BC Children's Hospital | Compass Mental Health Supporting Providers

Compass

Putting Mental Health and Substance Use Connection and Consultation in Your Hands

Nov 28th, 2022

Compass Connections Webinar Series
Moderator: Dr. Katharine Thomson. R. Psych

Disclosures

- None

Land Acknowledgement

With gratitude and humility we acknowledge that we work on the traditional, ancestral and stolen lands of the xʷməθkwəy̓əm (Musqueam), Skwxwú7mesh (Squamish), and Səlílwətaʔ/Selilwitulh (Tsleil-Waututh) Nations.

BC Children's Hospital | Compass Mental Health Supporting Providers

COMPASS CONNECTIONS: Somatization

Session 1: Identifying Somatization in Pediatric Populations

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About Compass

Compass connects community care providers across B.C. to the information, advice, and resources they need to provide evidence-based and timely mental health and substance use care to children and youth (up to 25 years) close to home.

Housekeeping

- Attendees are automatically muted. Please feel free to keep your cameras on but please note the webinar is being recorded.
- Please submit questions for the speakers via www.slido.com and join with event code **#2285109** OR click the direct link in the chat.
- Please submit technical questions through the “Chat” function
- The webinar recording will be made available at compassbc.ca
- An evaluation survey will be provided at the end of today’s webinar

Accredited by UBC CPD

- The Division of Continuing Professional Development, University of British Columbia Faculty of Medicine (UBC CPD) is fully accredited by the Continuing Medical Education Accreditation Committee (CACME) to provide CPD credits for physicians.
- This Somatization Webinar Series is an Accredited Group Learning Activity (Section 1) as defined by the Maintenance of Certification Program of the Royal College of Physicians and Surgeons of Canada, and approved by UBC CPD.
- You may **claim a maximum of 4.5 MOC Section 1 Group Learning hours** (credits are automatically calculated). This one-credit-per-hour Group Learning program meets the certification criteria of the College of Family Physicians of Canada and has been certified by UBC CPD for up **to 4.5 Mainpro+® credits**.
- Each physician should claim only those credits accrued through participation in the activity.
- CFPC Session ID: 198592-001

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CONTINUING PROFESSIONAL DEVELOPMENT
FACULTY OF MEDICINE

This is PART 1 of a three-part Somatization Webinar Series

Join us

- **December 5th** 12-1:30pm for PART 2:

  "Working with families to reduce diagnostic confusion about pediatric somatization"

- **December 12th** 12:00pm – 1:30pm for PART 3:

  "Treatment strategies for somatization in pediatrics"

Register at Compassbc.ca

Speaker Introduction

Andrea Chapman,
MD, FRCPC

Amrit Dhariwal,
PhD, RPsych

Speaker Introduction

Joanna McKay, RN

Sandra Westcott, MD, FRCPC

Somatization in Children and Teens

Session 1

Identifying Somatization in Pediatric Populations

Nov 28, 2022

Amrit Dhariwal, Joanna McKay, Andrea Chapman, Sandra Westcott

Series Objectives

After attending this webinar series, participants will be able to:

1. Define somatization, and identify challenges to assessing and treating somatization
2. Apply a model in the management of somatization with strategies for communicating compassionately and respectfully to patients and families
3. Practice effective intervention strategies and locate clinical resources for patient care

Disclosures

Relationship with Commercial Interests				
	AD	AC	SW	JM
Grants	BCCH Research Institute (BCCHRI) International Center for Emotionally Focused Therapy (ICEEFT) Provincial Health Services Authority (PHSA)	BCCH Research Institute (BCCHRI)	n/a	n/a
Research	Clinical studies of group and attachment focused family treatments for somatization	Clinical studies of group treatments for somatization	n/a	n/a
Honoraria/fees	n/a	n/a	n/a	n/a
Relationship with agencies related to content	Circle of Security International, ICEEFT	n/a	n/a	n/a
Others	Private practice in child and family psychology	n/a	n.a	n/a

Managing Potential Bias

- Self-reflection on conflict that may be perceived as creating bias
- Full disclosure of potential conflicts
- Views and opinions expressed in this presentation are ours alone
- Balanced review of literature and presentation findings

Acknowledgements

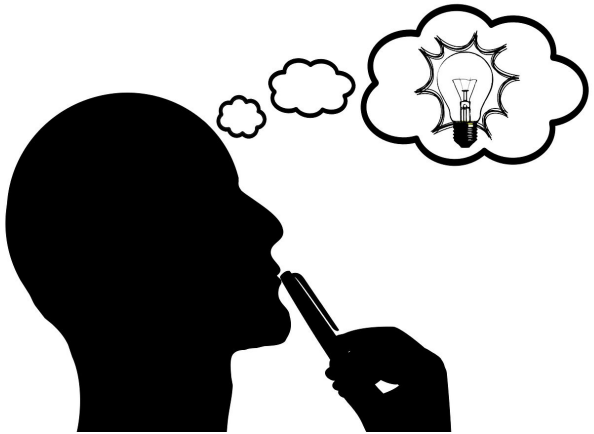
Today's Outline & Objectives

1. **Identify somatization in pediatric populations**
    - What is somatization in children and teens?
    - How common is it?
    - What causes it?
    - When does it become a diagnosis? And who makes the diagnosis?
    - What are each of our roles?
    - What is the model of care at BCCH?
2. Communicate effectively to reduce confusion and increase trust
3. Apply integrated treatment strategies

Today’s Seminar

- Information based on research and clinical experience
- Participant polls
- Sample scripts - what you can say to families
- Case presentation and role play
- Questions and discussion

Reflect



How familiar are you with the concept of somatization and somatic symptom disorders?

What feelings come up for you when working with somatization?

What is somatization?

Image from Sam's Journey: A Story of Somatization (Green & Penner)

Mind Body Dualism

Search The Guardian International edition
News website of the year

The big idea: should we drop the distinction between mental and physical health?

Edward Bullmore

Mon 12 Sep 2022 12.30 BST

The current false dichotomy holds back research and stigmatises patients

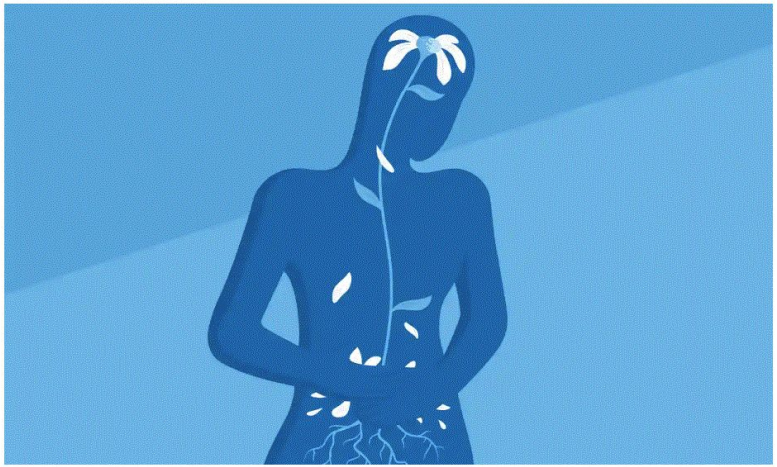


Illustration: Elia Barbieri

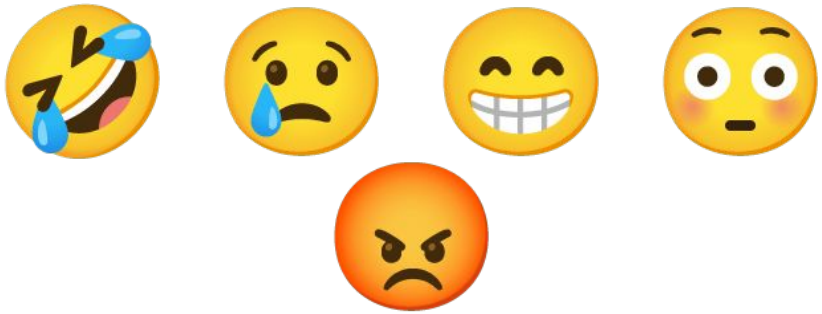
"We live in a falsely divided world, which draws too hard a line – or makes a false distinction – between physical and mental health...despite being disadvantageous to patients on both sides of the divide."

