



# Compass

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

**Dec 12th, 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 x<sup>w</sup>məθk<sup>w</sup>əyəm (Musqueam), Skw̓xwú7mesh (Squamish), and Səlílwətał/Selilwitulh (Tsleil-Waututh) Nations.

# COMPASS CONNECTIONS: Somatization

## *Session 3: Treatment Strategies For Somatization in Pediatrics*

Dr. Andrea Chapman, MD, FRCPC  
Psychiatrist at BC Children's Hospital

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Liaison Nurse at BC Children's Hospital

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Clinician-Researcher at BC Children's Hospital

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Fellow in Child and Adolescent Psychiatry at UBC

# 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.

## 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

# 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 3**

### **Treatment Strategies for Somatization in Pediatrics**

**Dec 12, 2022**

Amrit Dhariwal, Joanna McKay, Andrea Chapman, Sandra Westcott

# 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

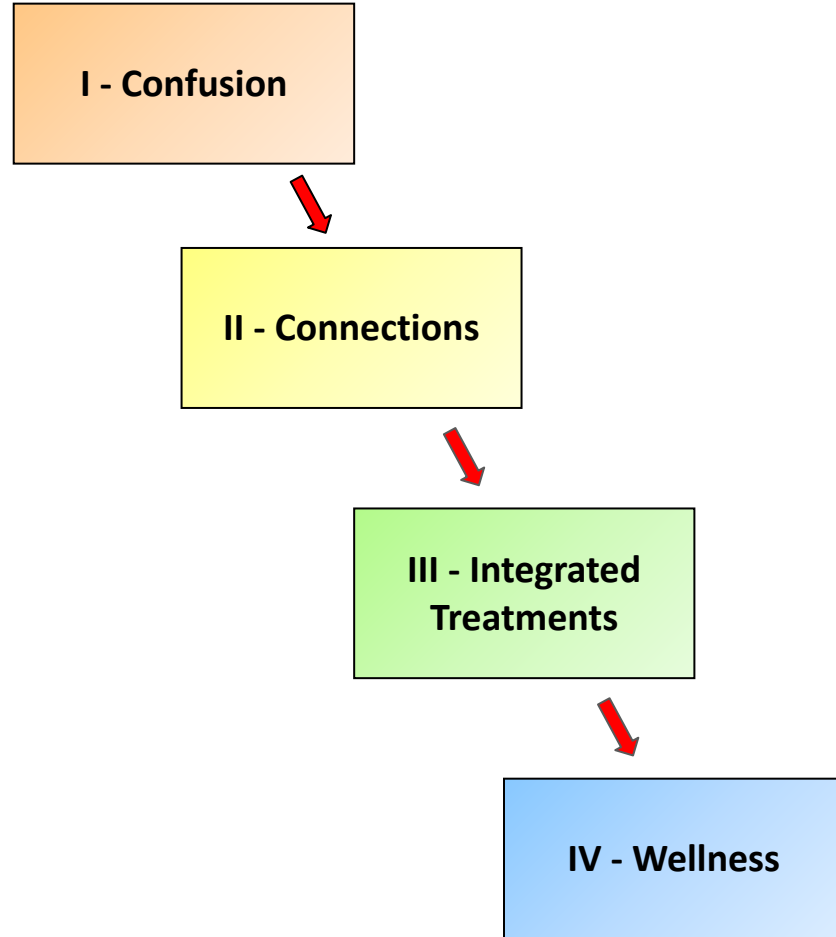


# Series Objectives

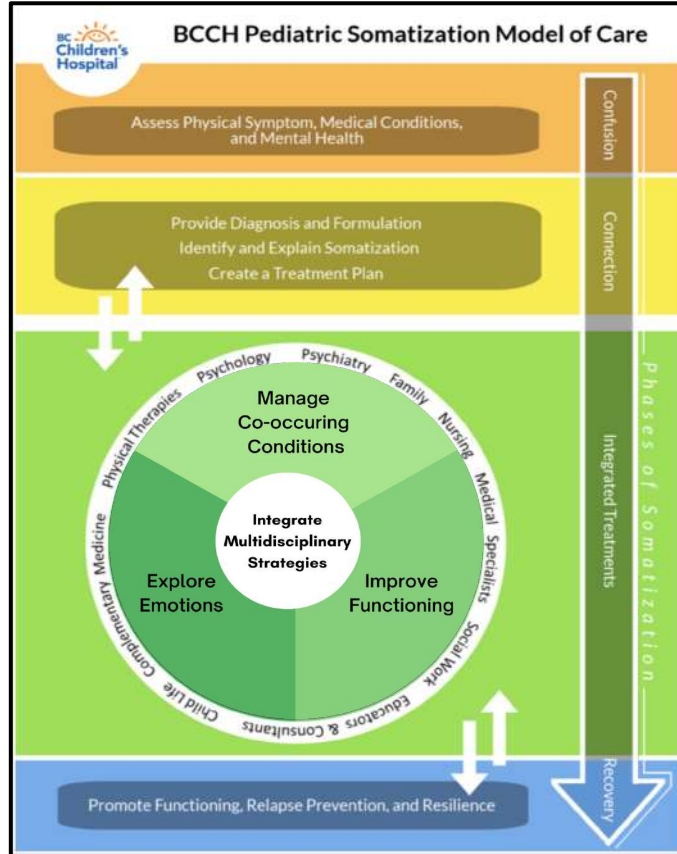
*After attending this webinar series, participants will be able to:*

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.

