Somatoform Disorders

Somatic Symptom and Related Disorders

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Background:

Education History:
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Work History:
• Private Practice 2009-present
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Somatic Symptom and Related Disorders

1. Epidemiology and Etiology
2. How we think about illness
3. Recent Changes, DSM IV-TR to DSM 5
4. The Office Visit:
   - History and Exam
   - Treatment:
     In everyday practice
     Evidence Based Treatments
     Therapeutic Frame & Transference/Counter-transference

Last 3 slides: resources & for later reference
• DSM IV Somatoform Disorders:
  • Somatization Disorder
  • Hypochondriasis
  • Pain Disorder
  • Body Dysmorphic Disorder
  • Undifferentiated Somatoform Disorder

• Conversion Disorder
Functional Somatic Symptoms

- Functional Somatic Symptoms (FSS) is defined as “Physical symptoms of unknown pathology.”

- About 10% of children complain of aches and pains that are likely medically unexplained at any one time.
  - Most are transient
  - Most don’t affect the child’s overall functioning
  - Organic causes are found in only about 20% of cases

  (Garralda, 2010)

- Up to 4% of all pediatric office visits are thought to be due to FSS

  (Campo and Reich, 1999)
PREVALENCE AROUND THE WORLD

1) FSS affects 10-30% of children and adolescents in the U.S. (Campo, Fritsch, 1994)

2) 10,000 Nordic children 2–17 y/o, at least one FSS reported by
   - 13% of 2- to 6-year olds
   - 17% of 7- to 12-year olds
   - 23% of 13 to 17-year olds (Berntsson & Kohler, 2001)

3) Spanish study, FSS in preschoolers: 20% of 3-5 y/o had 1+ somatic symptoms at any one time. (Domenech-Llaboria and colleagues, JAACAP 2004)

4) >1,000 5 -7y/o Danish children
   - 1-year prevalence of any FSS 23%
   - Pain: limb pain, HA, stomach aches most common
   - 40% of children with FSS reported multiple other somatic symptoms
   - multiple FSS were associated with greater impairment
Some Take Home Points:

• Prevalence of FSS increases with age.

• If one FSS is found, it tends to run in the company of another FSS.

• Somatoform pain disorder is the most common type amongst all variants of somatoform disorders in children and adolescents.

• Red flags: cluster of different pain complaints, repeat/persistent pain complaints, impairment associated with pain complaint (e.g. “I can’t go to school because of...”).
Gender and Prevalence,
Somatic Symptoms and Related disorders

Prepuberty: Prevalence equal

Post Puberty:
  Female incidence starts to rise
  Male incidence actually begins to fall

Children as a whole group: Female>Male, ratio 5:1(Aro, 1987).

Girls with somatic disorders tend to have comorbid emotional disorders such as anxiety and mood disorders.

Boys:
• Tend to have more comorbid disruptive behavior disorders.
• Abdominal pain in particular has been found to be associated more often with externalizing disorders (ODD, ADHD)
• Musculoskeletal pain has been associated with higher rates of depression.
Most common somatic complaints:

- Pain: Abdominal, head, musculoskeletal
- Fatigue
Abdominal Pain:
- Most common somatic complaint in preschoolers (Domenech-Llaberia et al., 2004; Zuckerman, Stevenson & Bailey, 1987).
- Accounts for 2%-4% of all pediatric office visits (Starfield et al., 1980).
- Prevalence increases into adolescence (Lieb et al., 2009).

Headaches:
- Of all FSS, headache is the most prevalent in school aged children and adolescents:
  - reported on a weekly basis by approximately 10 to 30% (Egger, Costello, Erkanli, & Angold, 1999; Fichtel & Larsson, 2002; Larsson, 1991; Oster, 1972)
  - reason for 1 to 2% of all pediatric office visits (Starfield et al., 1980).

Musculoskeletal Pain:
- Variable rates, some cite up to 32 % of school aged children.

Fatigue:
- Close to 50% of adolescents report it weekly, and 15% report daily fatigue. Chronic fatigue prevalence is less than 1% in adolescence (Belmaker et al., 1985; Garralda & Chalder, 2005; Larsson, 1991).
Persistence of Pain in Children and Adolescence

- Cross-sectional survey of 1,756 schoolchildren (mean age 10.8) identified 564 (32.1%) with musculoskeletal pain.
  - structured questionnaire given.
  - examined for hypermobility and physical fitness.
  - Reassessed again with the same structured questionnaire @ 1 and 4 years.