"In practice, physical diseases are treated by physicians working for medical services, and mental illnesses are treated by psychiatrists or psychologists working for separately organised mental health services. These professional tribes follow divergent training and career paths: medics often specialise to focus exclusively on one bit of the body, while psychs treat mental illness without much consideration of the embodied brain that the mind depends on. "

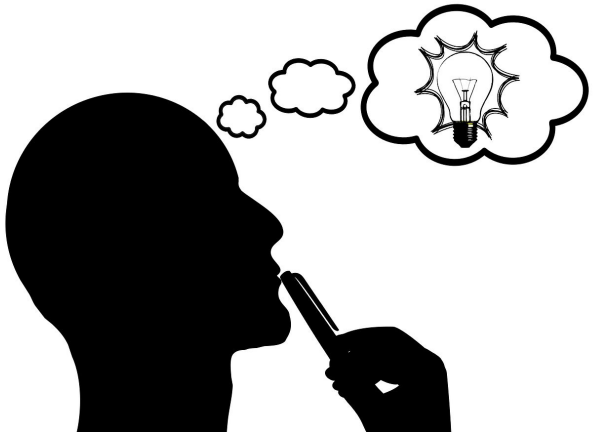
What is somatization?

What is Somatization?

Somatization is the **normal** and **involuntary** physical expression of *emotions*.



Reflect

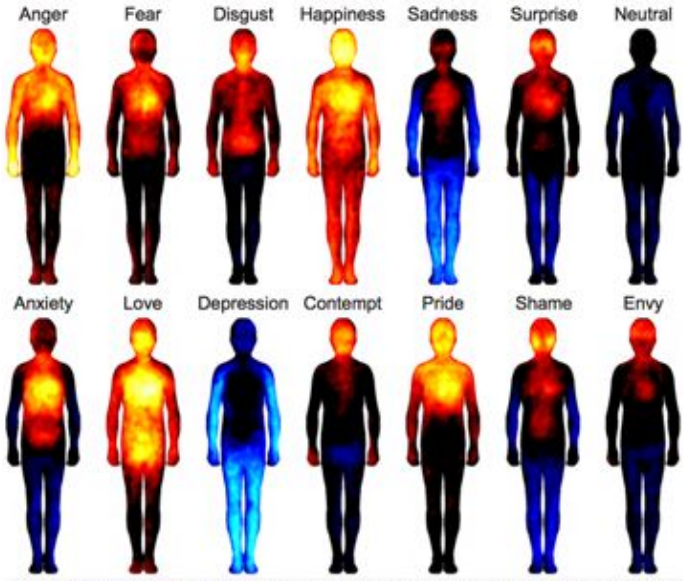


Where do YOU feel stress in your body?

Why do we somatize?

Somatization (or bodily felt emotion) confers evolutionary advantage

- It is **universal**, **real**, and serves a **purpose.**
- It is **adaptive** and aid in **survival**. You automatically get information about events that are occurring, your needs/goals/concerns, your sense of self, and actions you need to take.
- Others might witness your distress and **help**.
- Those sensations help you survive by rapidly and efficiently responding to your environment so you stay safe.



Damasio (2013); Dragos & Tanasescu, 2009; Nummenmaa, et al., (2013); Panksepp, 2005

Sample Script
What you can say to families

Why do we somatize?

Somatization is the the normal and real physical expression of emotions and stress.

All emotions are felt in our bodies physically.

Bodily sensations give us information about what we want or need to stay safe, so that we can quickly and automatically take action.

For example, knots in our stomach might tell you that you feel anxious, a foggy brain might tell you that you feel overwhelmed, and a spring in your step might tell you you are feeling joyful.

Somatization is very common and very real, it's something we all experience every day.

‘The Mind and Body Together’ Explained

https://www.youtube.com/watch?v=weRq8fwlI50

When is somatization a problem?

Although somatization is a normal experience, sometimes somatization is:

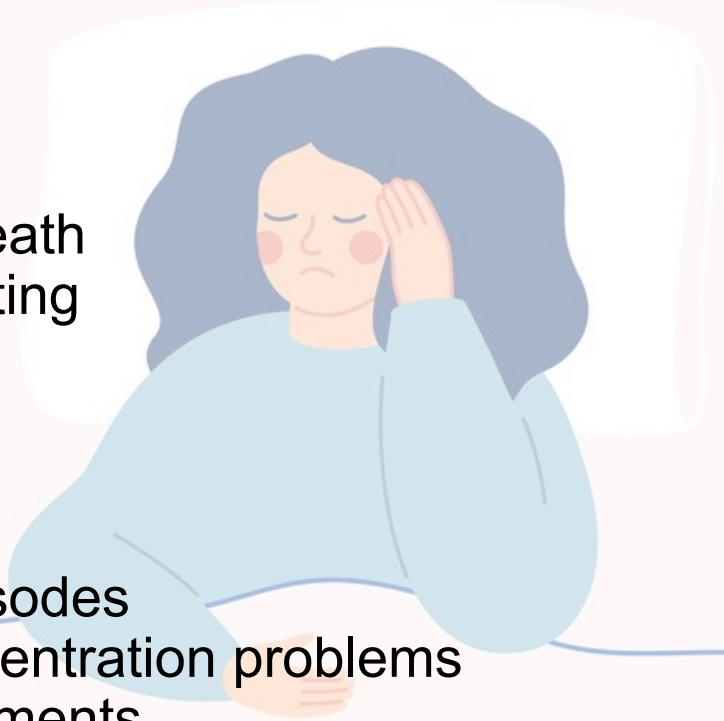
- frequent
- intense
- unusual

When it is distressing or interferes with daily function we call it a disorder.

DSM-5

What are common somatization symptoms?

- Pain
- Fatigue
- Weakness
- Dizziness
- Shortness of breath
- Nausea or vomiting
- Lump in throat
- Vision changes
- Numbness
- Fainting
- Seizure-like episodes
- Memory or concentration problems
- Abnormal movements



What is the burden of somatization?

- 6 - 13% prevalence in the pediatric population
- Gender disparity more frequent in girls than boys
- Age effects frequency increases with puberty
- Comorbid with depression, anxiety, and PTSD frequently
- 10-15% account for children's medical visits in primary care
- 2nd leading reason for consultations in pediatric hospitals

Le Resche et al., 2005; Saunders et al., 2020; van Geelen et al., 2015

How does culture influence somatization?

- **Somatization is common in all cultures**
- Cultural differences are not easily studied
- There may be cultural "idioms of distress"
- There may be cultural variations in mental health stigma, community trauma/stress
- Clinicians must make space for patients' and families' idiosyncratic meanings of sx.

Canna & Seligman, 2020; Kirmayer & Young, 1998; Kohurt, Rasmussen, Kaiser et al., 2014

How is somatization in kids different than in adults?

Parents become caught in symptom cycles with their kids. Together, they both influence distress and disability.

Typical Development
From Infancy to Adolescence

- *All babies cue emotions bodily*
- *Parents interpret cues and reflect back emotions*
- *Over time, this process helps kids learn their cues and independently organize emotions.*

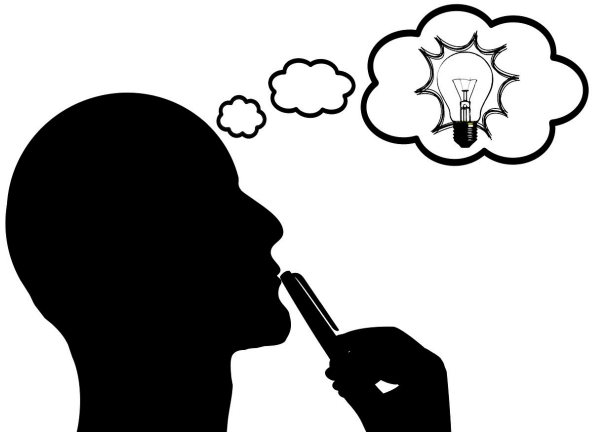
Clinical Development
With Complex Medical Hx

- *Bodily cues mean symptoms*
- *Parents worry, stay close, and vigilantly monitor kids*
- *Kids may feel insecure, avoid risk-taking or independence*
- *Kids struggle to understand bodily felt emotions*

Parents must be included in assessment and treatment

- Parents may portray DSM-5 criteria of 1) sx-related thoughts, feelings, or behaviours 2) impairment
- Kids need parents' support to learn how to respond to distressing bodily cues and independently manage emotional states.

Reflect



What might cause or contribute to somatization?

