too quickly to a psychiatric explanation troubles Michael Negraeff, the head of pain management at UBC's Department of Anesthesiology, Pharmacology and Therapeutics, although he concedes it runs both way – when a physical explanation is found, doctors "forget" the role of psychological factors. "There's stigma if we overattribute to psychology," he says. "But there's risk of overmedicalizing problems if we overattribute to biology." To design a better system, he says, "we just need to remember that all factors are important, not to dismiss any prematurely."

But patients want answers, understandably, ones without a social stigma attached to them. Sometimes, when Dr. Campbell proposes an appointment with psychiatry, people storm out. "One patient wrote a sarcastic note on the internet and called me an idiot." In some cases they just want a label slapped on their symptoms – and doctors give in. "I am not judging," says Dr. Campbell. "I was also doing this for the last 10 years. It was my way of keeping the conveyor belt going."

Creating a closer connection between ER doctors and clinicians at the Centre for Emotions and Health appears to have slowed at least one conveyor belt. Repeat ER visits for somatoform patients fell, on average, by 69 per cent following a pilot project. With the additional funding from the project, doctors were educated on how to identify people with medically unexplained symptoms and a senior psychiatry resident was temporarily placed in the ER to foster referrals.

A second pilot project, extended from three to four years and funded by the province, allowed the centre to hire additional staff to offer ISTDP to patients at several primary care clinics. As a result of early positive findings, the N.S. health department is now considering a provincewide program that would place more clinicians in more locations, giving local emergency departments and family doctors better access to ISTDP for their patients. The program would cost $1.8-million a year, Dr. Abbass estimates, but based on the research, he says, it could save at least $5-million.

Dr. Campbell says his collaboration with Dr. Abbass has already made his work more efficient. When he suspects a somatoform disorder, he now explains how stress works, and suggests a psychiatric evaluation at the same time that he proposes other medical tests.

He wants patients to understand that an emotional cause should be investigated with the same credibility as angina or migraines – not as the hail-Mary pass for a baffled doctor but, in the right cases, as legitimate as the CT scan checking for tumours.

Matthew Isnor developed Tourette's-like symptoms when he was 21. His facial twitches and throat clearing all but disappeared after seven sessions with Dr. Abbass, whom he says observes patients 'like a hawk' during therapy.

DARREN CALABRESE/THE GLOBE AND MAIL

It's been nearly two years since computer specialist Matthew Isnor finished his stretch of ISTDP to treat a case of Tourette's-like symptoms, which came on suddenly at age 21.

By the time, he was referred to Dr. Abbass, he'd seen a neurologist and a psychologist and was taking half a dozen prescriptions, the side effects of which, he says, were even worse than the constant facial twitches, snorts and ticks. On his video, he arrives, clearing his throat painfully, every 15 seconds or so. When he leaves, the snorting and hacking has lessened. Fast forward seven sessions, and they are barely noticeable.

In an interview interrupted only by occasional throat-clearing, Mr. Isnor says Dr. Abbass is "like a hawk" during therapy. "When he is asking you questions, he is paying attention to what you are saying, how you are saying it, even what your eyebrows are doing." Over a total of 20 sessions, they talked about unresolved anger from his childhood and the stress of having a brother with severe Tourette's, which is why Mr. Isnor's symptoms were first assumed to be hereditary. Digging deep into that emotional history, he says, is what slowly made him better. His symptoms are mild enough now that he has stopped his medication and resumed a normal life.

'I feel like a toxic waste dump,' patient Kim Hawes told Dr. Abbass when she first sought his help. After eight years on disability, she is back to work full time.

DARREN CALABRESE/THE GLOBE AND MAIL

Another patient, Kim Hawes is a public servant who returned to work after eight years on disability following 45 sessions with Dr. Abbas. She compares the therapy to "emptying pockets" of emotion one by one, "until they were all gone, and I walked out a free woman." Following an accidental chemical exposure at work, she developed debilitating sensitivities to certain environments. At one point, she could barely handle leaving her house. Last year, she took the train across the country. She has become a spokesperson for expanding the treatment to more patients. "I thought I would be on disability forever."

And then there this is Elizabeth Burns, the patient with uncontrolled vomiting, who arrived at her second session prepared to give therapy a chance. That day, she spoke about the sexual abuse that forced her to leave home when she was a teenager. Until then, she had told no one but her husband, her high school sweetheart.

“How do you feel?” Dr. Abbass asks, at the end of their second meeting.

“Lighter,” she says.

“Guilt and rage can weigh down a person,” he tells her. “In their bones, they can feel bad.”

A few days later, Ms. Burns went home from the hospital. “I guess he was treating me, not my stomach,” she says.

Now she is back to her normal life, gardening and spending time with her family, enjoying meals, cracking jokes. In the last year, she says she felt that familiar sickness in her stomach only twice.

When it happens, she slips away and pretends she is back in the room with Dr. Abbass, remembering their conversations. “Then I feel better, and I go back up, and join the world again.”

Editor’s note: Dec. 8, 2018: An earlier version of this story incorrectly identified Anton Scamvougeras and Andrew Howard as psychologists. In fact, they are neuropsychiatrists.

Comment