ABDOMINAL PAIN: INTEGRATING PSYCHOLOGICAL TREATMENTS INTO MEDICAL CARE

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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 care
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

- Neuroticism
- Catastrophizing
- Anxiety
- Somatization
- IBS symptoms severity
- Parental psychological factors

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

References:
van Tilburg et al J Psychosom Res 2013
**Coping with FAP**

<table>
<thead>
<tr>
<th>Mastery effort</th>
<th>Positive</th>
<th>Negative</th>
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</thead>
<tbody>
<tr>
<td>Engaged copers</td>
<td>Problem solving</td>
<td>Pain, disability, depression</td>
</tr>
<tr>
<td>Dependent copers</td>
<td>Catastrophizing</td>
<td>Pain, disability and depression</td>
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<tr>
<td>Self-reliant copers</td>
<td>Acceptance &amp; Minimizing pain</td>
<td>Pain, disability, depression</td>
</tr>
<tr>
<td>Avoidant copers</td>
<td>Catastrophizing</td>
<td>Pain, disability and depression</td>
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Interpersonal relationships

- Positive
- Negative

**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


**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

Parents and FAP

<table>
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<tr>
<th>Number of child's verbal symptom complaints</th>
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<tr>
<td>Distraction</td>
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Walker et al Pain 2006
Giving gifts, attention, excusing from school and chores etc. leads to feeling your symptoms are more serious

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
CBT for FAP

- Child catastrophizing (Hedges G = 0.28)
- Parent perceives child pain as a threat (Hedges G = 0.39)

Cognitive behavioral therapy for FAP

Single treatments not very efficacious

- Lack of evidence for:
  - Dietary treatment
  - Pharmacological tx
    - Cochrane 2008, Kortenens et al 2015

- Some evidence for:
  - Cognitive Behavioral Therapy (CBT)
  - Hypnotherapy
    - Cochrane 2008, Rutten et al 2015
Pain is multifactorial: Integrated care needed

Sensitizing medical events:
- Inflammation (infection, allergies)
- Distention
- Trauma
- Stress
- Mucosal disorder

Genetic predisposition

Sensitizing psychosocial events:
- Depression
- Anxiety
- Family stress
- Coping style
- Secondary gains

Disability

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

Who needs integrated care?

Severe
- Multidisciplinary approach
- Referral to pain center

Moderate
- Medical + behavioral treatment

Mild
- Education
- Reassurance
- Diet/lifestyle advice
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/spp/gastroenterology/index.aspx)

• American Society of Clinical Hypnosis (ASCH.net)