Sample Script
What you can say to families

Helping families understand somatization

It's easy to understand and relate to everyday somatization, like flushing if you are embarrassed, or a heart racing if you get a surprise.

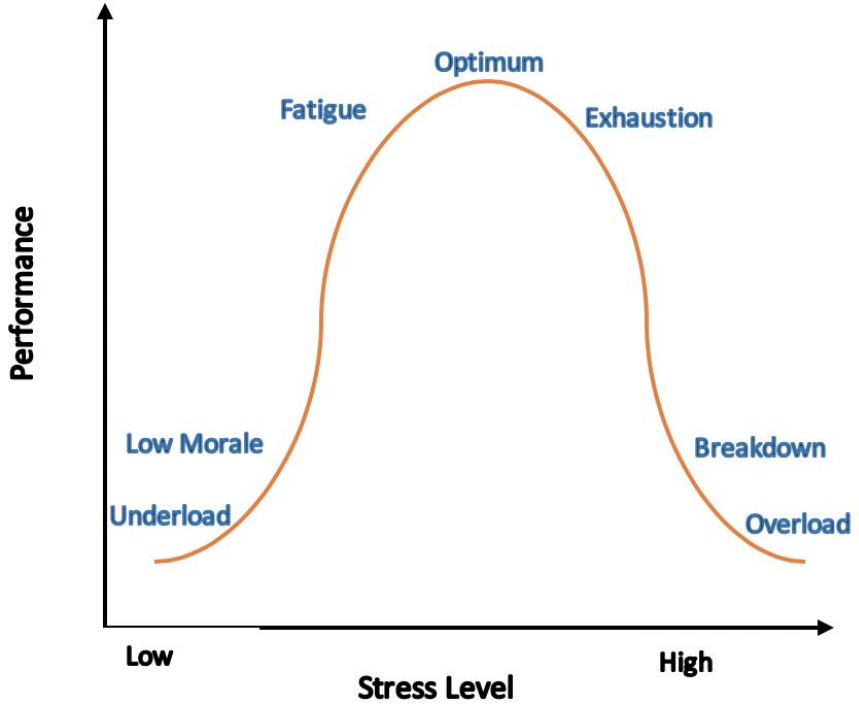
It's easy to understand less frequent somatization that occurs with specific stresses, like upset stomach before a big test, or a headache after a busy day.

It might be hard to understand somatization that is persistent. It is less typical and more intense, like chronic joint pain, nausea that won't go away, episodes that look like seizures but are not seizures.

Does somatization need a specific trigger?

Wear and Tear on the Body

(Allostatic Load)



Picard & McEwen (2018)

Potential Contributing Factors

	Biological	Psychological	Social
All stages	‘Organic’ disease Hx of somatization	Personality traits Emotional disorder	Life events
Predisposing	Genetics	Childhood trauma Attachment style / trust Personality traits	Childhood neglect or abuse Poor family functioning Symptom modelling of others
Precipitating	Physiological stress (ie poor sleep, drugs) Physical injury / pain	Stressful life events Dissociation	Stressful life events
Perpetuating	Plasticity in CNS Deconditioning	Illness beliefs (pt and family) Perception symptoms irreversible Invalidation Avoidance Fear of failing	Social beliefs of being ill Legal compensation Ongoing medical investigations and uncertainty Groups that reinforce beliefs

Adapted from Nicholson et al., 2020 and Stone, 2009

Have all children with somatization had trauma or abuse?

Not all who somatize have abuse or trauma histories

- However, somatization is about 3.3 to 3.9 x more likely if a person has a history of abuse/trauma.
- It is interrelated with other predisposing vulnerabilities.

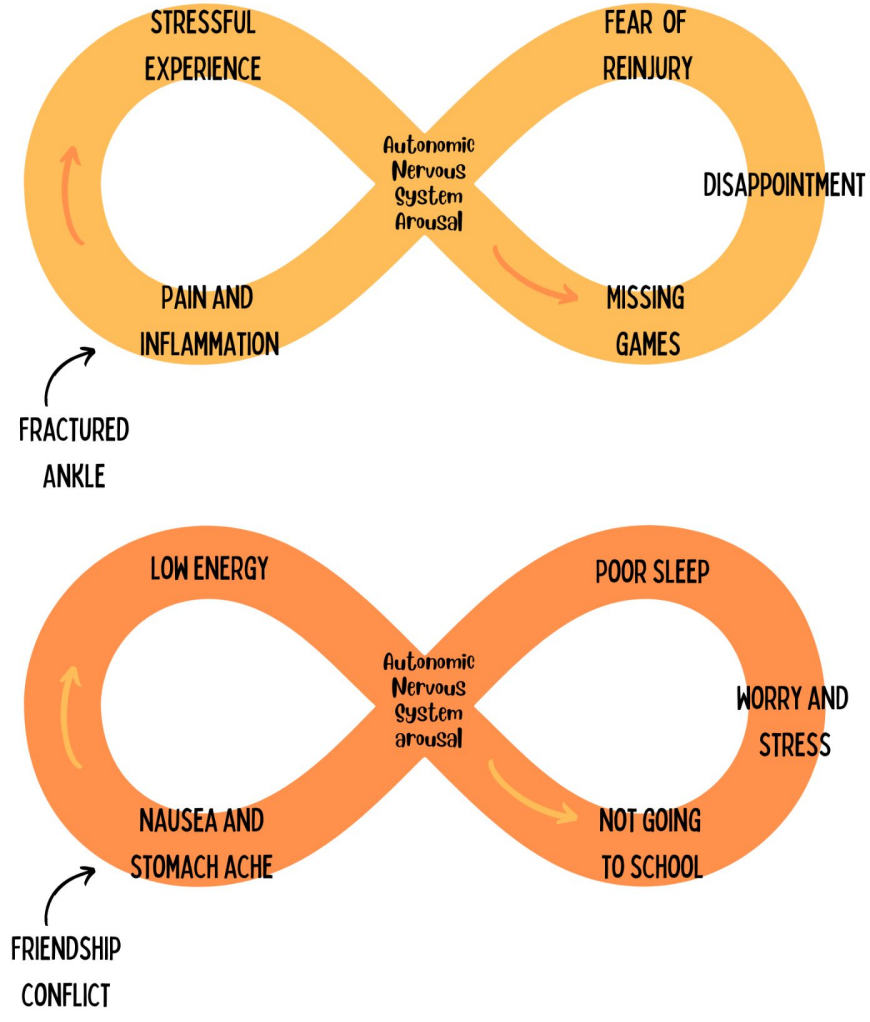
Risk for somatization can occur without adverse life experiences altogether

- E.g., high bodily attentional focus + low perceptual accuracy

The presence or absence of adverse life events does not help rule in or rule out the diagnosis.

Perez, Edwards, Nielsen, et al., 2021

What starts somatization?



Sample Script
What you can say to families

What causes somatization?

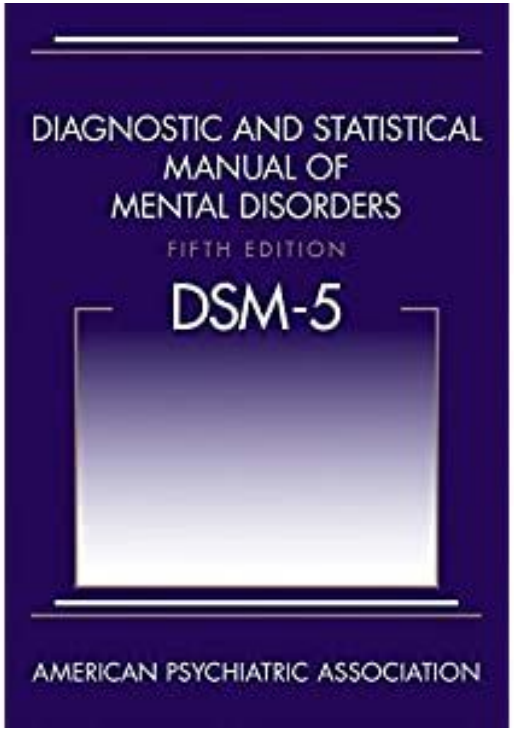
There are many pathways to somatization.

Sometimes, an illness starts the cycle going. Sometimes, stress and emotions start the cycle.

Regardless of what started a physical symptom, we know that many things can keep it going. (Like a snowball rolling downhill).