# Session 1 & 2 Recap: Phases



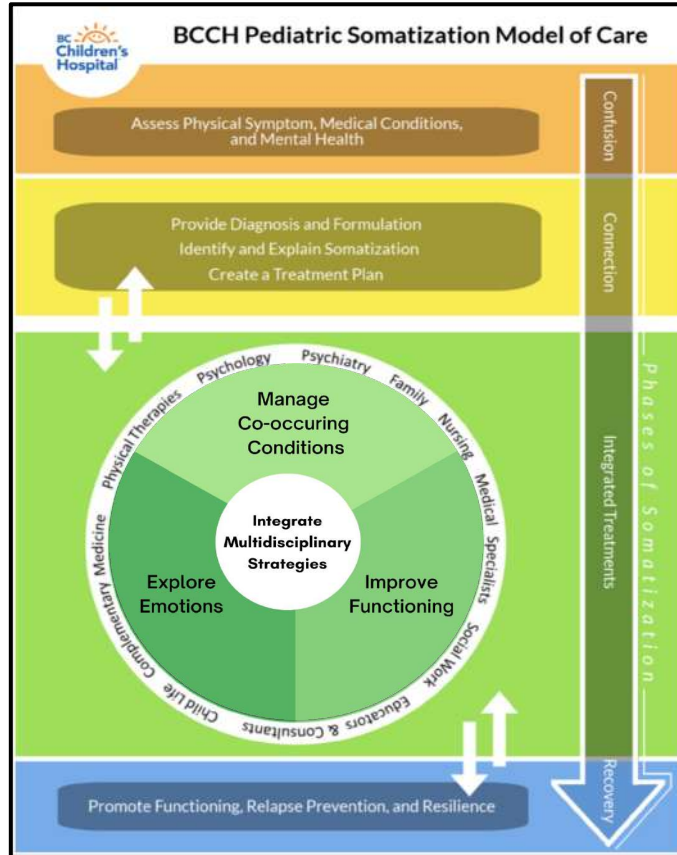
# Session 1 & 2 Recap: Model of Care



# Session 1 & 2 Recap: Roles

Primary Care  
Provider

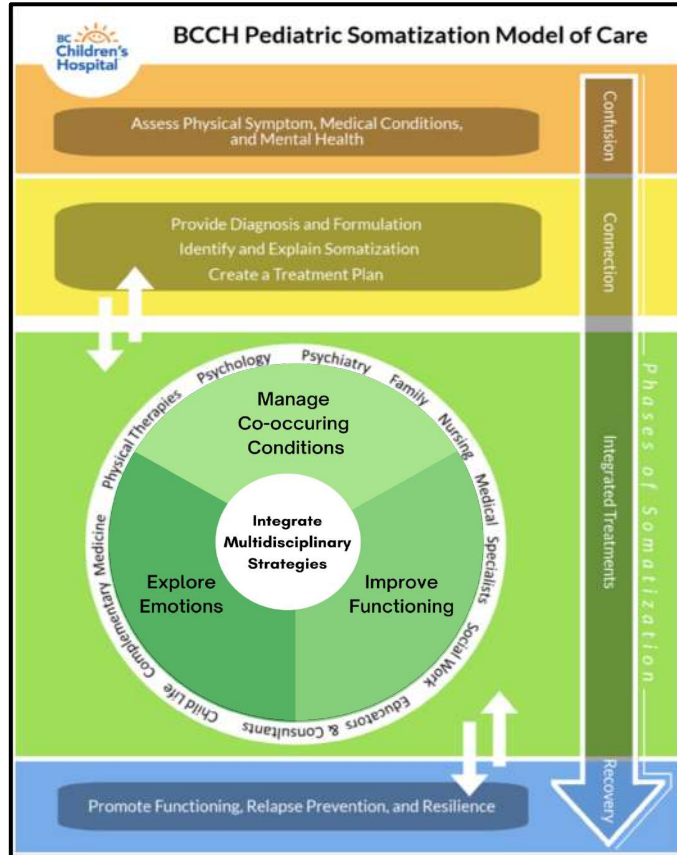
Specialist





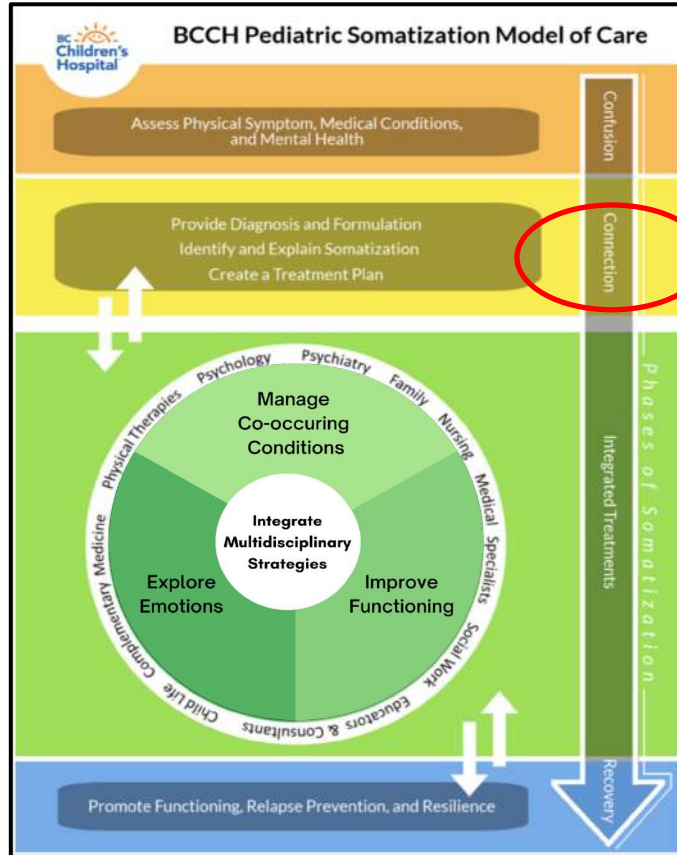
# Session 1 & 2 Recap: Roles

Therapist



Psychiatrist  
Psychologist

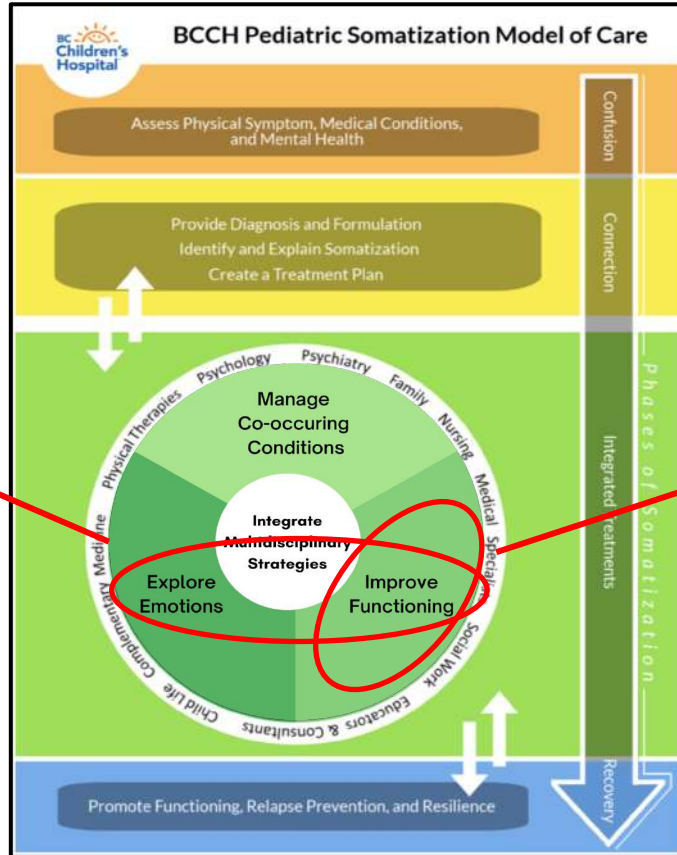
# Session 1 & 2 Recap: Roles



# Session 1 & 2 Recap: Roles

Occupational  
Therapist

School Team  
and  
Physiotherapist



# What You Said

## What challenges do you experience in supporting a move towards wellness?

### **Making the diagnosis**

- *Challenges with diagnostics*
- *Diagnostic clarity*
- *Feeling like the two paths approach is not missing anything unknown medically*
- *Knowing what is somatization versus something else*
- *As a school counsellor sometimes teachers/parents/support staff don't recognize the problems.*

