Chronic pain in adolescents: evaluation of a programme of interdisciplinary cognitive behaviour therapy

C Eccleston, P N Malleson, J Clinch, H Connell, C Sourbut

Aim: To determine the effectiveness of an interdisciplinary cognitive behavioural treatment for adolescents with chronic pain.

Methods: Fifty seven adolescents (mean age 14.28 years) with chronic pain and 57 accompanying adults underwent an interdisciplinary three week residential programme of group cognitive behavioural therapy. Mean chronicity of pain was 4.02 years; 75% were absent from full time education (mean absence 17 months).

Results: Post-treatment adolescents reported significant improvements for self-report of disability (mean difference 3.37 (95% CI 0.65 to 6.09)), physical function (mean difference timed walk of 2.61 seconds (1.02 to 4.2) and sit to stand of 3.22 per minute [0.79 to 5.65]). At three months post-treatment adolescents maintained physical improvements and reduced anxiety (mean difference 1.7 [0.72 to 2.67]), disability (mean difference 4.3 [1.44 to 7.17]), and somatic awareness (mean difference 4.43 (1.53 to 7.33)). Following treatment adults reported significant improvement in their report of adolescent disability (mean difference 4.43 (2.17 to 6.7)), adult anxiety (mean difference 1.73 (0.54 to 2.92)), depression (mean difference 1.6 (0.34 to 1.98)), and parental stress (mean difference 10.81 (2.91 to 18.78)). At three months significant improvements were maintained. At three months 64% improved school attendance; 40% had returned to full time education.

Conclusions: Interdisciplinary cognitive behavioural pain management (with family involvement) is a promising approach to the management of pain, pain related distress, and disability.
Table 1  Biographical and clinical details of 57 adolescents entering treatment programme