The symptom(s) itself can cause stress and anxiety. There might be associated stressors like the pressure of missing out on school, physical deconditioning, and sleep difficulties, all of which can add to the stress and make physical symptoms worse.

Somatic Symptom and Related Disorders



What are the DSM 5 Categories?

SSD: Somatic Symptom Disorder

- One or more **somatic** symptoms, distressing or disruption of daily life.
- Excessive thoughts, feelings, or behaviours related to the somatic symptoms:
  - Disproportionate and persistent thoughts about seriousness high level of anxiety
  - Excessive time and energy
- Persistent symptoms.

What are the DSM 5 Categories?

FND: Functional Neurological Disorder

(Conversion Disorder)

- Altered **voluntary motor** or **sensory function** symptom(s)
- Clinical findings show incompatibility between sx and recognized neurological or medical conditions.
- Not better explained by another medical or mental disorder.
- Significant distress or impairment in functioning or warrants medical evaluation.

What is the relation between SSD and FND?

Many call for SSD and FND to be combined into one diagnosis.

Those affected by somatization are likely to have multiple, diverse symptoms.

SSD and FND are frequently comorbid.

A transdiagnostic mechanism involving emotion regulation may explain the shared variance.

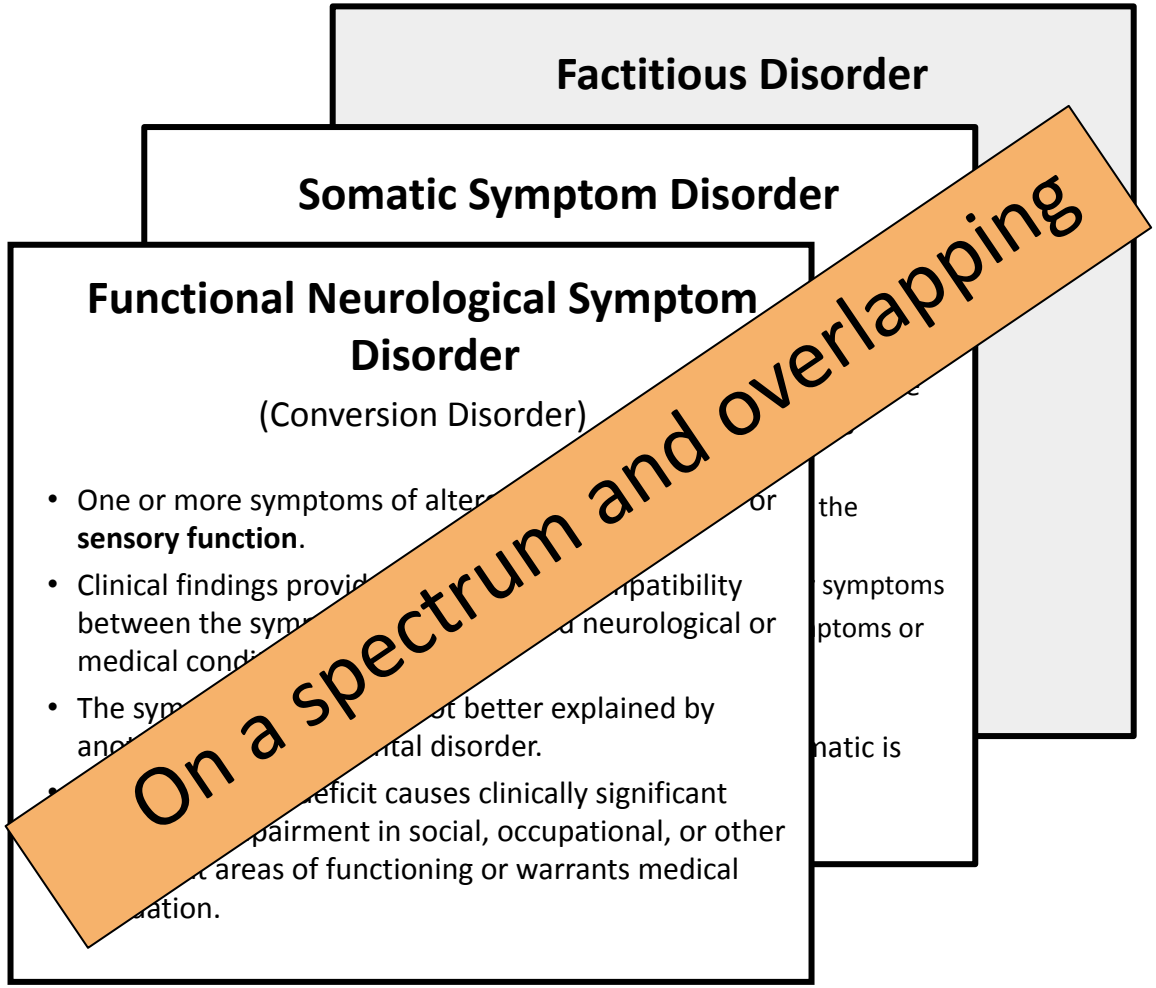
Burton, Fink, Henningsen et al., 2020; Guney, Sattel, Witthoft, et al., 2019; Fink & Schroder, 2010;

What are the DSM 5 Categories?

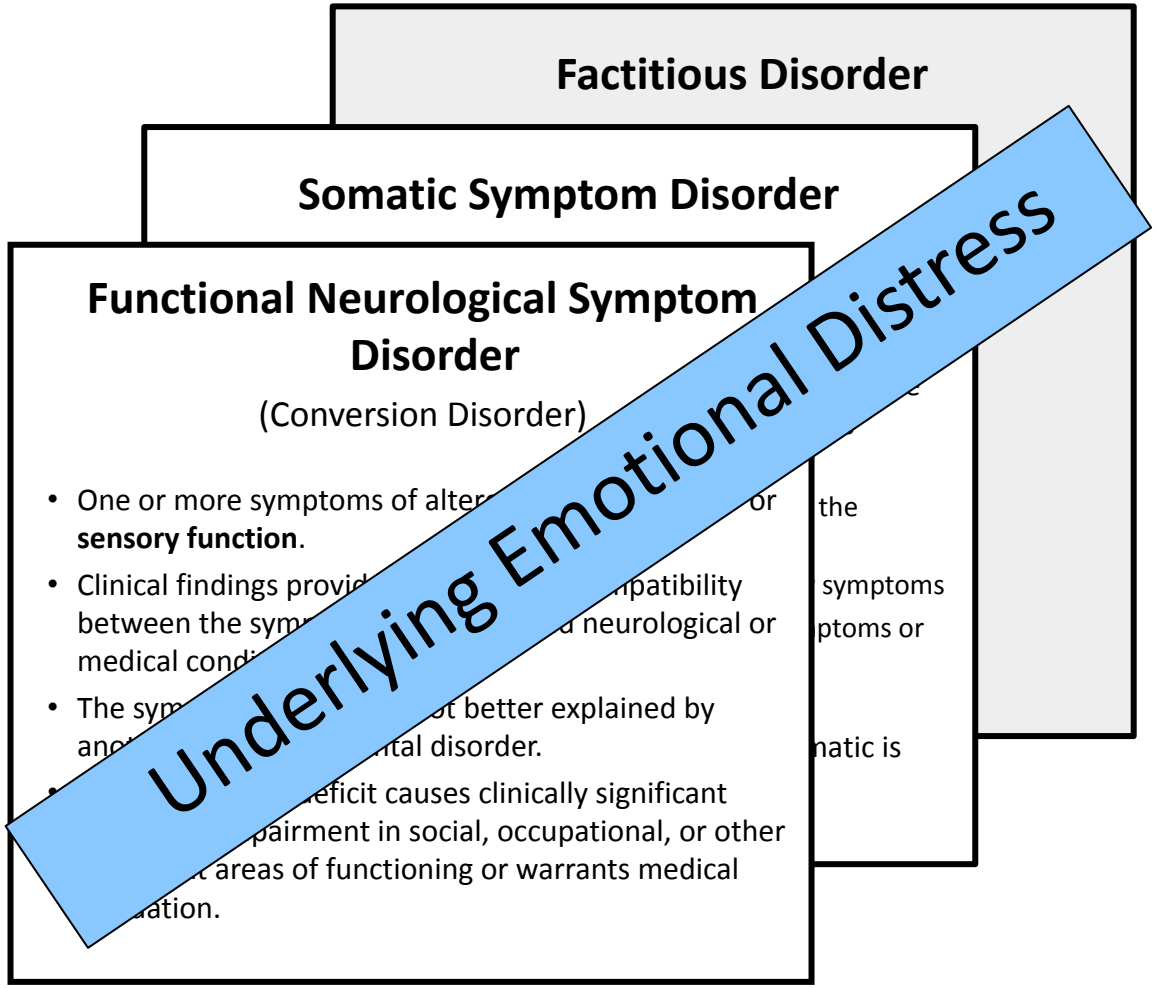
Factitious Disorder

- Falsification of physical or psychological signs or symptoms, or induction of injury or disease.
- Presents self as ill, impaired or injured.
- Behaviour is evident, even in the absence of obvious external rewards.

