ABDOMINAL PAIN: INTEGRATING PSYCHOLOGICAL TREATMENTS INTO MEDICAL CARE

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COI

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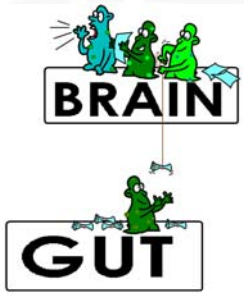
Learning Objectives

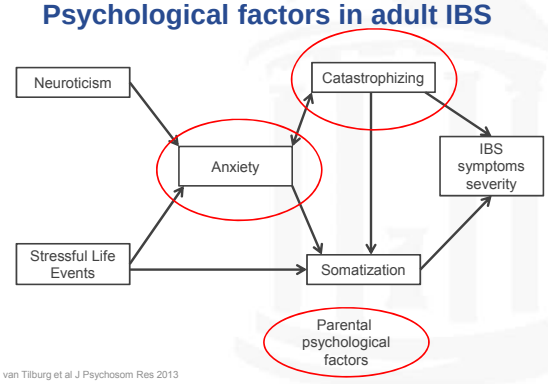
1. Describe the **role of psychosocial factors** in functional abdominal pain disorders
2. Identify evidence-based **psychological/behavioral treatments** for functional abdominal pain disorders and how to **integrate with medical c**are
3. Identify **patients most likely to benefit** from integrated care

Psychological factors in FAP

- Anxiety
- Depression
- Coping
- Catastrophizing
- Somatization
- Solicitousness
- Stress
- Trauma
- Etc.



Psychological factors in adult IBS



van Tilburg et al J Psychosom Res 2013

Psychiatric disorders and FAP

- About half of FAP patients have psychiatric disorder
- Anxiety disorders usually precedes FAP
- FAP usually precedes development of depression
- Anxiety/depression associated with:
  - Exacerbation of Pain
  - More disability
  - Maintenance of symptoms over time

Cunningham et al JPGN 2013; Ghanizadeh te al J Gastroenterol Hepatol 2008; Campo et al Pediatrics 2004; Shelby et al Pediatrics 2013; Mulvaney et al J Am Acad Child Adolesc Psychiatry 2006,Bohman et al BMC psychiatry 2012

Coping with FAP

Mastery effort

Interpersonal relationships	Positive	Negative
Positive	Engaged copers Problem solving ↓ Pain, disability, depression	Dependent copers Catastrophizing ↑ pain, disability and depression
Negative	Self-reliant copers Acceptance & Minimizing pain ↓ Pain, disability ↑ depression	Avoidant copers Catastrophizing ↑ pain, disability and depression

Walker et al, *Pain* 2008

Pain Catastrophizing =

Magnifying threat of pain
Worrying about pain
Feeling helpless

"The pain is terrible; I feel it is never going to get better"
"I can't stand it anymore; nothing will make it better"

Catastrophizing associated with increased:

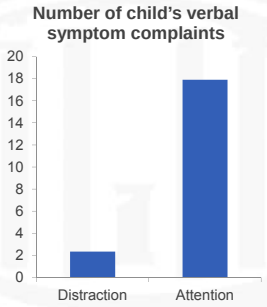
- Pain severity
- Pain maintenance over time
- Depression/anxiety
- Disability

Changing child catastrophizing reduces child pain complaints

Langer et al, Child Health Care 2009;Walker et al J Pediatrc Psychol 2007; Lavigne et al J Pediatr Psychol 2013; Levy et al Clin J Pain 2014

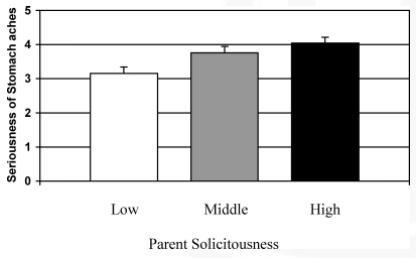
Parents and FAP

- Parents decide if child stays home from school or visits a doctor (disability).
- Parents help child cope
- Parental attention shows empathy but can inadvertently increase symptoms and disability



Walker et al Pain 2006

Giving gifts, attention, excusing from school and chores etc. leads to feeling your symptoms are more serious



Levy et al Am J Gastroenterol 2004

Psychological Treatment of FAP

- Cognitive Behavioral Therapy (CBT)
  - Addresses thoughts about pain and coping with pain
  - Usually includes both child and parent
  - Aimed at reducing disability and increasing quality of life
  - Most widely studied (6 RCT). All but one trial positive.
- Hypnotherapy/Guided Imagery
  - Natural state of selective focused attention in which person is more open to suggestions to change mind and body.
  - Impressive long-term results in 2 RCT

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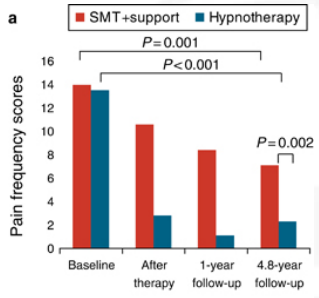
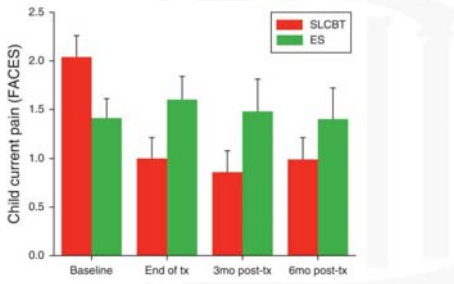
Hypnotherapy for FAP