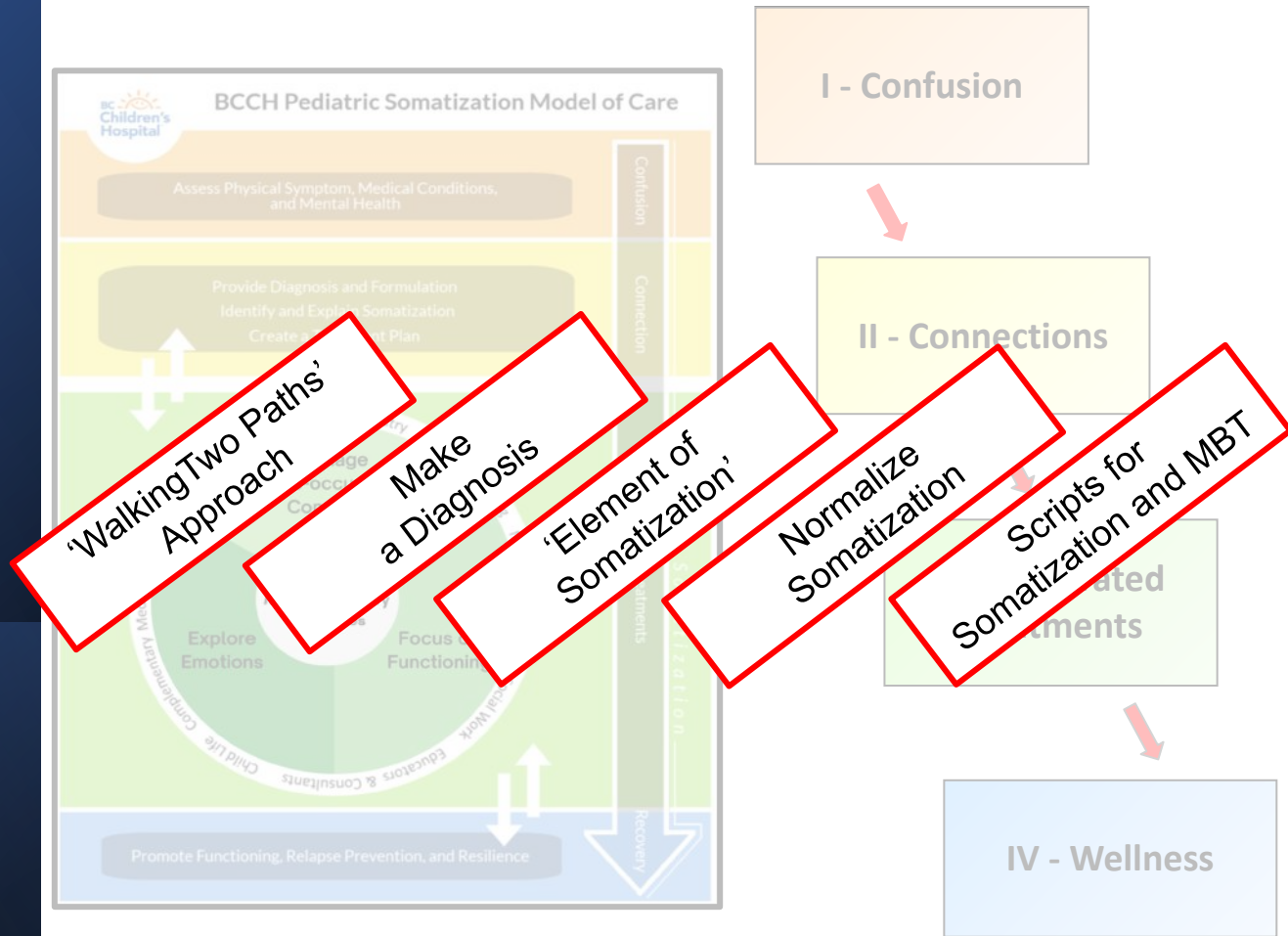
### **Not accepting the diagnosis**

- *Disbelief that the symptoms are explained by somatization.*
- *Teens that disbelieve or want a medical diagnosis*
- *To have the buy in from the client on the diagnosis*
- *Focusing on emotions versus clients wanting to talk about medical issues and frustration with system.*

### **Explaining the diagnosis**

- *Difficulty explaining somatization,*
- *How to develop a safe and trusting relationship, in order to open the dialogue*

# What You Said Strategies



# What You Said

## What challenges do you experience in supporting a move towards wellness?

### Treatment challenges

- *Coordination of care providers*
- *Lack of mental health psychology or counselling services*
- *Lack of resources*
- *Mental health barriers*
- *Fast paced environment of hospital and surgical services; not a lot of time to explore and implement treatment plans.*
- *Sometimes, the symptoms are their only means of connecting to others (parents, supports, healthcare) etc.*
- *Attention sometimes with younger people?*
- *Parents wanting fix*
- *Talking to parents who want a "fix" right away.*
- *Balancing between resting/taking it easy and encouraging activity.*
- *Tolerance for learning skills to address it (for folks who are often in crisis)*
- *Appropriate medication. What is the role of psychopharmacology?*
- *Shifting identification with illness role to wellness/function mindset*
- *Difficulty focusing on function rather than symptom alleviation (pain, etc.)*
- *Relationship with somatization and other Dx such as anxiety, depression, BPD*
- *Supporting with an eating disorder*

# Today's Outline & Objectives

1. Identify somatization in pediatric populations
2. Communicate effectively to reduce confusion and increase trust
3. **Apply integrated treatment strategies**
  - Manage Co-occurring Conditions
  - Explore Emotions
  - Improve Functioning





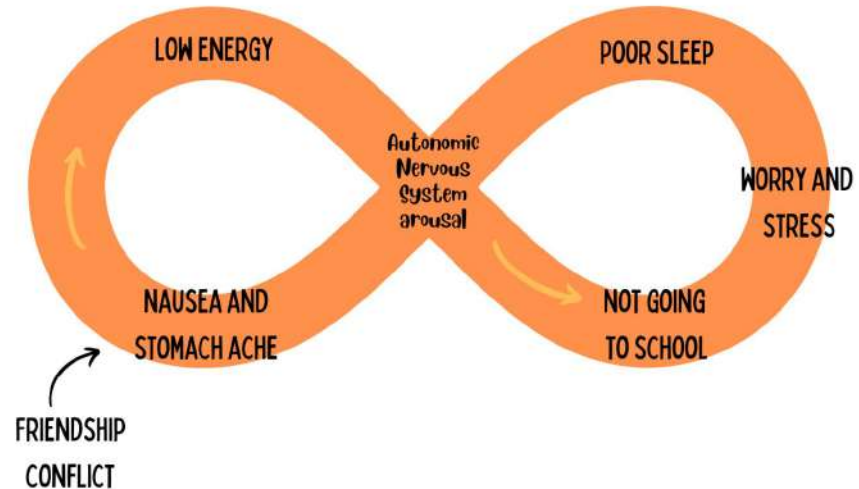
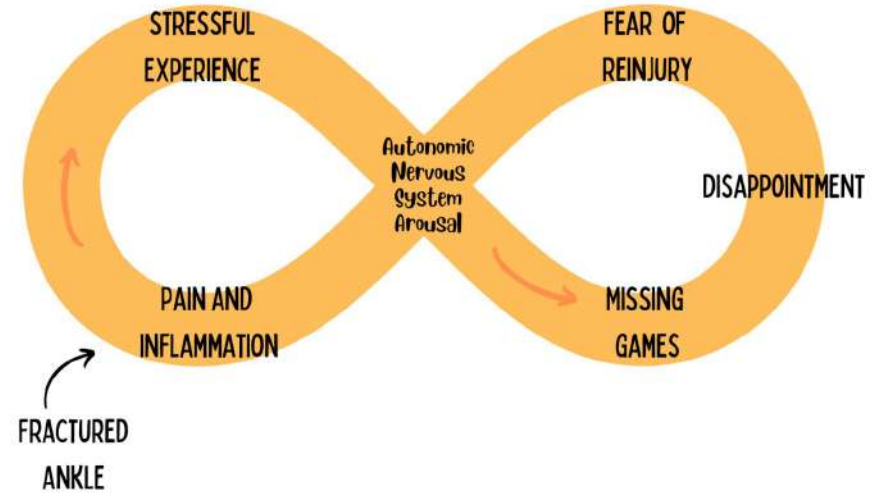
# Manage Co-occurring Conditions



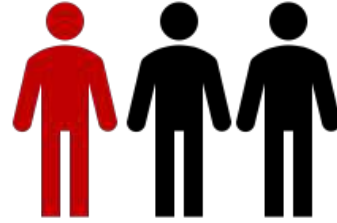
- ❑ Arrange for a medical provider to be involved and do follow up visits
- ❑ Continue to assess and treat physical symptoms judiciously
- ❑ Psychotherapy and pharmacotherapy for psychiatric comorbidities



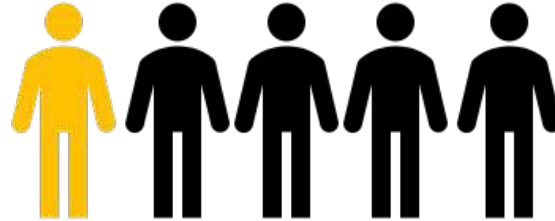
# Recall: What starts somatization?