Is it easy to tell the difference between somatic and factitious?



Is it important to tell the difference?



What diagnostic terms are best to use?

Categorical diagnoses are useful and important, however can be challenging in somatization.

Often, we struggle with conceptualizing the mind and body integration and labeling it for ourselves and families.

Examples of this complexity include:

- Disorders that may have a strong element of somatization:
  - e.g., IBS, Dysautonomia, Chronic Pain, Long Covid, Post Concussion Syndrome
- Disorders where there is controversy and lack of evidence in our system:
  - e.g., Chronic Lyme Disease with no lab markers

We may want to know what is ‘mind’ and what is ‘body” but that is a false distinction.

What diagnostic terms are best to use?

We strongly encourage the use of the word **somatization**.

- medicine needs a common term
- our patients need a common term

We avoid

- not making a diagnosis
- ‘medically unexplained’
- vague and couched terminology
- benign but not accurate diagnosis

We have also noticed a positive change in people’s comfort with the term in the past 5-10 years.

What are some examples of diagnostic terms?

The term somatization can be used in different ways, reflecting the complexity and reality of each individual situation

- You have “non-epileptic seizures” which is a **somatization disorder**. The technical term is a Functional Neurological Disorder.
- You have chronic pain with an **element of somatization**.
- Your symptoms and test results tell us that your Crohn’s illness is **affected by somatization** right now.
- You’ve been diagnosed with dysautonomia which is a condition that often has a **strong element of somatization**.
- Your diagnosis is **Somatic Symptom Disorder.**
- You have functional dyspepsia (now called a disorder of gut-brain interaction) and **somatization**.

Who diagnoses somatization?

Somatization is a ‘medical’ diagnosis **based on**:

- history
- physical exam
- investigations

Somatization **is** diagnosed by:

- the medical professional who has expertise in that symptom and disorders related to that symptom

Somatization diagnosis **is not** based on:

- temperamental traits
- stressors
- comorbid psychiatric conditions

What if the diagnosis is not 100% certain?

Like any other conditions, making the right diagnosis may take time.

Providing information about the preferred diagnosis and the differential diagnosis is helpful and appropriate.

Specifically for suspected somatization, we suggest a ‘walking two paths’ approach

- *I am going to order some tests and refer you to a cardiologist, but I think that somatization may be causing your symptoms. While we wait for those results, I think it’s important for you to learn more about somatization and the mind body connection.*

What is the right amount of investigation?

“I don’t want to over-investigate, but I’m worried about missing a diagnosis.”

Be thorough with investigations and referrals in the early phase.

- appropriate and warranted
- reassuring to everyone involved
- families can be more confident engaging in somatization treatments

Be careful about over-investigation when the diagnosis is more certain.

Be explicit about the ‘walking two paths’ approach.

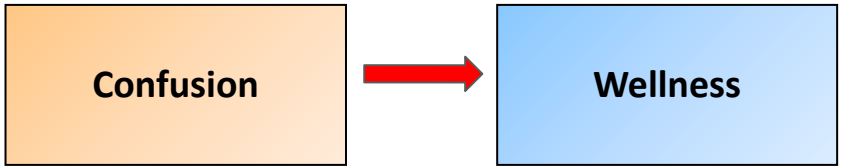
Who treats somatization?

Everyone has a role (family doctor, nurse practitioner, pediatrician, counsellor, psychiatrist, teacher, physiotherapist, etc.)

Every situation is different, depending on patient situation and resources available.

Goal is for all of us to help move the child/family from confusion to wellness

- Primary care providers may be more involved in the first months, with fewer appointments later on - but please stay involved!
- Therapists may take more of an active role during the treatment phase



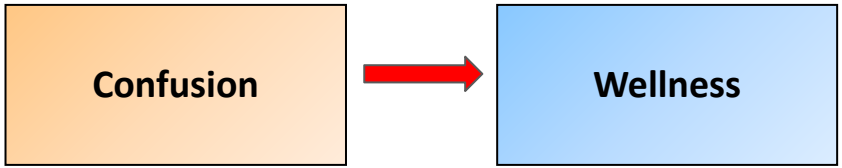
What if there isn't a team available?

Everyone wants a case manager and a team.

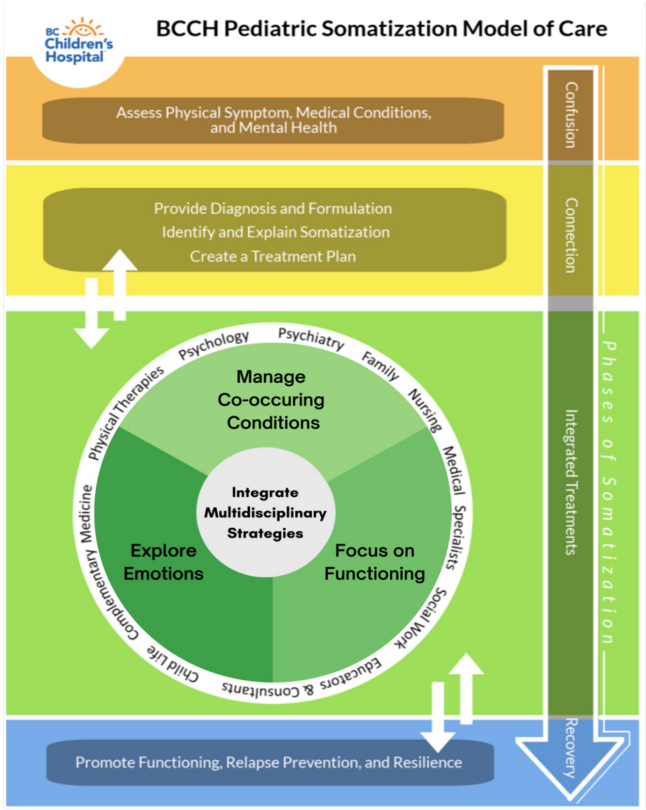
Individuals can make a difference.

Small interventions can have a big impact:

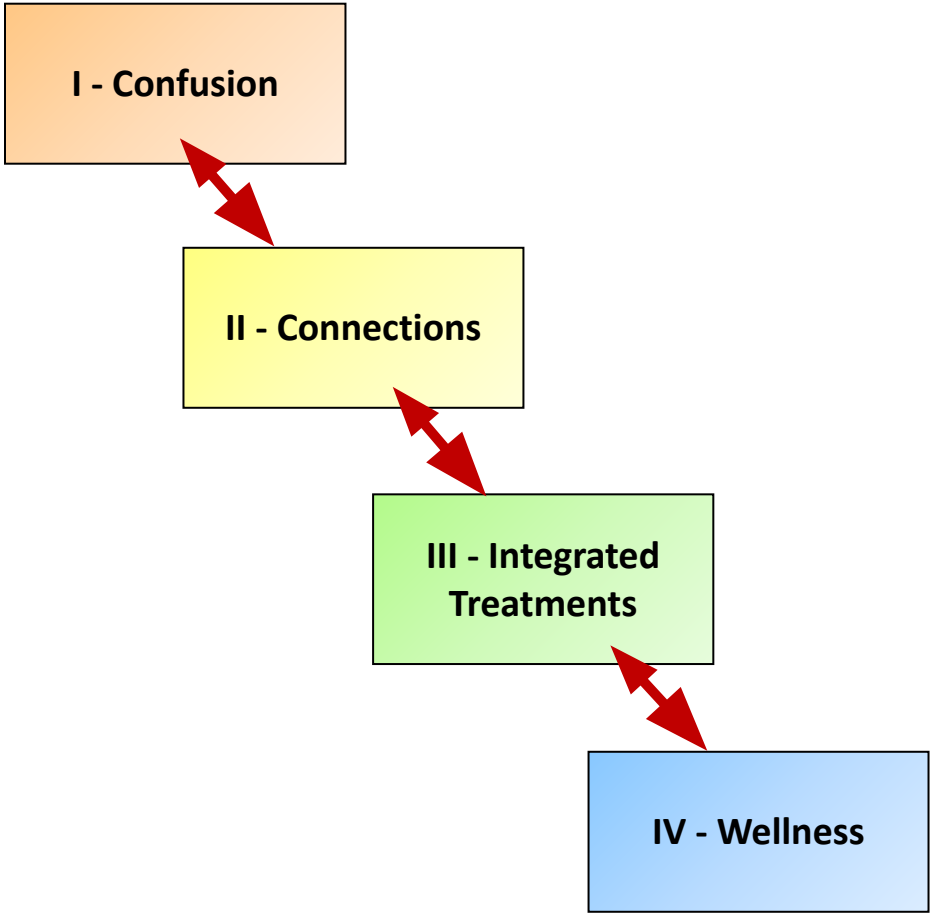
- Validation
- Assessment and reassurance
- Guide treatment strategies
- Continued involvement