Results:

- At 1-year follow up:
  - 53.8% (95% CI 48.8-58.8) of original group reporting musculoskeletal pain reported pain persistence “Persistent Preadolescent Musculoskeletal Pain”

- At 4-year follow up (adolescence):
  - 63.5% (95% CI 58.7-68.1) of the original group identified with musculoskeletal pain still reported musculoskeletal pain.
  - Those identified at 1 year as having “Persistent Preadolescent Musculoskeletal Pain” had approximately 3 times higher risk of pain recurrence at the 4 year

- Neck most common site of pain.

- Independent predictors included age, HA history, hypermobility, combined musculoskeletal pain at presentation.

Prognosis in children with persistent functional abdominal pain?:

Population Based Cohort Study: Britain’s Medical Research Council’s National Survey of Health and Development; 5,362 children born in 1946 Britain followed until time of last wave of data collection in 1989.

• Hypothesis:

1. Children with abdominal pain have anxious parents
2. These children come from families with high rates of physical illness
3. These children would grow up to suffer from high rates of medically unexplained physical symptoms & psychiatric disorder.

• Main outcome measures:

1. Persistent functional abdominal pain in the child defined as abdominal pain in the previous year over 3 points in time (ages 7, 11, 15).
2. At age 15, parent’s past medical history, self-report of nervous complaints elicited for either parent, maternal neuroticism rated (Madsley Personality Inventory).
3. Measures of physical symptoms and psychiatric disorders at 36 years of age.

Results:

1. High rates of complaints about physical health among the parents of children with persistent abdominal pain.

2. Mothers had higher neuroticism scores.

3. Children with persistent abdominal pain were more likely to suffer from psychiatric disorders in adulthood. ODDS RATIO 2.72 (95% CI 1.65 to 4.49)

4. Children were not especially prone to physical symptoms once psychiatric disorder was controlled for ODDS RATIO 1.39 (0.83 to 2.36).

5. Of note, none of the children went onto develop IBD.
Implications:

• pay attention to parental illness burden.
• pay attention to illness perception by parents (anxiety) and how they may inadvertently reinforce illness behaviors.
• persistent functional abdominal complaint may predict development of future psychiatric morbidity.
• Other studies point to abdominal pain persisting into adulthood in up to 25-50% of cases.
• Especially once a medically unexplained pain symptom becomes persistent, it must be treated assertively to prevent long term morbidity and comorbidities from developing.
Etiology of FSS

May be related to:

- Stressful events related to schooling & social relationships.
- Psychopathology.
- Childhood abuse, neglect, and other trauma.
- Less educated, lower socio-economic status.
- Developmental difficulties expressing feelings by language.
- Pubertal development.
- Poor parental health.
- Genetic effects.
- Childhood social learning of illness behaviors.
- Alexithymia.
Alexithymia

- Inability to use words to describe feelings.

- A helpful concept to understanding psychosomatics.

- Finnish Adolescents, 10% of girls and 7% of boys found to be Aleythymic.

- Associated with:
  - Mothers with low level of education
  - Single Parent Home
  - Living in Rural Area

Mattila AK et al, 2007; Joukamaa M et al, 2007
Causes for Alexithymia

- Born that way/Emotional Intelligence
- Acquired by trauma
- Learn by example:
  - Alexithymia rates relatively consistent for North American and European cultures.
  - Subculture Differences: Amongst Migraine, SLE, RA outpatients, African Americans had a higher rate of both alexithymia and pain complaints than did Caucasian Americans.

Conceptualizations
Illness vs Disease Model:
Medical school teaches us to establish a differential list of disease possibilities according to presenting symptoms, and to start ruling out disease to explain the illness.

The Pros:
• When the investigation leads to discovery of disease, the disease can be treated.
• When the investigation leads to discovery of disease, the patient’s illness is viewed as being outside their control, eliciting further compassionate care and treatment.