Vlieger et al Am J Gastroenterol 2012

CBT for FAP



Levy et al Am J Gastroenterol 2010

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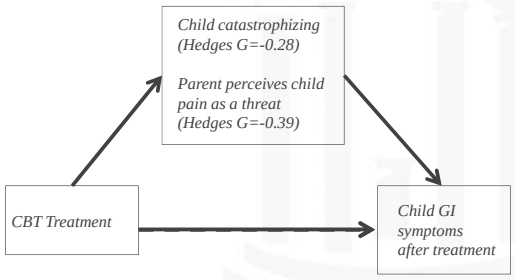
Cognitive behavioral therapy for FAP



Levy et al *Clin J Pain* 2014

Single treatments not very efficacious

- Lack of evidence for:
  - » Dietary treatment
    Cochrane 2008; van Tilburg & Felix, 2013
  - » Pharmacological txt
    Cochrane 2008, Korterink et al 2015
- Some evidence for:
  - » Cognitive Behavioral Therapy (CBT)
  - » Hypnotherapy
    Cochrane 2008, Rutten et al 2015

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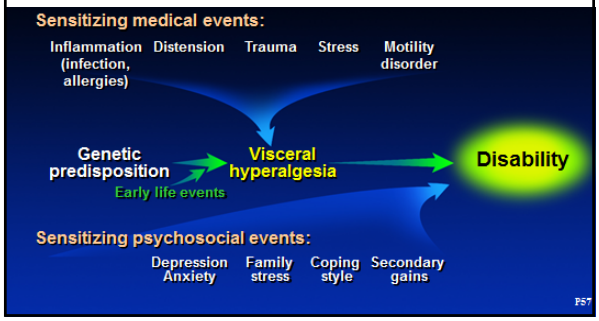
Pain is multifactorial: Integrated care needed

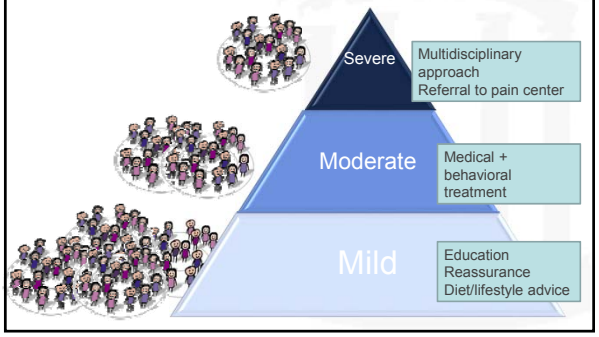


Integrated care of pain

- Coordinated care from several disciplines:
  - Pediatricians
  - Psychologists
  - Others (physiotherapy, nutrition)
- 1 RCT and 9 non randomized trials:
  - Large effects on disability
  - Moderate effects on pain

Hechler et al Pediatrics, 2015

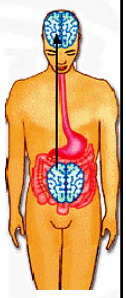
Who needs integrated care?



How to deliver integrated care?

(a) Integrate psychologist in GI practice
- Less stigma and dropout
- Adds value: fewer medical appointment/calls
- Can be billed under health and behavior code

(b) Referral to outside psychologist.
- Families may be resistant to referral
- Lack of therapists
- Make sure psychologist knows how to deal with pain and does not simply focus on treating anxiety.



Other options for integrated care

- Multidisciplinary pediatric chronic pain clinics
  - For most severely disabled patients
  - Available in 24 states
- E-treatments
  - Skype (laws differ by state)
  - Internet/phone CBT (Palermo et al *Pain* 2015)
  - Audio-recorded hypnotherapy (van Tilburg et al *Pediatrics* 2009)
  - Phone (Levy et al, NASPGHAN 2015)

Important tips

- All children with moderate symptoms can benefit
  - No moderators found in our own studies
  - Anxiety not special indication for care
  - High disability will have highest need
- Not every families open to integrative care
  - Those who do will have better outcomes
  - Integrated care is beneficial for organic disease such as IBD as well

Important tips-continued

- Know the psychologist
  - » Treatment main focus on pain instead of anxiety
  - » Educate psychologist on GI issues
- Remain available
  - » Sends the message that it is important and you do not want to get 'rid' of family
  - » Schedule regular follow-up appointments

How to find a psychologist?

- American Pain Society Multidisciplinary Care centers for Chronic pain (tonya.palermo@seattlechildrens.org)
- NASPGHAN list for psychologists working in GI (NASPGHAN.org →professional education→ motility resources; tilburg@med.unc.edu)
- Outside of academic centers: Contact Society of Pediatric Psychology Division 54 Pediatric Gastroenterology Interest Group for local recommendations (http://www.apadivisions.org/division-54/sigs/gastroenterology/index.aspx)
- American Society of Clinical Hypnosis (ASCH.net)