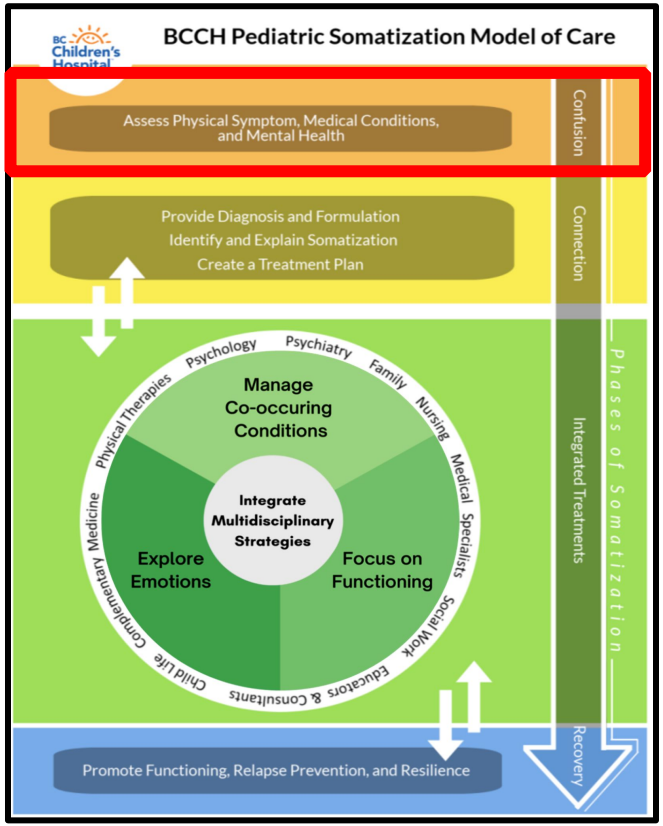
Overview of Treatment Approach



BCCH Somatization Model of Care



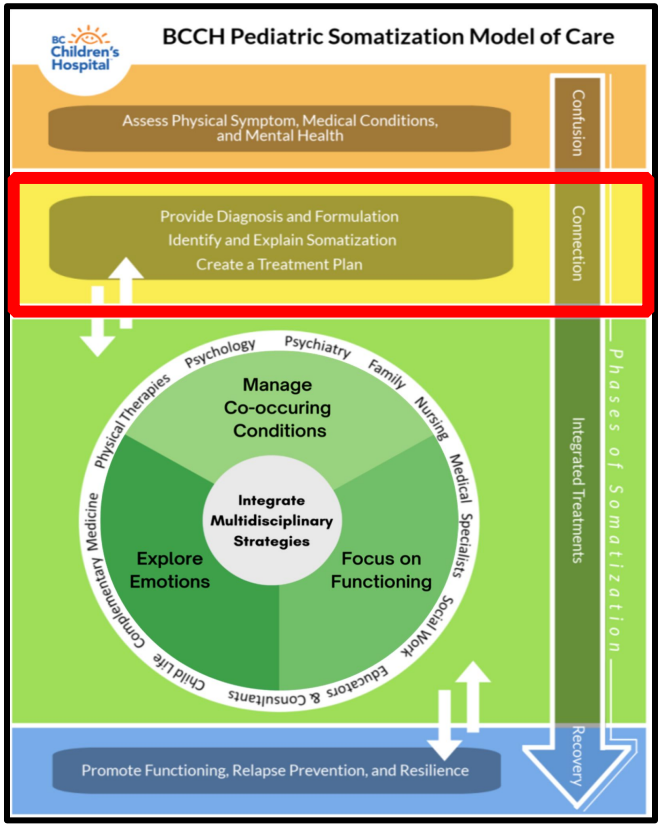
BCCH Somatization Model of Care



Confusion

- Assess the physical symptom thoroughly
- Attend to mental health and emotional factors

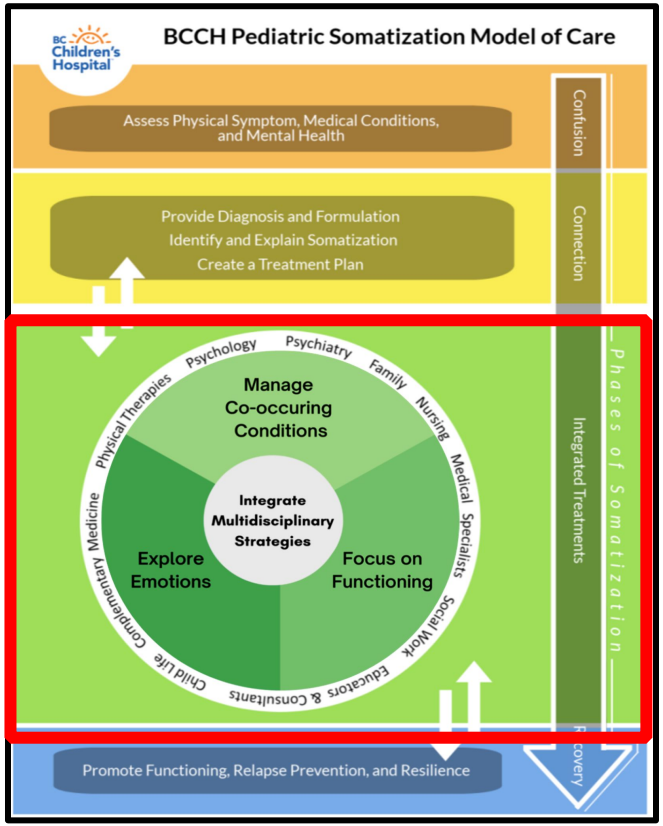
BCCH Somatization Model of Care



Connections

- Provide a diagnosis
- Explain somatization and the ‘mind and body together’
- Develop a treatment plan

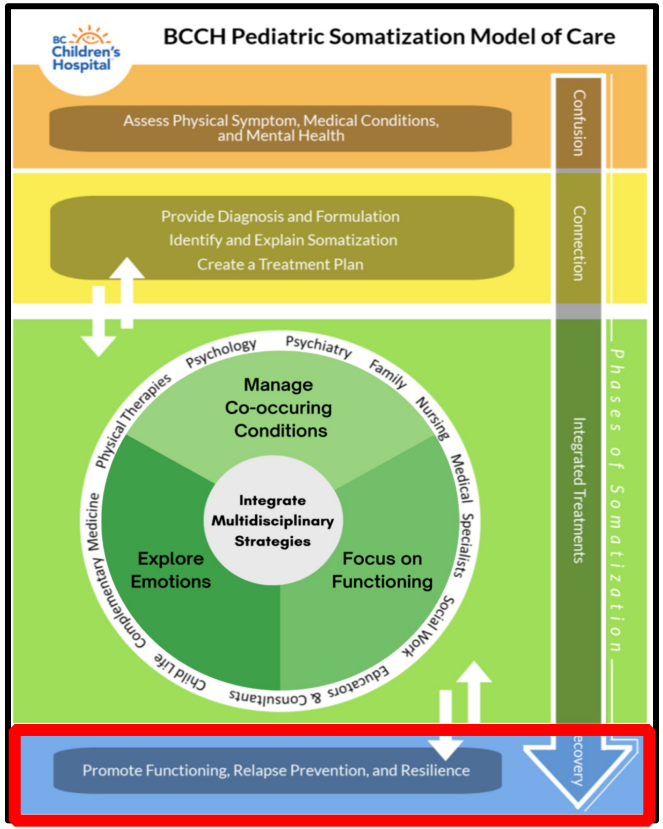
BCCH Somatization Model of Care



Treatments

- Manage co-occurring conditions
- Focus on functioning in all areas
- Explore emotions and develop emotional coping

BCCH Somatization Model of Care



Wellness

- Goals are growth and development:
  - having meaningful experiences,
  - having a range of emotions,
  - experiencing joy,
  - thriving

Introductions

Zara
(patient)

Pat
(mother)

Grace
(family doctor)

Zara (patient)

My name is Zara. I'm 16 years old and I live in Fort Nelson. A year ago I started having stomach pain and nausea that wouldn't go away. It's there all the time. I used to get really good grades, and I was busy with volleyball, skiing and hanging out with friends. Most days I can't go to school because I'm too nauseated. My friends don't really understand - it's like they are moving on with their lives. I feel like I'm all alone and no one understands. I just want someone to give me a diagnosis and fix this so I can go back to my normal life.