The Cons:
• When disease isn’t found, the opposite can happen toward those we are caring for.
  • Moral judgment
  • Lack of compassion
  • Possible lack of further inquiry and treatment.
What might it be like for the child, when the disease isn’t found and they don’t feel believed?
And what happens if the lack of answers begets further testing?
• Unnecessary labs, imaging, specialist consults?
• Physician inadvertently reinforces the patient’s conception that they do in fact have a disease?
• Helplessness and frustration for the physician and patient?
• Increased cost of care?

Reality Check:
• Logical fallacy
• Tests never provide 100% reassurance
• More tests = greater likelihood of false positives
What happens if we don’t get to know a patient first, but focus first on “ruling out” disease, and once a workup is “negative”, then we send the patient to a counselor or psychiatrist?

This could:

• Feel like rejection/abandonment as though they are being sent away and punished for being bad.
• Feel shameful (falsehood/moral problems).
• Cause a patient to not feel believed about a real concern they have.
• Send a strong message that only their biology matters.
Pitfall to Avoid

• Setting yourself up to say, “I can’t find anything wrong,” sounds like “Nothing is wrong.”

• Making someone feel like you’re sending them away.
WWBHD?

Possible solutions
Getting the History:

- Focus on full characterization of the chief complaint
  - shows you take the patient seriously
  - sets up discussing symptoms, rather than testing for symptoms

- Ask what the symptom keeps them from doing
  - immediately brings in the psychological and social context.

- In your mind, focus on the onset & duration of specific cognitive and somatic symptoms to see if you can identify a temporal relationship between cognitive symptoms (anxiety, depression, etc) and the medical condition.

- Let them know you are curious about them. Daily symptom journals can show you take them seriously.

- For the Child With Trauma: Radical Acceptance for the provider that they may just not be ready to talk, yet Creating a Psychologically Safe Environment in your office, so that they can talk when ready to. Keep the relationship. Don’t send them away.
Physical Exams are Important

Physical exam for functional symptoms at every visit
  ▪ reinforces your diagnosis
  ▪ checks for changes over time (psychosomatic diagnoses are never 100%)
  ▪ demonstrates close monitoring, without need for further tests

Just say upfront that other life factors can be impacting their symptoms
  ▪ No surprise later when you say want to treat life factors—this was part of the original plan
Explanation Type 1: The Undesired Conditioned Response as Possible Explanation.

- Example: headaches daily before school
- Hypothesize aloud that this initially happened a few times before school when child tried focusing on difficult mathematics homework. Child’s brain then associated going to school with the headache.
How else do doctors think?

**Causal Comorbidity**

(versus coincidental comorbidity)

- **Somatopsychic**: mental disorder as consequence of preexisting physical disease.
- **Psychosomatic**: mental disorders predispose to, cause, or perpetuate physical disease.
Somatopsychic vs. Psychosomatic

PROS: Helpful in helping us target an underlying etiology for treatment.

CONS: Could lead to false dualism of mind-body relationship.
• ID and CC: Jason is a 14 year old male brought in by his mother for CC of stomachaches.

• HPI: Jason began complaining of persistent, dull, non-localized stomachaches about 2 months ago, upon entering high school. He has not attended school for the last 2 weeks, and states he has 9/10 pain. He has not slept well, and is not eating well. He also complains of tension in his neck and shoulders. He has been irritable and edgy toward his mother. He feels distracted “From my stomachache” and can’t concentrate on homework. Diarrhea, Nausea, Constipation, bloody stools denied.

• FH: Anxiety, Depression, ADHD. Hashimoto’s Thyroiditis, Crohn’s Disease, Irritable Bowel Syndrome.

• PMH: Asthma. Brief period of separation anxiety and school phobia in 1st grade.

• SH: Denies drug or alcohol use. Mother states he is hanging out at the local coffee shop with “The wrong crowd.”

• PE: pain on palpation at all four quadrants, bilateral tremor with outstretched hands.
Somatopsychic Approach to Anxiety Presentation:

- **DIET:**
  - Excessive ingestion of caffeinated beverages or energy drinks?

- **SUBSTANCES:**
  - Intoxication (Amphetamines, THC, Cocaine, Hallucinogen)
  - Withdrawal (Alcohol, Benzodiazepines, opiates, barbiturates)
  - Common Medicines (corticosteroids, anticholinergics, asthma medications, decongestants, thyroid medications, etc.).