# Co-existing Conditions are Common!



People with IBD who also have IBS  
*(a disorder of gut-brain interaction)*



People with psychogenic non-epileptic  
seizures who also have epilepsy

# Ongoing Medical Follow Up

1. Manage co-existing medical conditions
2. 'Two paths' approach to ongoing management of somatic symptoms
  - Reassurance
  - Judicious assessment and treatment
  - Support interventions
  - Appropriate referrals
  - Consultation with other providers



**Regularly scheduled follow ups with medical provider, independent of symptoms, can help improve outcomes.**

# Psychiatric Conditions are also Common!

Psychiatric conditions are **common** among youth with somatization, particularly:

- Anxiety
- Depression
- PTSD

Comorbid psychiatric disorders are associated with greater disability

Treat psychiatric conditions as usual, with pharmacotherapy and psychotherapy



# Medications



- No clear evidence that psychiatric medications treat somatic symptoms
- However, medications may help treat co-occurring psychiatric conditions
- Consider side effect profile in context of somatic symptoms, for example:
  - Mirtazapine for treating someone with depression and chronic N/V
  - SNRI for anxiety or depression in someone with chronic pain
  - Escitalopram instead of sertraline in someone with significant GI symptoms
- Start low and go slow!!



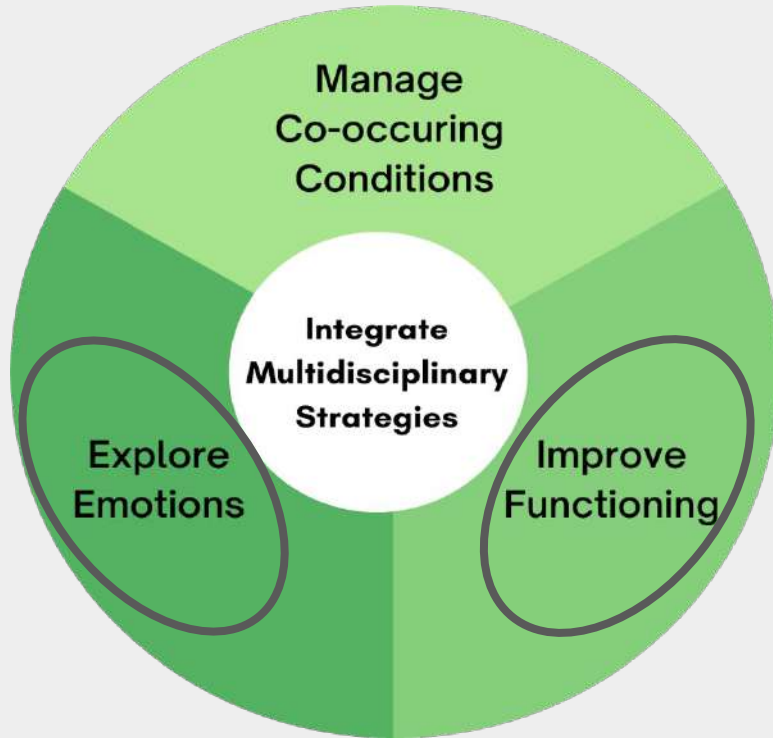
# Transdiagnostic Treatment



**Many psychological strategies are  
transdiagnostic,**

**and can help youth cope with  
symptoms and distress regardless of  
whether due to somatization vs  
medical condition vs psychiatric  
condition**

# Emotions + Functioning



- ❑ Ordering of these two components may vary, depending on your role, your clinical style, the stage of treatment, and patient needs.
- ❑ **Inpatient example:** you may recommend concrete functional improvement strategies and refer for psychotherapy.
- ❑ **Outpatient example:** you may learn about emotional barriers before attempting to implement functional improvement strategies

## Why focus on emotions + functioning?

# Summary of Evidence: Systematic Reviews and Meta-Analyses

## 1. **Gold standard:** cognitive and behavioural approaches

(Bonvanie et al. 2017, Fisher et al., 2017; Hulgard et al., 2017; Elliot et al., 2020)

- **Focus on:** varying focus on behavioural exposures, thought challenges, inclusion of parents.
- **Benefits:** moderate effect on reducing symptom load and disability
- **Limitations:** 1) effects vanish after 6mo/1yr, especially for teens; 2) unclear what the important treatment components should be (e.g., parents varying included) 3) effects for SSD (pain, IBS, CFS) not FND

## 2. **Increasing evidence:** psychodynamic and emotionally focused approaches (Abbass et al. 2021; 2020 2012; 2009)

- **Focus on:** increasing awareness of emotions in the body, their psychological meanings, and actions needed to resolve
- **Benefits:** large or mod effect on physical sx, disability psychiatric sx, interpersonal problems, and social adjustment; effects larger than CBT
- **Limitations:** 1) evidence in pediatric populations is only emerging 2) other research groups needed



# Emotions + Functioning

## Psychotherapeutic Steps to Wellness

### Stage 1: Engage family to jointly formulate emotional focus.

- Talking about mistrust is a way into their emotional and interpersonal worlds. So is talking about disappointment of not getting better.
- Requires significant empathy and validation. Keep creating holding space and activation for interpersonal/emotional focus.
- Support embodied mentalizing (i.e., exploring how experiences have taken a toll on the body; noticing shifts in body language in the moment)

### Stage 2: Focus on how this focus has recurred in life.

- Constantly linking interpersonal needs, primary and secondary emotions, perceptions, behaviours, and symptoms.
- Microslicing narratives to create nuanced, differentiated understanding.

### Stage 3: Empower them to take charge of the process.

# Emotions + Functioning

## Mind and Body Together Group

Unpublished manual (Dhariwal, Chapman, et al, 2022)

Single-arm open label trial pilot study (Dhariwal et al., 2018)

Treatment mechanism study (Dhariwal, Lui, et al., forthcoming)