Pat (mother)

I'm Zara's mom. Our lives have changed so much since this started; I can't work, my other children aren't getting enough attention, and my husband and I argue about what to do. We were a normal family before this. I'm so worried about Zara. She isn't herself anymore - she was always so good at everything. She never complained of anything before, even when she was really hurt. Our family doctor has ordered tests and has seen us a bunch of times, but there's no answer. We waited for 10 months to see a gastroenterologist and they said that there's nothing wrong with Zara. We've been to Emergency 4-5 times but no one does anything. They say it's all "in her head". Zara's pain and nausea are real; you can't tell me that there isn't a physical cause when I sit here and watch her in pain. It feels like no one is listening, and meanwhile my daughter is getting worse and worse.

Grace (family doctor)

I'm Zara's family doctor. I've known Zara and her family since she was young. I've done repeated physical exams, investigations and I think that this is functional. I also sent Zara to see a pediatric GI specialist to make sure. Even though I've been thorough, I worry that I'm missing something. I used to like seeing Zara, but now I dread it. I've tried to explain things to Zara and her parents, but they just seem really frustrated. It's difficult to find the right words. I'm not sure how I can help them understand. And I'm really busy, these appointments take a long time.

Miriam (psychologist)

I’m Zara’s mental health clinician. I am meeting Zara and her Mom for the first time after Zara has been diagnosed with somatization. I’m not sure what they’ve been told and what they understand about this diagnosis. I’m trying to figure out how I can help.

Role Play

Zara
(patient)

Pat
(care provider)

Grace
(family doctor)

Role Play

Zara: My pain and nausea are worse than ever, and I just want someone to treat this so I can get back to school and volleyball.

Grace: These symptoms have had a big impact on your life, and you've felt frustrated that none of the medication you've tried has helped.

Last week you saw a pediatric gastroenterologist. I received the results and your diagnosis is called a disorder of gut-brain interaction (another term for that is a functional GI disorder). This is a condition that is affected by somatization.

Pat: I don't understand, how did you make this diagnosis?

Role Play

Grace: For Zara's symptoms, we look for two types of conditions. The first type is what we call a structural condition – that means that there is something wrong with the structure of your esophagus, stomach, or intestines, like inflammation, injury, growths, and lesions.

The second type is a messenger system condition. A gut-brain interaction disorder means that the problem is in how your stomach receives and sends messages to your brain and how your brain receives and sends messages to your stomach.

Zara, in order to make your diagnosis, the pediatrician and I have asked a lot of questions about your symptoms, done physical exams, and ordered investigations. The pediatrician has arranged a scope which should happen in a few months, but all of the information we have now points to a messenger system condition.

Somatization is a big part of messenger system conditions. This is actually very common and treatable.

Role Play

Pat: Sometimes I worry no one is taking us seriously. I see her in pain, and this is real physical pain. I've done a lot of reading and I'm worried about Crohn's disease. My cousin has Crohn's, and their diagnosis was missed for two years. Also what about mesenteric adenitis? My uncle is a doctor and he said we need a lot more tests. She hasn't even had a scope yet.

Grace: It makes sense that you want to make sure nothing is being missed. That's why Zara will be getting a scope,but it will take a few months. And we already have a diagnosis and we don't want to wait to start treatment.

We call this "walking two paths" – that means that I will continue to assess your symptoms and, when necessary, do some testing. At the same time I would like Zara to learn about gut brain interaction disorders and somatization.

I'm going to give you a website for more information about diet and other strategies. I also want to talk to you about this word "somatization".

Role Play

Pat: I've never heard this word somatization. What does it even mean?

Grace: Somatization is the term we use for the normal and real physical expression of emotions and stress. All emotions are felt in our bodies physically. For example, when we are sad, tears come out of our eyes, when we are happy, we feel light throughout our body. Stomach aches, dizziness, fatigue, shaking episodes are all examples of somatization symptoms. Somatization is very common and very real, it's something we all experience every day.

Almost every symptom that has been going on for a long time is affected by somatization. That means that stress and emotions can make any physical symptom worse. For example, on stressful days, migraines can be a lot more intense.

Role Play

Zara: But why did this happen to me when I wasn't even stressed? Everything was perfect before this started.

Grace: When this all started, you and your whole family were sick with a viral gastritis. This is a common way that disorders of gut-brain interaction start – something sets off the gut sensitivity and then other things keep the messenger system activated. You don't have a virus anymore, but your system is still reacting. Somatization means that stress is one of the things that makes the symptoms worse.

Zara: It kind of makes sense to me. I get that my symptoms are a bit worse when I'm worried about tests at school.

Role Play

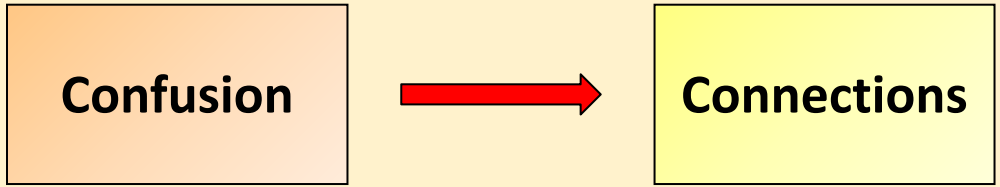
Grace: Zara, are you open to learning more about somatization and the treatments for gut-brain interaction disorders?

There's a website with more information and I can also make a referral to a group program at BC Children's Hospital so you can meet other youth with chronic physical symptoms. Often you feel like you are alone with this, and that no one can understand. Do you think it would help to meet other youth in a similar situation?

Zara: I wouldn't mind meeting other people too. But do I have to go to Children's Hospital?

Grace: Great question – no, it's a virtual group with teens from all over BC. The youth have sessions together and then the parents have sessions too. The group is called "The Mind and Body Together Group" and it helps you understand how stress and emotions can play a role in long standing physical symptoms, in medical conditions, and in mental health conditions. You will also learn about strategies that have been helpful for other teens and parents.