- **GENERAL MEDICAL CONDITIONS:**
  - Hyper/Hypo-thyroid, pheochromocytoma, hyperparathyroid.
  - Acute porphyria
  - Partial seizures (associated with panic attacks and can present with fear, depersonalization, etc).
  - Hypoxia, hypoglycemia, etc.
Psychosomatic Thinking:

- Anxiety, for example could:
  - directly alter the pathophysiology of the disease process (eg, associated elevations in cytokines and autonomic activation)
  - foster maladaptive health behaviors (eg, inadequate sleep, dietary indiscretion, or substance abuse), non-adherence.
Explanation Type #2: Symptom having multiple triggers, with final common pathway

- Stomach aches as caused by
  - extra acid, bowel contractions, sensitized nerves
  - stress increases difficulties of all three
- Say need multiple approaches to successfully treat the pain, with therapy as one of them
- Reassure even if stress is only causing 10% of the problem, it is essential to treat as part of the overall clinical picture.
Resident’s last resort thinking.

Is this real or is this fake?

Real=disease        Fake=on purpose?

IF NO

IF YES

somatoform conversion etc.

Factitious Malingering
Conversion Disorder

• Onset generally from late childhood.

• No specific childhood prevalence figures are available.
  • A pediatric surveillance in Australia over a 2-year period yielded a prevalence of 2.3-4.2 cases per 100,000 children in pediatric practice.
  • Prevalence in an inpatient child psychiatric setting has been reported as 1-2%.
  • 2-3 times more common in females except for pseudo-seizures.

• Conversion symptoms are a more common way for psychiatric disorder to present in non-Western clinical settings.

• Limited data suggest that Conversion Disorder frequently occurs in relatives of individuals with Conversion Disorder.
  ▪ Modeling.
  ▪ Genetic factors, including temperament (personality traits).

• Non-genetic factors such as sexual abuse in childhood.
• La belle indifference (lack of concern about the nature or implication of the symptom).
• Motor conversion disorders are more common than sensory, and primarily involve the major muscle groups.
• Weakness occurs more commonly than dystonia.

**Common Comorbidities:**
1. Anxiety Disorders, especially Panic Disorder
2. Depressive Disorders
3. Somatic Symptom Disorder
4. Medical and Neurologic Conditions
• ID and CC: Elizabeth, who goes by Liz, is a 16 year old female who presents to your office with chief complaint of “I don’t feel like I’m in my body.” The symptom started when she was 13, and she is being referred by a seizure specialist in pediatric neurology. Pediatric specialist is concerned about anxiety.

• HPI: Liz had above chief complaint starting age of 12 and was referred to a neurologist by her primary care provider. She was given the diagnosis of seizures with aura by neurology, and over the next several years was placed on Depakote, Lamictal, Carbamazepine, and Keppra. Symptoms did not remit. Pediatric Neurologist states aura is not explained by site of seizure, and patient has not ever had an overt seizure. It had been diagnosed based on EEG finding. PCP had concerns about lack of response to treatment which was interrupting academic progress, which is why Liz was ultimately referred for a second opinion with the pediatric specialist.

• PMH: Seizure with Aura.
Explanation #3: Automatic Brain Reflexes-the non epileptic seizure.

- Give example like vagus nerve reflex can cause fainting or “butterflies in the stomach”
- Similar to non epileptic seizure:
  - Muscles twitched when you didn’t want them to
  - Somewhere on pathway between your nerves and muscles, a reflex message got mixed up
  - Fortunately not a permanent cause and should get better (give positive expectations)
  - Kids with this trouble often worry about this happening again, so want you to work with a counselor on those worries
Another Common Model of Thinking:

- **Non-Categorical Approach:** Considers the illness experience in context of general dimensions (e.g. family cohesion’s impact on health outcome, etc.)
- **Diagnosis Specific Approach:** The diagnosis-specific approach considers the illness experience in the context of a disease.
  - Example: Studies in asthma and diabetes suggest psychological symptoms that are disease-specific that impact treatment and prognosis.
DSM conceptualizations

...AND WHY THE RECENT CHANGES?