Patient-oriented: group is based on patient suggestions

Tolerable and satisfactory to patients and parents

Improvements occur over time in symptoms and functioning

### PROCESS OF CHANGE...

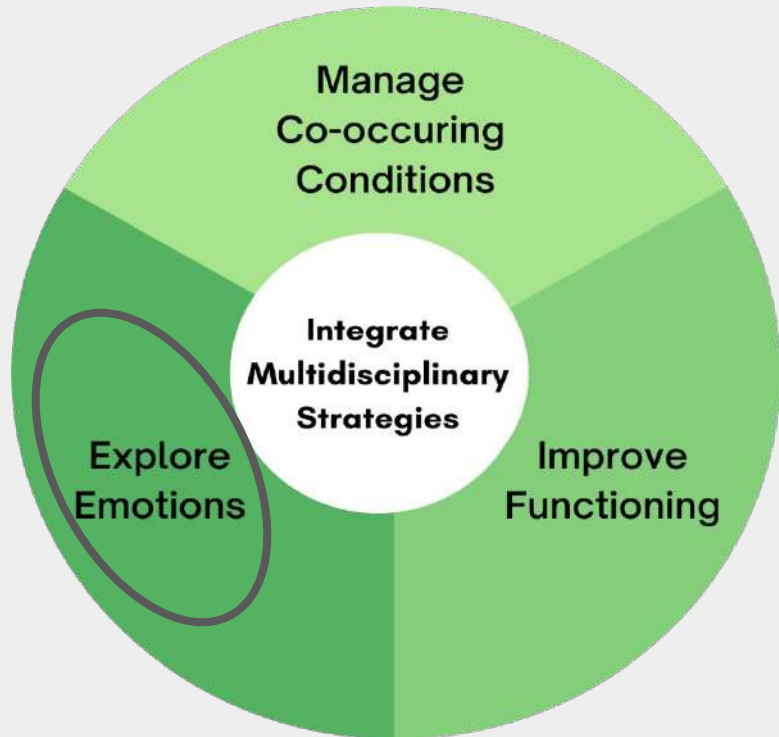
**Step 1.** Exposure to similar others provides normalization and belonging

**Step 2.** This creates a safe foundation to learn more about somatization

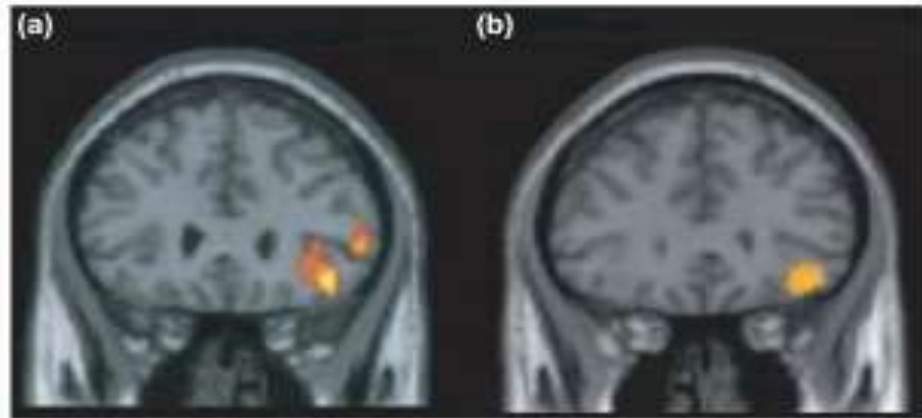
**Step 3.** New information prompts engagement with MH strategies



# Explore Emotions: Practical Strategies



# Legitimizing emotions in the body



Social pain regulation

Physical pain regulation

- THE BRAIN IS SPARKED IN SIMILAR AREAS BY PHYSICAL PAIN AND SOCIAL PAIN. Whether we get physically injured, or lose an important relationship, our brain sends a similar kind of “alarm” signal.
- THIS MAKES SENSE FROM AN EVOLUTIONARY PERSPECTIVE! Activating physical protection helps us survive danger. So too does activating social bonds - we need other humans for survival.

# Normalizing emotional stress: it is **necessary** for growth

## Testing Boundaries

Explore and Experiment  
Be Creative  
Become Independent  
Push Away From Caregivers  
(And Seek Out Caregivers)  
Break Rules  
Take Risks

## Connecting Socially with Peers

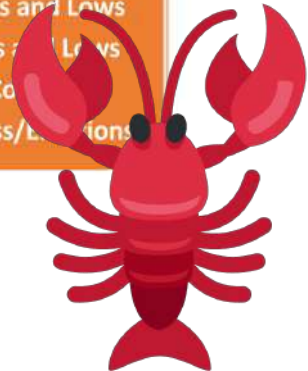
Hang out in Groups  
Care What Others Think  
Desire to be Liked  
Have Conflicts  
Have a Crush  
Go Out with Individuals  
Fall in Love

## Searching for Identities

Find Out What You Are Good At  
Find Out What Makes You Happy  
Develop Self-Esteem  
Care About Appearance  
Care About Health and Well-Being  
Make Choices About the Present  
Set Goals for Future

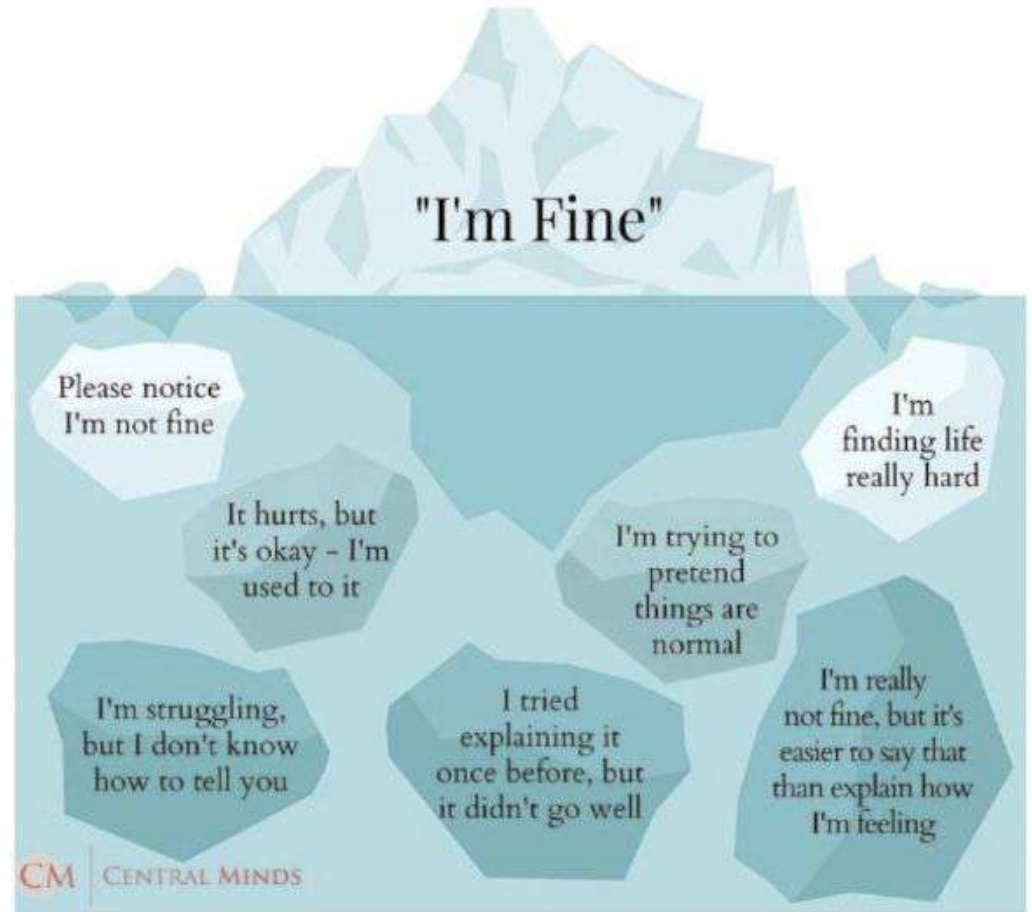
## Experiencing Emotions

Be Affected By Stress  
Complain About Stress  
Be Confused  
Experience Both Highs and Lows  
Swing Between Highs and Lows  
Find Ways to Cope  
Learn to Manage Stress/Emotions