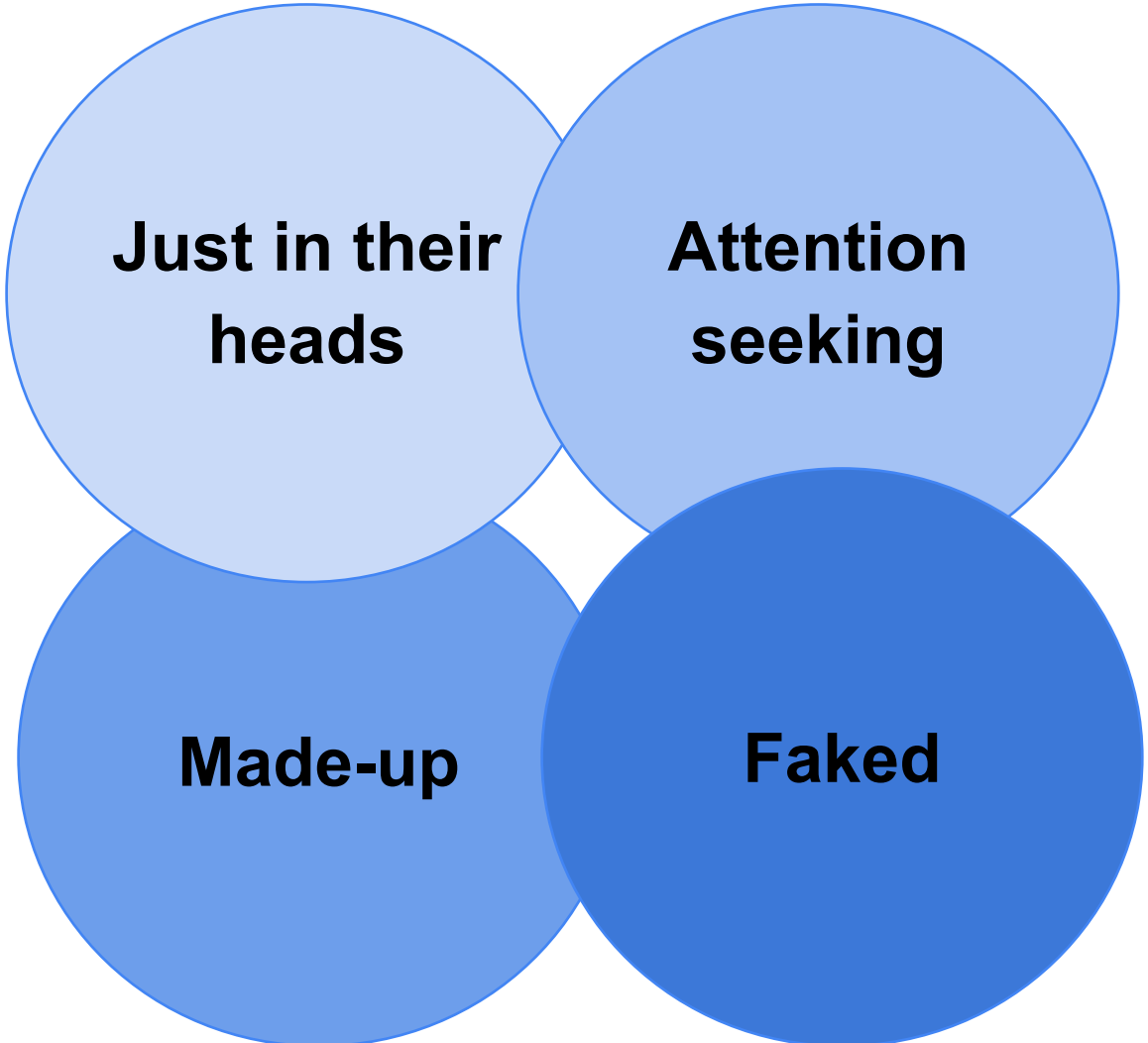
Moving from Confusion to Connections



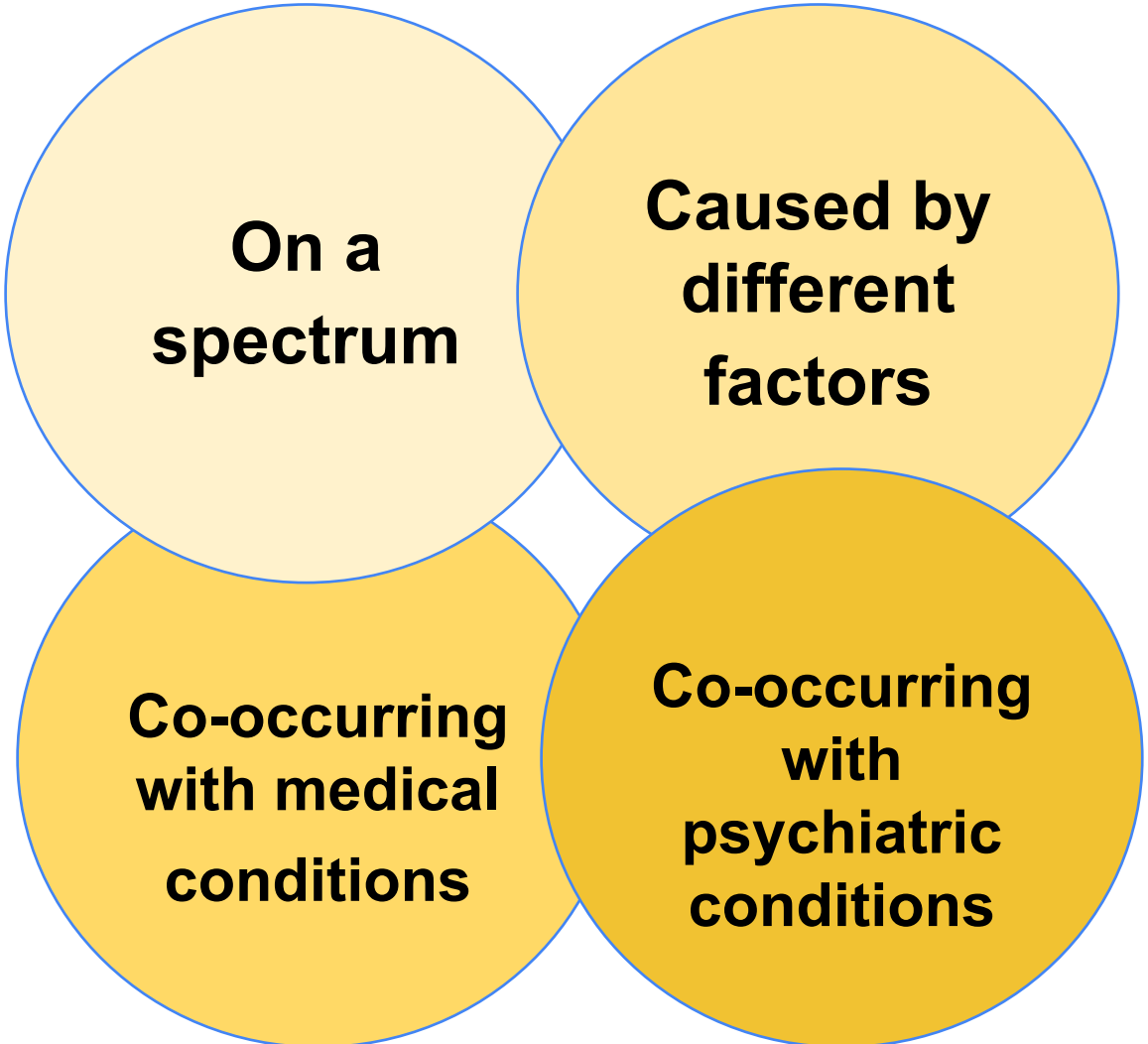
Today's Recap

1. **Identify somatization in pediatric populations**
   - What is somatization in children and teens?
   - How common is it?
   - What causes it?
   - When does it become a diagnosis? And who makes the diagnosis?
   - What are each of our roles?
   - What is the model of care at BCCH?
2. Communicate effectively to reduce confusion and increase trust (important for every provider involved)
3. Apply integrated treatment strategies

In Summary, Somatization is NOT . . .



In Summary, Somatization IS . . .



Clinical Pearls

Confusion → **Connections**

1. Use the word “somatization”
2. Explain and normalize somatization
3. Stay involved

Resources for Professionals

1. Pediatric Somatization: Professional Handbook, BC Children's Hospital: https://compassbc.ca/resources

2. Stay tuned for the Somatization Toolkit! Compass Toolkits: https://compassbc.ca/toolkits

3. Mind and Body Together Group Referral http://www.bcchildrens.ca/health-professionals/refer-a-patient/outpatient-psychiatry-referral

Resources for Families

1. BCCH/Kelty Mental Health: Family Handbook, Videos, Stories, Podcast
   https://keltymentalhealth.ca/somatization

2. AACAP (American Academy of Child Psychiatry: Family Facts
   https://www.psychiatry.org/File%20Library/Psychiatrists/Practice/DSM/APA_DSM-5-Somatic-Symptom-Disorder.pdf

3. Boston Children's Hospital: Information on Somatization
   https://www.childrenshospital.org/conditions/somatic-symptom-and-related-disorders

4. SickKids Toronto
   https://www.aboutkidshealth.ca/article?contentid=3770&language=english

Next week…

1. Identify somatization in pediatric populations
2. **Communicate effectively to reduce confusion and increase trust**
    - Focus on understanding reasons for confusion and mistrust and practical strategies to help your patients move forward
3. Apply integrated treatment strategies

Thank you!

Join us next week on **December 5th 12-1:30pm** for PART 2:

"Working with families to reduce diagnostic confusion about pediatric somatization"