PROS of categorical distinction:
• Essential to clinical decision-making
• Allows efficiency in communication

CONS of categorical approach:
• Patients either fit or didn’t fit into a diagnosis
• Ignores dimensional approach of seeing mental health symptoms on a spectrum.
“Somatic Symptom and Related Disorders”
(Formerly Somatoform Disorders)

Relevant to know for primary care:

1. Focuses more on positive symptoms vs focusing on ruling out medical symptoms.

2. Focuses on the fact that the lack of medical explanation doesn’t equate to a psychiatric condition (allows that medical causes sometimes can’t be pinpointed).
“Somatic Symptom and Related Disorders” Chapter

1. Somatic Symptom Disorder
2. Illness Anxiety Disorder
3. Conversion Disorder
4. Factitious Disorder
5. Psychological Factors Affection Other Medical Conditions
6. Other Specified Somatic Symptom and Related Disorder
7. Unspecified Somatic Symptom and Related Disorder
Somatic Symptom Disorder
Now Encompasses 4 Former DSM IV Diagnoses Including:

1) Somatization D/O:
   • described a small minority of somatizers with very specific & lengthy list of symptoms that was not clinically useful.

2) Undifferentiated Somatoform D/O

3) Pain D/O ➔ ”Somatic Symptom Disorder, with Predominate Pain.”
   • In DSM-IV, the pain disorder diagnoses focused on whether pain was due to psychological factors vs. medical diseases. “There is a lack of evidence that such distinctions can be made with reliability and validity since psychological factors influence all forms of pain”—American Psychiatric Association.

4) Subsumes about 75% of former Hypochondriasis
Somatic Symptom Disorder

DSM-5 Criteria

A. One or more somatic symptoms.

B. Excessive thoughts, feelings, behaviors

C. State of being symptomatic is persistent (typically more than 6 months).
HOPE FOR POTENTIAL OUTCOMES:

• More comprehensive reflection of individual’s clinical picture (thoughts, feelings, and behaviors).

• Shifting the focus from the absence of a medical explanation for somatic symptoms could help decrease the pejorative nature to diagnoses which previously implied that the physical symptoms “Weren’t real.”

• Better recognition of mind-body dualism.

• It may prevent unnecessary studies.

• Much more user friendly to the clinician.
Illness Anxiety Disorder

Subsumes about ¼ former "Hypochondriasis"

**DSM-5 Diagnostic Criteria:**

A. Preoccupation with having/acquiring a serious illness.

B. Somatic Symptoms are not present OR if somatic symptoms are present, *only mild intensity*

**Specify Type:**

- Care-seeking type
- Care-avoidant type
Conversion Disorder
(Functional Neurological Symptom Disorder)

When a neurological symptom is found to be incompatible with neurological pathophysiology.

• Stresses importance of the neurological exam.
• A patient should not be diagnosed with Conversion Disorder simply because the results from the investigations are normal, or because the symptoms are bizarre.
• Relevant psychological factors doesn’t have to be demonstrable at the time of diagnosis.

Another Example:
You examine for a child’s ankle plantar flexion while the child is on the bed, and you find marked unilateral weakness. The child tip toe walks well. Look for internal inconsistencies.
Factitious Disorder

(previously its own chapter)

- Factitious Disorder Imposed on Self
- Factitious Disorder Imposed on Another (Munchhausen by proxy)
- Diagnostic Features:
  - Falsification of physical/psychological signs/sx, or induction of injury/disease, associated with identified deception.
  - The individual presents themselves (or victim) as ill/impaired/injured.
  - The deceptive behavior evident in the absence of obvious external rewards (vs Malingering).
Other “Specified” Somatic Symptom and Related Disorder
1. Pseudocyesis (false belief of being pregnant).
2. Would fall into aforementioned DSM 5 diagnoses except for duration criteria, etc.

“Unspecified” Somatic Symptom and Related Disorder
Example might include situations where there is not enough information to make a more specific diagnosis.

Psychological Factors Affecting Other Medical Conditions
1 + clinically significant psychological or behavioral factors adversely affect a medical condition by increasing the risk for suffering, death, or disability. Example of panic attacks triggering asthma, etc.
BODY DYSMORPHIC DISORDER
• Repetitive behaviors/mental acts in response to preoccupations with perceived defects/flaws in physical appearance.

Moved to "OCD and Related Disorders"
• Reflects increase in evidence that it is a component of OCD, much like hoarding disorder, excoriation (skin-picking) disorder, etc.