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Number</th>
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<tbody>
<tr>
<td>Female</td>
<td>41</td>
</tr>
<tr>
<td>Age (mean)</td>
<td>14.28 years</td>
</tr>
<tr>
<td>SD (range)</td>
<td>1.60 (11–17)</td>
</tr>
<tr>
<td>Accompanied by</td>
<td></td>
</tr>
<tr>
<td>Mother</td>
<td>44 (77.2%)</td>
</tr>
<tr>
<td>Father</td>
<td>7 (12.3%)</td>
</tr>
<tr>
<td>Both parents</td>
<td>3 (5.3%)</td>
</tr>
<tr>
<td>Grandmother</td>
<td>3 (5.3%)</td>
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<tr>
<td>Adults at home</td>
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<tr>
<td>Father</td>
<td>41 (71.9%)</td>
</tr>
<tr>
<td>Stepfather</td>
<td>8 (14.0%)</td>
</tr>
<tr>
<td>Mother</td>
<td>56 (98.2%)</td>
</tr>
<tr>
<td>Siblings</td>
<td></td>
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<tr>
<td>None</td>
<td>8 (14.0%)</td>
</tr>
<tr>
<td>One</td>
<td>31 (54.4%)</td>
</tr>
<tr>
<td>Two</td>
<td>13 (22.8%)</td>
</tr>
<tr>
<td>Three</td>
<td>4 (7.0%)</td>
</tr>
<tr>
<td>Four</td>
<td>1 (1.8%)</td>
</tr>
<tr>
<td>Employment status at home</td>
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</tr>
<tr>
<td>Full time</td>
<td>20 (35.1%)</td>
</tr>
<tr>
<td>Part time</td>
<td>14 (24.6%)</td>
</tr>
<tr>
<td>Disabled</td>
<td>6 (10.5%)</td>
</tr>
<tr>
<td>Homemaker</td>
<td>10 (17.5%)</td>
</tr>
<tr>
<td>Student</td>
<td>2 (3.5%)</td>
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<tr>
<td>Unemployed</td>
<td>5 (8.8%)</td>
</tr>
<tr>
<td>Diagnosis</td>
<td></td>
</tr>
<tr>
<td>Fibromyalgia</td>
<td>9 (15.8%)</td>
</tr>
<tr>
<td>CRPS</td>
<td>15 (26.4%)</td>
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<tr>
<td>Diffuse idiopathic pain</td>
<td>14 (24.6%)</td>
</tr>
<tr>
<td>Localised idiopathic pain</td>
<td>7 (12.3%)</td>
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<tr>
<td>Disease related</td>
<td>8 (14.0%)</td>
</tr>
<tr>
<td>Headache</td>
<td>1 (1.7%)</td>
</tr>
<tr>
<td>RAP</td>
<td>2 (3.5%)</td>
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<tr>
<td>Renal pain</td>
<td>1 (1.7%)</td>
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<tr>
<td>Onset</td>
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<tr>
<td>Sudden</td>
<td>28 (49.1%)</td>
</tr>
<tr>
<td>Gradual</td>
<td>23 (40.4%)</td>
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<tr>
<td>Unknown</td>
<td>6 (10.5%)</td>
</tr>
<tr>
<td>Chronicity</td>
<td></td>
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<tr>
<td>Mean</td>
<td>4.02 years</td>
</tr>
<tr>
<td>SD (range)</td>
<td>3.57 (1–15)</td>
</tr>
<tr>
<td>Frequency of pain</td>
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<tr>
<td>Persistent</td>
<td>47 (82.5%)</td>
</tr>
<tr>
<td>Intermittent</td>
<td>4 (7.0%)</td>
</tr>
<tr>
<td>Not known</td>
<td>6 (10.5%)</td>
</tr>
<tr>
<td>Site of primary pain</td>
<td></td>
</tr>
<tr>
<td>Total body</td>
<td>26 (45.6%)</td>
</tr>
<tr>
<td>Head</td>
<td>1 (1.7%)</td>
</tr>
<tr>
<td>Limb</td>
<td>15 (26.4%)</td>
</tr>
<tr>
<td>Back</td>
<td>8 (14.0%)</td>
</tr>
<tr>
<td>Abdomen</td>
<td>4 (7.0%)</td>
</tr>
<tr>
<td>Hip</td>
<td>3 (5.3%)</td>
</tr>
</tbody>
</table>

**Table 1** Biographical and clinical details of 57 adolescents entering treatment programme.

CRPS, complex regional pain disorder I; RAP, recurrent abdominal pain.

Adolescent measures

- **Pain.** Two continuous visual analogue scales of intensity (VAS) were used to measure current pain, and level of pain over the previous week.
- **Anxiety.** The Spence Children’s Anxiety Scale (SCAS) provides an overall measure of anxiety and six subscales, each tapping a specific aspect of child anxiety. The scale has concurrent validity in relation to other child report measures of internalising problems (for example, the Child Depression Inventory (CDI) and other measures of child anxiety.
- **Catastrophic thinking about pain.** The Pain Coping Questionnaire (PCQ) is a self report tool especially designed for young people in pain to measure which coping strategies they adopt. The catastrophic thinking subscale is particularly relevant to this population.
- **Disability.** The Functional Disability Inventory (FDI) assesses independent living, taking into account the affect of pain on the child's everyday functioning and the caretaking burden on the family.
- **Somatic awareness.** The Modified Somatic Perception Questionnaire (MSPQ) is a 22 item measure of the frequency and breadth of diffuse somatic complaints. Although not standardised with adolescents, it is the closest available measure with adequate face validity for adolescents.
- **Depression.** The Children’s Depression Inventory Short Form (CDI) measures the severity of depressive symptoms. The age normed T scores above the 90th centile are considered clinically significant.
- **Function.** Two timed measures of function were used. First, time taken to walk a 10 metre distance, and second, the number of sit to stand movements completed within one minute.
- **School attendance.** Two measures of school attendance were calculated. First, the number of half day sessions (range 1–10) attended in the previous school week were recorded. Second, seven categories of school attendance were also recorded (graduated, full time, part time (1–4 sessions), part time (5–9 sessions), home tutoring, none, left having completed schooling).

