

“No, it's not all in your head": Messages and methods in treating youth with somatic symptoms

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Goals for Today

- The challenges and benefits of assessing and treating somatic symptoms in an integrated care setting
- Pitfalls and helpful messaging
- Coordination of medical and behavioral health approaches
- Examples of interventions that both pediatricians and behavioral health providers can conduct in the office.

Somatic complaints are **COMMON!**

Estimates range from 10-30% of all acute pediatric visits!



Potential Clinician Frustrations

- Fear of missing a critical diagnosis
- Perceive patients as using unnecessary time, expertise, and resources
- Families may feel judged
- Anticipatory frustration that the problem can't be fixed (and not by me)



Why Does It Matter What We Do?



FAST FACTS

Students with disabilities

Question:

How many students in postsecondary education have a disability?

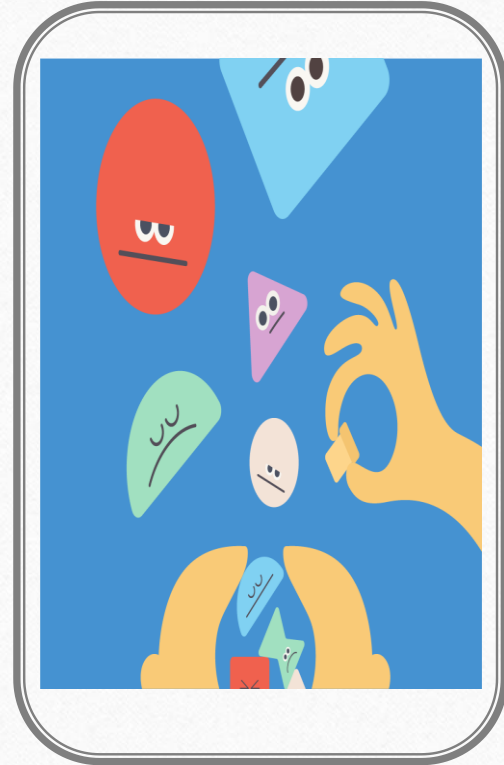
Response:

Nineteen percent of undergraduates in 2015–16 reported having a disability. In 2015–16, the percentage of undergraduates who reported having a disability was 19 percent for male students and 20 percent for female students. There were some differences in the percentages of undergraduates with disabilities by

A CHALLENGE TO US ALL!

- Headache
- Stomach ache
- Fatigue
- Insomnia
- Chest pain

**THESE DIAGNOSES HAVE PSYCHOSOCIAL
ORIGINS UNTIL PROVEN OTHERWISE**



Common Diagnostic Diversions

Stomach ache:

- Constipation
- Lactose deficiency
- Food allergy
- Reflux

Headache:

- Sinus infection, chronic sinusitis
- Migraine
- Allergy
- Poor vision

Common Diagnostic Diversions

Fatigue:

- Anemia
- Mononucleosis
- Lyme disease
- Thyroid disorders

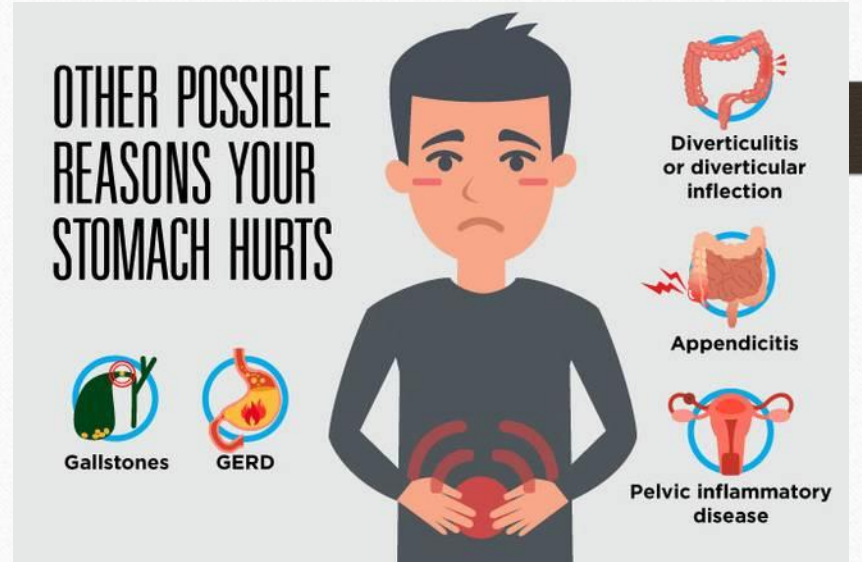
Chest Pain:

- Costochondritis
- Reflux
- Allergy
- Bronchitis
- Slipping rib syndrome

Approaches to Include

INCLUDE:

- It is my job to help to be sure that there is nothing dangerous or frightening going on
- Whenever we deal with complex problems, we also need to think of how the mind plays a role.
 - IF we don't, we may never be able to fully help



Approaches to Avoid



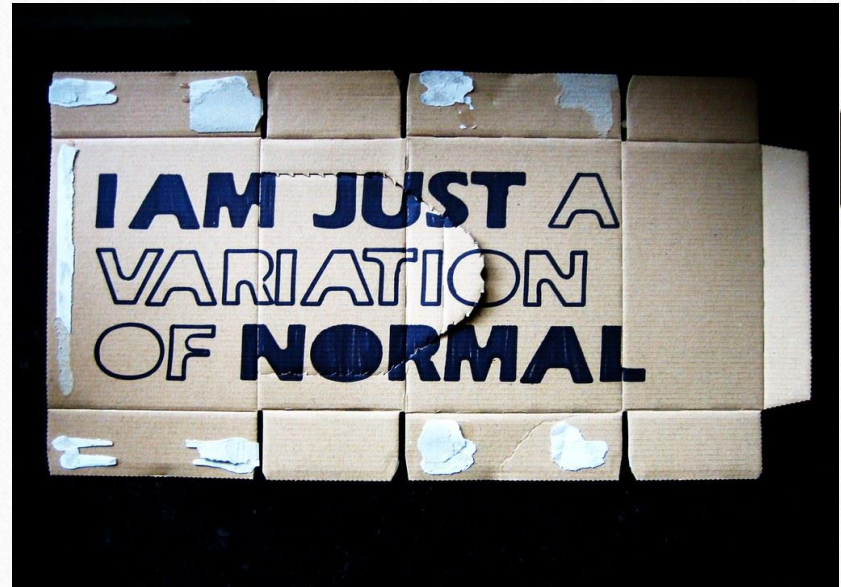
AVOID:

- Asking the question “is anything stressing you?”
 - *Might as well say that it's all in your head...and maybe you're kinda crazy....and it's time to find you someone else to fix up your mental state*

Framing the visit

Please, Please...state out loud that really wonderful people, normal people, can have somatic pain!

“It’s often the best kids that really feel that there’s nothing wrong, but their body is trying to get their attention.”



Your role in setting the stage

Reinforcing that you still see the patient as **THEM**, care and respect them, **EVEN** if this may be coming from their head!

Share that you will be following along, sharing in care, rooting for them even if you will be sharing in their care with other providers.



You're OK

- Open the door to allow patients to share their secret thoughts
 - I can't stop thinking about...
 - I'm worried that...
 - If anyone knew what I think...



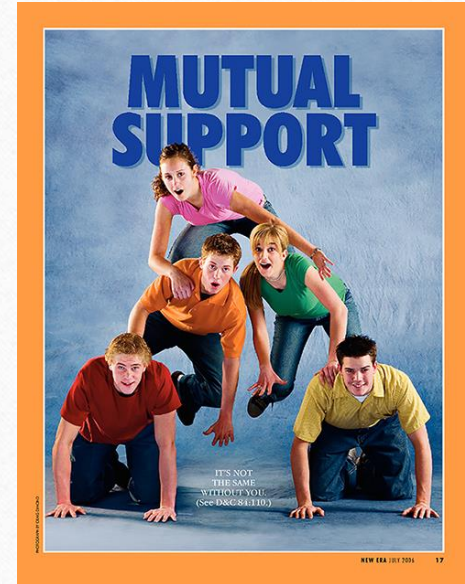
Some centering principles for the clinician

- You don't need to "FIX" the problem.
- "It's not what you think as much as what you do"
- "Can you think of anything that may help"

Sharing in care

Some of these kids find ready relief in the experience of absorbing that someone cares and validates them. Others need longer processing.

Optimally, we would all have the opportunity to share in the care of somatic patients with mental health experts. It is better for patients, and better for us!!



Behavioral Health:

Approaches to Include- Approaches to Avoid

INCLUDE:

- Explanations of how thoughts, emotions, behaviors influence the biology and vice versa
- Linking interventions to symptoms
- Referencing the medical recommendations and Dr. XXXX
- Lots of communication, collaboration – other BH providers, school.