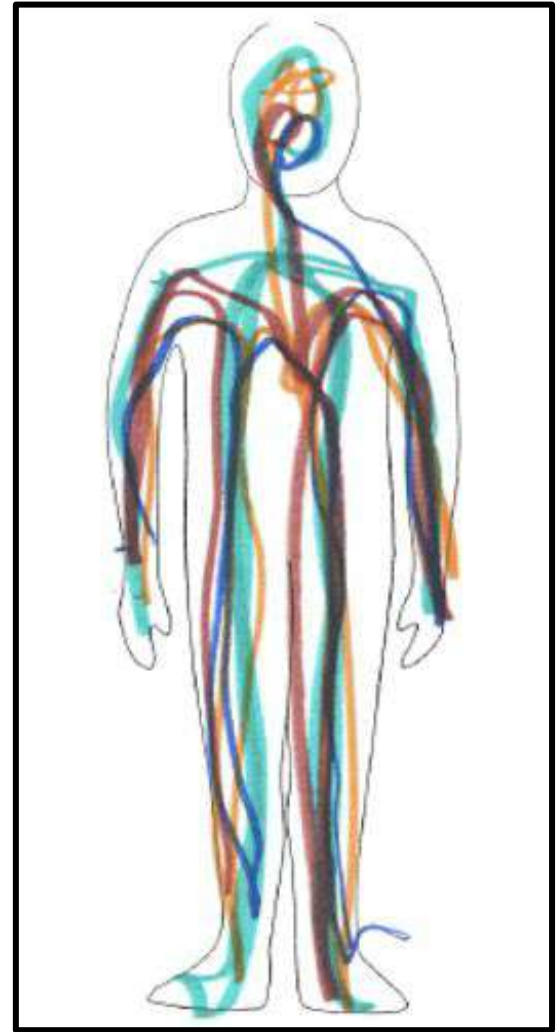




# Noticing “I’m Fine”



Acknowledging  
**Inside**  
is different from  
**Outside**



## Discovering what is “inside” or underlying somatization

- Feeling like there is **too much pressure** in life (school, performance, etc.)
- Growing up and **independence feels scary**.
- Feeling like you **need others** to help you.
- But very **aware of others' feelings** and worrying about burdening them with your problems.
- **Perfectionistic tendencies** and not wanting to show any weaknesses or ask for help.
- **Bottling up**, downplaying, or ignoring negative emotion states – sometimes doing this so well that you are **unaware of your own emotions**.
- **Worrying about your physical well-being** and survival instead of emotional state.
- Feeling **powerless** to change anything.



# Identifying **costs** of suppressing distress



*Imagine holding your ball underwater. As long as you hold it there, the surface of the pool is smooth and serene.*

*But your actions in the pool are limited. You can't move around easily. The longer you hold it underwater, the more tired you become. Before long, it comes shooting up through the surface of the water and if you're unlucky, it smacks you right in the face.*

*When this happens, you might frantically try to shove the ball under again. This makes sure the waves subside in the short-term. It also ensures that you'll continue to be stuck in the same place.*

*Ultimately learning how to let the ball rise to the surface, slowly with control becomes the goal. The ball might stay near or float away, but you are free to decide where to go.*

# Supporting Parents to Be With Child's Distress

Way	Positive Intention	Example
<b>Matching</b>	Allowing them space to feel their emotions and figure out what to do. Not trying to change anything.	<i>Sitting there, nodding, holding hands, etc., matching body language or facial affect</i>
<b>Reflecting</b>	Mirroring back what you see and hear, so the person knows you are getting it.	<i>"You're wanting me to know just how hard this is." "You feel unsure about that test."</i>
<b>Validating</b>	Letting them know their way of seeing things is legitimate.	<i>"It makes sense you that you don't want to talk about this right now." "No wonder you're scared. Anyone would, having walked in your shoes."</i>

Way	Positive Intention	Example
Reassurance	Calming you down by telling you everything is going to be ok.	<i>“Everything will be ok.” “You will be fine.”</i>
Downplaying	Helping you see the problem is not that big of a deal.	<i>“It’s nothing to worry about.” “Just let it go.”</i>
Problem-solving	Giving you advice or suggestions about what you could do.	<i>“Why don’t you try…” “Let me help, take over…”</i>
Distraction	Changing the situation so you are doing something less stressful	<i>“Let’s take your mind off this” “Let’s talk about…”</i>
Cheerleading	Helping you focus on all of your wonderful qualities instead.	<i>“You are so strong.” “But you’re so good at…”</i>
Shutting down	Protecting you from having to talk about your problems.	<i>Silence or one word answers. “Let’s talk later..”</i>
One-upping	Helping you feel like you are not alone by telling you their probs	<i>“That reminds me of…” “Others have it worse”</i>
Questioning	Asking you why you feel the way you do so they u can understand.	<i>“Are you ok?” “Why do you let it affect you?”</i>
Appeasing	Helping you in the way you want, by asking you to verbalize it.	<i>“Tell me what to do.” “What do you want?”</i>
Defending	Making sure they know you are on their side, and trying to help.	<i>“I’m not the bad guy.” “What did I do now?”</i>
Correcting	Noticing an error in your way of seeing things and wanting to fix..	<i>“You’re looking at the glass half empty.”</i>
Over-identifying	Sharing in your experience by adding their own meanings to it	<i>“Oh no, this the worst!”“You must feel like…”</i>

# Supporting Parents to **Be With** Child's Distress

## **Being With**

**When a parent acknowledges, accepts, and  
mirrors back a child's feelings....**

My parent is here for me.

My feelings are mine.

But I'm not alone in my feelings.

My emotions don't overwhelm my parent.

My parent is not trying to fix my feelings.

My parent trusts me to handle my emotions.

It's ok to have and express my emotions.

I'm safe.

# Role Play

How to  
provide  
psychoed on  
emotions in  
the body



**Pat**  
(parent)



**Miriam**  
(psychologist)

# Role Play

## Providing psychoeducation on emotions in the body

Key points in this example:

- Reinforce Mind and Body Together
- Be open to learning from patient and family
- Identify positive intentions and validating them (repeatedly)
- Scaffold from the bottom up starting with information that matches their understanding, moving to information that expands (but yet doesn't contradict) their understanding.
- Ensure new information ties to their questions (not clinician's agenda)

# Role Play

**Pat:** I feel so terrible because I didn't know that Zara had all this stress. Are all her symptoms just because of stress? Was I missing something all this time? I should have helped her better. Do you think there was something really bad that happened to her?

**Miriam:** I can see you care deeply about Zara and you have a lot of questions. I'm also sensing you're taking on a lot of responsibility for Zara's symptoms, is that right? more

**Pat:** I'm her mother, I should have known. If something bad happened to her, she must have felt so bad and couldn't tell me. That's why she's having these symptoms. Her body is doing the talking for her.

**Miriam:** All you want to do as a parent is protect her.

**Pat:** Yeah

**Miriam:** So I'm noticing you said her emotions or something bad seem to be the only reason for her symptoms?

# Role Play

**Pat:** I feel I should have known.

**Miriam:** Can I add something to your understanding?

**Pat:** Sure.

**Miriam:** Actually, it's a combination of emotions and biology that contribute to symptoms. She wouldn't have had these symptoms if she didn't already have some physiological vulnerability. It doesn't mean there was something really bad, like a trauma that happened. The slow accumulation of everyday smaller stressors can be significant, that can cause the wear and tear effect on the body too. For Zara, the stress of having pain and nausea probably is something that continues to contribute to her distress and symptoms.

**Pat:** That helps me a little. At least I know it's not ALL in her head.

**Miriam:** Yeah, I agree. We know that emotions don't just live in your head - all emotions and stresses are bodily felt. They are a mind and body experience.