In adults, 24-28% have tried committing suicide

EQUAL male to female ratio (Phillips and Kelly 2009)
Arguments against DSM 5 change to Somatic Symptom & Related D/O have been met with some controversy.

1. DSM IV Somatic Symptom D/O already falsely captured 15% of patients with cancer/heart disease and 26% of IBS/Fibromyalgia, and it had a false positive rate of 7% amongst the healthy in the general population.

2. Further increases in false positives, if they should occur, is harmful because it could result in clinicians missing underlying medical causes for the symptoms.

Ultimately, APA sticks by the changes.
Bringing conceptualizations together in clinical practice: place the patient experience into context.

- **Bio-psycho-social Model:**
  - Cell
  - Organ
  - Systems
  - Organism
  - Patient
  - Family
  - Community
  - Sub-Culture
  - Society/Nation

- **The 5 Ps Model.**
The 5 Ps

1. Presenting Problem?

2. Predisposing: What factors predisposed the person toward the development of the problem?
   - Biology: in utero exposures, genetic, medical, medication
   - Psychology: Temperament, Cognitive Abilities, Developmental Level
   - Social: Multiple moves, abuse/neglect, early losses

3. Precipitating: What brought them to this point/why present now?

4. Perpetuating: What are the maintaining factors to the problem?
   - Bio (Medical? Substance Use?)
   - Psycho (Coping Skills? Insight/Judge ment?)
   - Social (Relationships, Bullying, Moving, etc.)

5. Prognosis (with Protective factors).
What if No Explanation Can Fit Other Than Somatization?

• I use the humble approach
  • Suggest saying our *profession isn’t smart enough* to understand everything about the body, and in this case we do not have an easy answer “why”.

• Express your relief that you learned there is nothing physically damaging happening.

• Give positive expectation of improvement (Motivational Enhancement).

• Say in situations like this, find it most useful to work on child’s *coping* to improve *functioning*. 
Partner with therapist to work on this coping, **while you continue to see the child.**

Inherent to these explanations:

Get thee to a therapist

- Talk about therapist as a “support” person needed for both patient and your treatment plan
- Be explicit that we’re not sending the child to a therapist because of “mental illness”
Individual Therapy

There is a lack of evidenced-based practices related to the treatment of somatoform disorders in children and adolescents (Campo & Fritz, 2001). There are number of controlled studies of pharmacotherapy and psychotherapy for somatoform disorders in adults.

CBT still has best evidence in adult studies

Mindfulness-based CBT approach with small to moderate effect size in adults
Medication

Medication Trials of Efficacy of Various Antidepressants with Adults:

- 12 wk multicenter randomized double blind study demonstrated efficacy and tolerability of Effexor ER in adult primary care patients with multisomatoform disorder and comorbid MDD, GAD, or Social Anxiety Disorder per DSM IV criteria. The study showed Effexor ER as effective in relieving somatic physical symptoms, particularly pain in these symptoms (Kroenke et al, 2006)

- 8 week randomized placebo controlled study, Prozac had better analgesic effect than placebo for persistent somatoform pain disorder but the analgesic effect may be related to antidepressant effect (Luo, 2009)

- Randomized 12 week open label trial of Prozac 20-60 mg daily and Zoloft 25-350 mg daily in patients with undifferentiated somatoform disorder showed that both agents had a potential role in treatment and no serious side effects were reported (Han, 2008)
Children:

—Because of the possible relationship between serotonergic neurotransmission and gut sensation, as well as observed associations between anxiety and functional abdominal pain, the SSRI citalopram was evaluated as a treatment for FAP in an open label study of 25 affected children and adolescents, with 21 (84%) of the treated youth exhibiting a favorable treatment response based on clinician ratings of much or very much improved. Improvements in child and parent ratings of abdominal pain were accompanied by improvements in ratings of anxiety, depression, and other somatic symptoms.