AVOID:

- Assuming that families don't accept mind/body connection
- Closing the door to other mental health providers/services
- Our own form of dualistic thinking – assuming everything is stress/anxiety

Cognitive-Behavioral Treatment Components

- Monitoring of symptoms, triggers, patterns
- Lifestyle changes (e.g., normal sleep, meals)
- Cognitive strategies
- Exposure, goal setting
- Pain management
 - Diaphragmatic breathing
 - Relaxation strategies
 - Biofeedback
 - Hypnosis
- Problem-solving, coping with stress & anxiety
- Parent reinforcement of well behavior & coping
- School advocacy



Monitoring of symptoms, triggers, patterns

- Externalizes the symptom
- Can now have a range vs. Pain/No Pain
- What do you track?
 - “Pay attention to your pain at all times so that you can mark it on this sheet”.
 - “Sometimes you might not need to write anything down b/c the pain is not bothering you. You might forget about the discomfort sometimes and that’s ok too”
 - “Keep track of how comfortable your belly is feeling and how good you’re feeling”.
 - “Write down what you did today to be active/social/relaxed”.



Lifestyle changes

Sleep (*Vege et al., 2004; Zhou et al., 2011*)

- Sleep deficit in adolescents
- Sleep delays due to pain and accommodations due to pain/anxiety (e.g., parent in the room, TV on)
- Treatment: Sleep hygiene, relaxation



Meal Content/Volume

- Skipping meals/grazing
- Fear that eating will trigger pain



Relaxation Training



- A group of techniques designed to provide cognitive distraction as well as produce physiological and psychological changes
- Can decrease arousal, muscle tension, and negative mood states
- Can be combined with imagery, yoga, meditation, biofeedback, self-hypnosis

Changing maladaptive thoughts about pain

- Addressing automatic negative thoughts with positive coping statements

"I'm always in pain!"

>>>

"I usually feel good in the afternoon."

"I can't do anything because of my pain!"

>>>

"I can still _____ even though I have pain."

Limit catastrophizing and "all-or-none" thinking

Increasing functioning: Doing things despite pain

- “Rehab model” (e.g., starting PT before your knee has completely healed)
- Functioning in spite of “nemesis” (externalization)
- Set interim goals and reward achievement
 - School attendance
 - Social activities
 - Integration of pain management skills, active coping

Parental Role

- Being good role model for coping and functioning
- “Coaching”/praising development of coping responses
- Expressing confidence in child
- Encouraging independence
- Maintaining routines/structure/rules



Working with the School

- Parent-School communication about the problem
- Undiagnosed educational needs?
- Academic accommodations
 - Make up missed work
 - Avoid retention, if applicable



Working with the School

- Avoidance of secondary gain at school
 - Social stressors at recess, gym
 - Time in nurse's office: "He has a special relationship with the nurse"
 - Pattern of being sent home
 - Pattern of parent "bringing the medicine"
- If needed, gradual transition back into school



Medications Can be Helpful



For patients that seem to have a persistent gnawing background of anxiety or depression (particularly if runs in family history) SSRI's can be exceptionally helpful

- Fluoxetine-*esp. for low energy*
- Sertraline-*esp. for spinning thinking*
- Escitalopram-*esp. for combined symptoms*

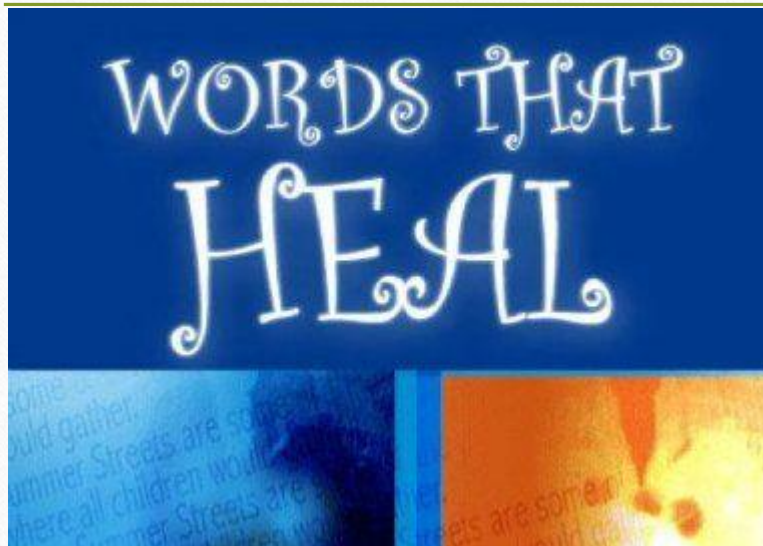
Alternatives to SSRI for symptom management (older adolescents)

- Gabapentin for anxiety and insomnia
- Hydroxyzine for anxiety and insomnia
- Trazodone for intractable insomnia



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- Consistent messages
 - Reinforcing themes presented by other team members
 - Divide and conquer tasks, e.g., parent/child, school, other providers
 - Coordinated discussion about next steps if additional care is needed
 - **SUPPORTING ONE ANOTHER**

Your Words and Your Care HEAL!



QUESTIONS?