# Role Play

**Pat:** I really just want her to get better

**Miriam:** I think that must be why you are taking on so much responsibility, and I sense guilt too, for her well-being. It's harder to let go and recognize that Zara has her own work to do, which is not fully in your control. It's hard to play a supportive role.

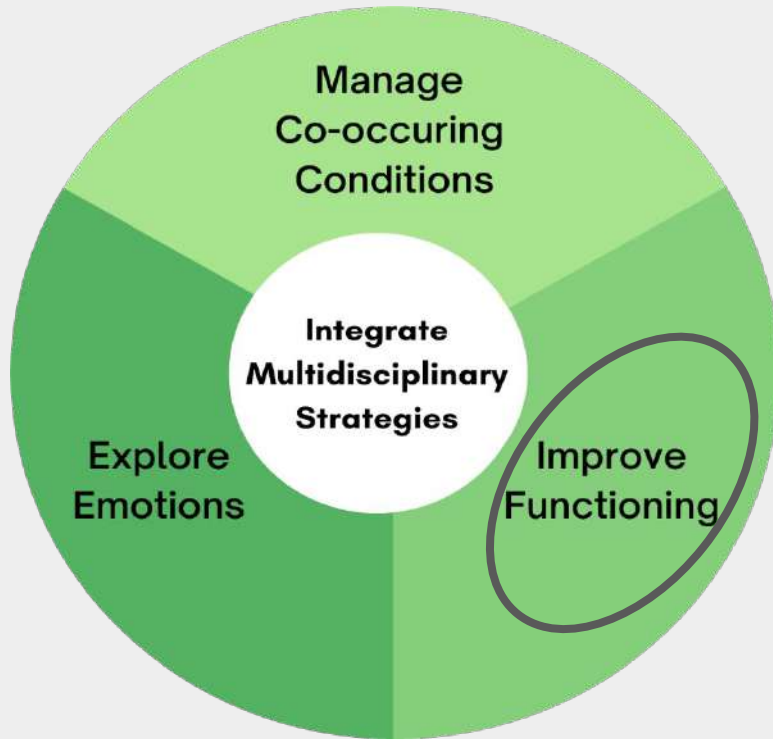
**Pat:** Exactly...

**Miriam:** Can we talk about some of the ways to “be with” all of this?

**Pat:** Sure - anything. I struggle with knowing what to do or how to respond when she's suffering.

**Miriam:** Let's talk about the concept of “being with”

# Improve Functioning: Practical Strategies



# Identifying inner dialogues relevant to functional improvement: Youth

## What's Bad if Things Stayed the Same?

- *I feel behind at school.*
- *I can't do dance or do sports.*
- *I feel tired, drained, and burned out.*
- *I have appointments all the time.*
- *I can't hang out with friends.*
- *I have too much time with my family.*
- *I don't have independence.*
- *I'll still don't have answers*
- *I don't have control over my life*

## What's Good if Things Stayed the Same?

- *I have less pressure. I can sleep and stay home if not well.*
- *My parents and teachers get less upset with me when I miss things.*
- *People check in on me more often and give me more attention.*
- *I get more help and support.*
- *I don't have to deal with my fear of change.*
- *People accept physical problems more easily than emotional ones.*

## What's Bad About Recovering?

- *Expectations will go back to normal or will go even higher.*
- *When I just need a break, no one will take me seriously.*
- *I might not trust that I'm actually okay. Symptoms could return.*
- *I'll be on my own, I'll get less care.*
- *I'll get mentally better, but physically worse*
- *I won't be able to explain I can't do something because of my mental health (vs physical health).*

## What's Good About Recovering?

- *I will be able to do more things (volleyball, school, party)*
- *I will have a social life*
- *I will have more freedom.*
- *I won't be a "sick kid", afraid to have symptoms, going to appointments.*
- *No more stigma, I won't be called lazy.*
- *I'll be normal, not explain myself to anyone*
- *Victory over my illness.*

# Identifying inner dialogues relevant to functional improvement: Parents

## What's Bad if Things Stayed the Same?

- Missing school, work, normal activities
- Witnessing child physical distress
- Not knowing why symptoms are happening or how long they will last
- Isolation from community and peers
- Seeing child's emotional well-being deteriorate (becoming increasingly sad, withdrawn).
- Feeling helpless as a caregiver
- Child becoming center of attention due to high needs, which changes the dynamic in other family relationships (e.g., siblings)
- Child feeling singled-out, feeling like a burden to family
- Child not meeting the expectations, which are only increasing with age
- Parents' feelings of guilt

## What's Bad About Recovering?

- Change will be hard.
- Child will need help and resources to get better: attention, 1:1 time, finances.
- Child may become emotionally more difficult or challenging (e.g., energetic, testing limits, etc.)
- Others may resume unsolicited advice-giving about raising children.
- Loss of support from the school and community. Family may withdraw support and we will become "invisible".
- Loss of clear reasons (explainable to others) to avoid hard activities
- Loss of moments of connection/comfort for child related to symptoms
- Parents need to develop a new identity themselves (going back to work, new roles in the family, etc.)

## What's Good if Things Stayed the Same?

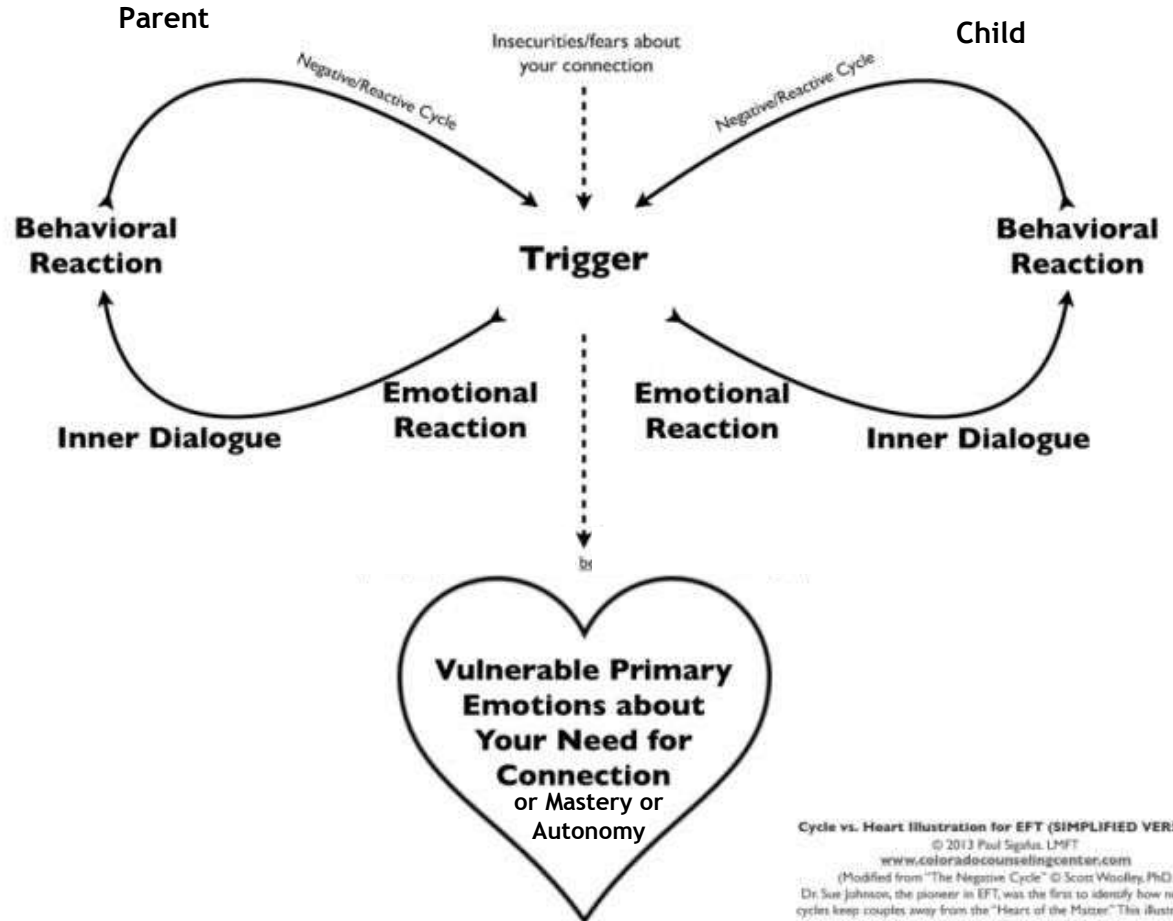
- Don't have to think of fun activities to do and organize
- Feeling strong in the face of difficulty
- More connection and increased support in parent-child relationship.
- Learning and utilizing new parenting strategies, e.g. tracking pain/feelings.
- Others becoming more understanding of the limitations of physical symptoms
- Can "manage" or survive (but not thrive); predictable lifestyle
- Extra support: extra assistance, tax benefits, disability/financial help
- Cheaper when kids don't participate in activities
- Fewer late nights waiting up for kids, worrying about them being out in world by themselves..