**Table 1** Biographical and clinical details of 57 adolescents entering treatment programme.

**Adult measures**

Adult versions exist of the two pain VASs and the FDI, with adults responding to questions relating to their perceptions of their child’s pain and disability respectively. Adults also completed the MSPQ based on their own experiences, and two further measures specific to adult affective distress were administered:

- **The Hospital Anxiety and Depression Scale (HAD)** is a brief affective measure designed to detect mood disorder in hospital populations. Scores over 8 for both anxiety and depression are considered clinically significant.
- **The Parenting Stress Index (Short Form)** is an instrument which screens for parents who are experiencing stressors that are consistently related to dysfunctional parenting. Scores over the 90th centile are considered clinically significant.

**Treatment team**

The treatment team included a paediatric rheumatologist, clinical psychologist, physiotherapist, occupational therapist, and a nurse. All had experience of rehabilitation of patients with pain and complex disability. The effectiveness of ICBT is critically dependent on a strong therapeutic alliance between patient and therapist and, to a lesser extent, a strong group alliance between patients. A process of clinical evidence testing was adopted within regular team meetings in which all team members provide observations of individual progress (or otherwise) which are tested against others' observations and consensual discussion. The clinical psychologist determined the speed and direction of therapy.

**Treatment**

Operant and cognitive behavioural principles were incorporated in all aspects of the treatment. A primary theme of the programme was the promotion of positive change despite pain, independence from medical and social care, and return to normal everyday adolescent activity. Therapy was informed from a number of sources. Overall treatment contact time was 110 hours (60 hours of physical and occupational activity; 35 hours of cognitive therapy; and 15 hours education). Over a 18 month period, seven programmes of six dyads and three programmes of five dyads were run. Each treatment session lasted 50 minutes. The day was structured as a school day from...
Corrected p < 0.01 and all confidence intervals are given at 95%. Table 2 presents summary data for adolescents on all measures pre, post, and three months following treatment; table 3 presents summary data for the accompanying adults.

### Immediate treatment effects for adolescents

There were significant increases in both timed measures of function and in the adolescents’ reports of their own disability. Adolescents improved how fast they could walk 10 metres from 12.81 seconds to 10.20 seconds (mean difference of 2.61 seconds (95% CI 1.02 to 4.2); SE 0.786), the number of stand-ups performed in one minute from 13.51 to 17.04 (mean difference 4.43 (1.53 to 7.33); SE 1.13). Adolescents maintained the improvements on how fast they could walk 10 metres from 12.81 seconds to 10.20 seconds (mean difference of 2.61 seconds (95% CI 1.02 to 4.2); SE 0.786), the number of stand-ups performed in one minute from 13.51 to 17.04 (mean difference 4.43 (1.53 to 7.33); SE 1.13). Adolescents maintained the improvements on how fast they could walk 10 metres from 12.81 seconds to 10.20 seconds (mean difference of 2.61 seconds (95% CI 1.02 to 4.2); SE 0.786), the number of stand-ups performed in one minute from 13.51 to 17.04 (mean difference 4.43 (1.53 to 7.33); SE 1.13).