—Two published RCTs of the tricyclic antidepressant (TCA) amitriptyline for pediatric FAP produced mixed results, with a recent review concluding that there is no convincing evidence for the efficacy of TCAs in pediatric FAP. Past reports of sudden death in association with the use of TCAs in children, their potential for lethality in overdose, and the absence of proven efficacy in the treatment of both FAP and pediatric depression make it difficult to confidently recommend TCAs for youth with anxiety and FSS.
SSRI medications have been associated with a number of potential adverse effects, which are most often dose-related and short lived, but some adverse effects of SSRIs may be especially important to consider in physically ill children:

• Alterations in platelet function produced by SSRIs are important to consider in patients bleeding disorders, low platelet counts, or being treated with NSAIDS

• QT interval

• Drug-Drug Interactions including toward serotonin syndrome:
  • dextromethorphan, -triptans, etc.
  • Pay attention to P450 isoenzyme interactions
Therapeutic Frame

• Know your limits

• Set the frame for yourself before family returns to clinic again as to what you can and can’t do for them.

• Talk to a colleague. This is overwhelming.
Transference/Countertransference

- Anger
- Anxiety
- Discomfort
- Helplessness
- Over-involvement
- Avoidance
• Chronic physical illness a significant risk factor for developing anxiety disorder.
  • 40% of chronically ill children report anxiety symptoms.
  • Children with asthma report higher levels of anxiety than unaffected peers.

• Children with epilepsy:
  • 171 children with epilepsy
  • 33% of affected children reported mood and anxiety sx. compared with 6% of children without epilepsy
  • of the 33% who reported mood and anxiety symptoms, 63% met the criteria for an anxiety disorder. (Caplan et al)

• Children who survive life-threatening illnesses & treated in critical care settings are especially vulnerable to develop PTSD, with point prevalences ranging from 10% to 28%.
Adaptation/Coping Styles to Illness

**Approach Oriented Coping:** thoughts/behaviors directed at managing the stressors/feelings stressors elicit.

**Avoidance Oriented Coping:** efforts by child to avoid the stressor.

**Problem Focused Coping:** directed at altering the stressor. May be most adaptive.

**Emotion Focused Coping:** aimed at regulating emotional responses to the stressor.

*Important thing is to let the child make the most use of his or her preferred coping style.*
For Future Reference:

Try to DO:
- Make an effort to understand and discuss with the family, the family’s beliefs about the illness including their level of conviction for physical causes, satisfaction with investigations, and views about the mental health referral and treatment.
- Acknowledge that patients have a real illness disrupting their life and impacting on the family.
- Explore alternative explanations for the symptoms.
- Discuss fully the physiological mechanisms contributing to symptoms.
- Emphasize that it may take time to recover but the majority of young people do very well.
- Help the family and child develop ways of coping with the symptoms and reduce functional impairment

Try NOT to Do:
- Question the reality of the symptoms.
- Do not convey a sense of embarrassment when communicating a diagnosis of somatoform disorder or other psychiatric diagnoses.
- Be lead down the path of explaining whether something is medical or psychiatric. These are usually false dualisms.
For Future Reference

Emphasis is on reducing impairment as a team

In the office:
-Motivational techniques tailored to stimulate ambivalent children.
-Collaboratively finding a way to get better that is acceptable to the child.
-Developing active, problem focused techniques to deal with specific symptoms and impairments (e.g., distraction, muscular relaxation for headaches, graded physical exercise for muscular problems and fatigue).
-Helping the Family Work Toward Sleep hygiene and Diet.

Referral:
-Psychological interventions, such as cognitive behavioral therapy for comorbid emotional disorders.
-Use of family work to deal with family factors that maybe contributing to the symptoms or interfering with their resolution.

Collaborative Care:
-Collaborative care with therapist, family, liaison with school and social services.

Goal: Gradually shifting the burden of responsibility from clinician to parent and patient.
Resources At Seattle Children’s Hospital (For Future Reference):

- PAL
- Adolescent Medicine Clinic Which Treats:
  - Unexplained chronic pain Including for headaches, musculoskeletal pain and fatigue
  - Chronic illnesses
  - Behavioral Health
  - Wellness Clinic
- Psychiatry and Behavioral Health
- Pain Clinic including the more intensive Pain Rehabilitation Program:
  - Treating chronic pain, complex regional pain syndrome, central sensitization, visceral hyperalgesia/functional abdominal pain, musculoskeletal pain and headache.
  - They also help patients who have pain related to a disease that has become disabling.
- Other Specialty Clinics (Neurology, Orthopedics, Gastroenterology)