### Three month treatment effects for adolescents

Compared with pretreatment data there were statistically significant positive effects of treatment on anxiety (mean difference 6.35 (2.33 to 10.37); SE 1.99), catastrophic thinking about pain (mean difference 1.7 (0.72 to 2.67); SE 0.48), disability (mean difference 4.30 (1.44 to 7.17); SE 1.42), and somatic awareness (mean difference 4.43 (1.53 to 7.33); SE 1.27). Adolescents maintained the improvements on how fast they could walk 10 metres from 12.81 seconds to 10.20 seconds (mean difference of 2.61 seconds (95% CI 1.02 to 4.2); SE 0.786), the number of stand-ups performed in one minute from 13.51 to 17.04 (mean difference 4.43 (1.53 to 7.33); SE 1.13). Adolescents maintained the improvements on how fast they could walk 10 metres from 12.81 seconds to 10.20 seconds (mean difference of 2.61 seconds (95% CI 1.02 to 4.2); SE 0.786), the number of stand-ups performed in one minute from 13.51 to 17.04 (mean difference 4.43 (1.53 to 7.33); SE 1.13). Adolescents maintained the improvements on how fast they could walk 10 metres from 12.81 seconds to 10.20 seconds (mean difference of 2.61 seconds (95% CI 1.02 to 4.2); SE 0.786), the number of stand-ups performed in one minute from 13.51 to 17.04 (mean difference 4.43 (1.53 to 7.33); SE 1.13). Adolescents maintained the improvements on how fast they could walk 10 metres from 12.81 seconds to 10.20 seconds (mean difference of 2.61 seconds (95% CI 1.02 to 4.2); SE 0.786), the number of stand-ups performed in one minute from 13.51 to 17.04 (mean difference 4.43 (1.53 to 7.33); SE 1.13). Adolescents maintained the improvements on how fast they could walk 10 metres from 12.81 seconds to 10.20 seconds (mean difference of 2.61 seconds (95% CI 1.02 to 4.2); SE 0.786), the number of stand-ups performed in one minute from 13.51 to 17.04 (mean difference 4.43 (1.53 to 7.33); SE 1.13). Adolescents maintained the improvements on how fast they could walk 10 metres from 12.81 seconds to 10.20 seconds (mean difference of 2.61 seconds (95% CI 1.02 to 4.2); SE 0.786), the number of stand-ups performed in one minute from 13.51 to 17.04 (mean difference 4.43 (1.53 to 7.33); SE 1.13). Adolescents maintained the improvements on how fast they could walk 10 metres from 12.81 seconds to 10.20 seconds (mean difference of 2.61 seconds (95% CI 1.02 to 4.2); SE 0.786), the number of stand-ups performed in one minute from 13.51 to 17.04 (mean difference 4.43 (1.53 to 7.33); SE 1.13). Adolescents maintained the improvements on how fast they could walk 10 metres from 12.81 seconds to 10.20 seconds (mean difference of 2.61 seconds (95% CI 1.02 to 4.2); SE 0.786), the number of stand-ups performed in one minute from 13.51 to 17.04 (mean difference 4.43 (1.53 to 7.33); SE 1.13). Adolescents maintained the improvements on how fast they could walk 10 metres from 12.81 seconds to 10.20 seconds (mean difference of 2.61 seconds (95% CI 1.02 to 4.2); SE 0.786), the number of stand-ups performed in one minute from 13.51 to 17.04 (mean difference 4.43 (1.53 to 7.33); SE 1.13).

### Immediate treatment effects for accompanying adults

There was a statistically significant increase in the adult perception of adolescent function (FDI adult: mean difference 4.43 (2.17 to 6.70); SE 1.13). There were statistically significant improvements in adult anxiety (mean difference 1.73 (0.54 to 2.92); SE 0.59), adult depression (mean difference 1.16 (0.34 to 1.98); SE 0.41), and adult parental stress (mean difference 10.81 (2.91 to 17.81); SE 3.93).
Three month treatment effects for accompanying adults

Compared with pretreatment data adults continued to report a statistically significant change in their perception of adolescent function (mean difference 3.57 (0.27 to 6.87); SE 1.63), and the adult self reported data continued to show statistically significant improvement. There were statistically significant improvements in adult anxiety (mean difference score 2.12 (0.87 to 3.36); SE 0.62), depression (mean difference score 1.35 (0.31 to 2.39); SE 0.52) and adult parental stress (mean difference score 11.50 (0.58 to 22.42); SE 5.4). In addition, there was a statistically significant effect of treatment on somatic awareness compared with pretreatment data (mean difference 2.52 (0.7 to 4.3); SE 0.9). There were no significant changes in scores between post-treatment and three months following treatment.

Return to school at three months

Prior to treatment, only 14 adolescents were in full time education; three months following treatment 29 were attending full time education. Of the 14 in full time education pretreatment, one had graduated and one worsened. Therefore at three months following treatment 12 of the 29 patients had remained in full time education and 17 patients had returned to full time education. Prior to treatment 12 adolescents were receiving no formal education; at three months following treatment only one adolescent was still not receiving any formal education. Table 4 gives full details. Of the 42 patients whose category of schooling could have improved, 27 improved at least one category of schooling, 12 remained the same, and 3 worsened. One patient who was in full time education worsened to part time education.

First, the finding that adolescents do not report changes on many of the self report measures immediately post-programme is intriguing. Some of the reasons may be methodological because measures used have been developed based on normal routines situated in home environments. However, this is not true for all of the measurement instruments. It may be simply unrealistic to expect adolescents to adjust quickly within three weeks on some of the affective measures, or it may be that treatment was only effective for changing physical outcomes.

Second, the exact process of therapeutic change in ICBT is unknown: in particular, how changes in one class of outcomes affect changes in another class of outcome. Only recently have the methods for such “process of therapy” studies been developed in chronic pain research. Also of interest is how parental variables affect adolescent variables. For example, a recent study of depression in chronically ill children found that child pain and maternal depression could predict child depression. In future studies with larger numbers of patients and adults it will be important to test the hypothesis that immediate post-treatment changes in parental affect have a mediating role for adolescent outcomes measured at three months, in particular school attendance.

Finally, although this is the first study of ICBT and adolescent chronic pain with a large enough sample to enable robust statistical analyses of treatment effects, there is no substitute for well designed and executed randomised controlled trials. Without a credible treatment comparison group we are not able to control for any non-specific effects of treatment setting, staff-patient relationships, or changes from normal environments. Although there are significant practical barriers to a successful trial, these are surmountable with multicentre collaboration. This study provides guidance on treatment content, delivery, and measurement.

DISCUSSION

Adolescent chronic pain and disability are notoriously unresponsive to unimodal and unidisciplinary treatments. An interdisciplinary team working within a cognitive behavioural framework is a promising avenue for development. Although the outcomes of this effectiveness study were broadly positive the study raises issues for further discussion.

Table 4 School attendance data; change in mean number of half-day sessions per week attended for all 56 patients and for the 42 patients who could have improved the number of sessions of formal education attended

<table>
<thead>
<tr>
<th>Category of schooling</th>
<th>Pretreatment</th>
<th>Three months post-treatment†</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full time</td>
<td>14</td>
<td>29</td>
</tr>
<tr>
<td>Part time (&gt;5 sessions)</td>
<td>11</td>
<td>7</td>
</tr>
<tr>
<td>Part time (&lt;5 sessions)</td>
<td>6</td>
<td>9</td>
</tr>
<tr>
<td>No school</td>
<td>12</td>
<td>12</td>
</tr>
<tr>
<td>Left school</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Hospital school</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>Home tutor</td>
<td>8</td>
<td>7</td>
</tr>
</tbody>
</table>

*p<0.01.
†Of the 42 patients who could have improved, 27 improved at least one category of schooling, 12 remained the same, and 3 worsened. One patient who was in full time education worsened to part time education.

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Authors' affiliations
C Eccleston, J Clinch, H Connell, C Sourbut, Pain Management Unit, University of Bath and The Royal National Hospital for Rheumatic Diseases, Bath, UK
P N Malleson, Division of Pediatric Rheumatology, Department of Pediatrics, University of British Columbia, Vancouver, Canada

REFERENCES
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