## What's Good About Recovering?

- Child could go to school, participate in activities, plan for future
- Child will have more fun and happiness
- Child will have less pain/discomfort
- Child can be independent so parents can go out again, less strain at work, decreased late nights, co-sleeping and other situations in which parents give comfort but impinges on their own time
- Fewer doctor's appointments.
- Reduced feelings of invalidation in medical settings.
- Parents experience positive feelings and enjoy life; time for self-care
- Re-balance of time and attention to siblings
- Feeling of mastery, hope, overcoming
- Less pressure on parents knowing kids are ok

# Linking the pattern together

antecedents  
and  
consequences  
of illness  
behaviours



Cycle vs. Heart Illustration for EFT (SIMPLIFIED VERSION)

© 2013 Paul Sigelus, LMFT

[www.coloradocounselingcenter.com](http://www.coloradocounselingcenter.com)

(Modified from "The Negative Cycle" © Scott Woolley, PhD)

Dr. Sue Johnson, the pioneer in EFT, was the first to identify how negative cycles keep couples away from the "Heart of the Matter." This illustration is just my attempt to visually organize her concepts.)

(what the other can't see - because of the fear driven cycle)

# Empowering Families to Become Proactive

Acute Medical Model	Rehabilitation Model
Goal is to cure the illness or injury and return you to your life as it was before	Goal is to increase functioning, develop more independence, and attain a meaningful quality of life
Health care team provides treatment	Health care team works with you to develop strategies and skills
Focus is on what health care providers can do for you	Focus is on developing tools and skills that work for you
Progress may be quick	Progress will take time, and there are often ups and downs along the way
Treatments may work spectacularly, but they can carry risk	Treatments are more effective the more you do them, and are almost always good for you
Best suited for acute injuries or illnesses	Best suited for chronic conditions and long-standing physical symptoms

# Shifting from Acute Medical to Rehabilitation Model



**Zara**  
(patient)



**Grace**  
(family doctor)



# Role Play

## Shifting from acute medical to rehab model

Key points in this example:

- Praise efforts to return to functioning.
- Validate that moving towards wellness is hard work.
- Convey hope that things can get better.
- Explain rationale for the rehabilitation model and shifting attention to function.



# Role Play

**Grace:** So were you able to get to school last week?

**Zara:** Well, I went on Thursday for the first block but then my nausea was worse than ever and I had to go home.

**Grace:** It sounds like your nausea is so strong these days. I wonder if that's discouraging, you may have had hopes that your appointment with the gastroenterologist would have pointed you to a specific treatment, like a medicine to take.

**Zara:** I almost wish she had told me I had stomach cancer - just so I would know and I knew what to do.

**Grace:** Oh wow, these symptoms are so awful that you just want clear answers even if you had a really bad disease so you could have it treated.

**Zara:** Yes, I get the mind body stuff but it's not a quick fix. And I'm not sure I understand exactly what to do.

# Role Play

**Grace:** That makes so much sense Zara. I am very confident that things will improve - that's what I've learned from my other patients with similar symptoms. You're right, we don't have a quick fix, but we do have very good treatments to help your brain-body messages get back on track and for you to build confidence in your health. I know you met with your therapist who is going to help too.

Today I wanted to talk about one piece of the treatment - the one we call "improve functioning". I'm not sure if you remember from our last appointment, but this is part where it's important to focus on the things in life that matter to you - the things you enjoy and value like spending time with friends and playing volleyball, and the things that you need to do, like going to school.

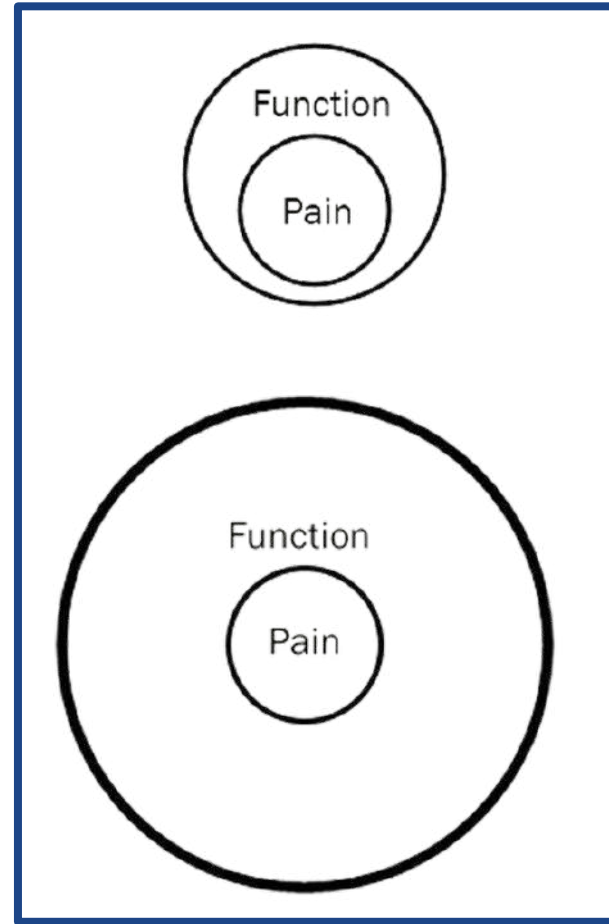
When any of us have physical symptoms, at the beginning we pay a lot of attention to the symptoms - that makes sense because symptoms can be the body's way of warning us that something is wrong. We rest, go to the doctor, and stop activities. With gut-brain interaction and somatization symptoms, we shift to a new approach. Now we know that your symptoms aren't dangerous, they are real and intense, but they aren't dangerous, so we are going to ask you to do less resting and more getting back to normal activities.

# Role Play

**Zara:** But what if my symptoms are too bad?

**Grace:** That's the hard part but the really important part. In a rehabilitation model you continue to do small pieces of activities even when you have symptoms. It's like retraining your muscles after you've had a broken leg - even if it's uncomfortable, you continue to do some activity. This way you are helping your muscles and your brain-body messenger system gain confidence. Let me show you a picture that might help explain why this is important.

# Shifting from Acute Medical to Rehabilitation Model



- Caitlyn Dunphy, OT

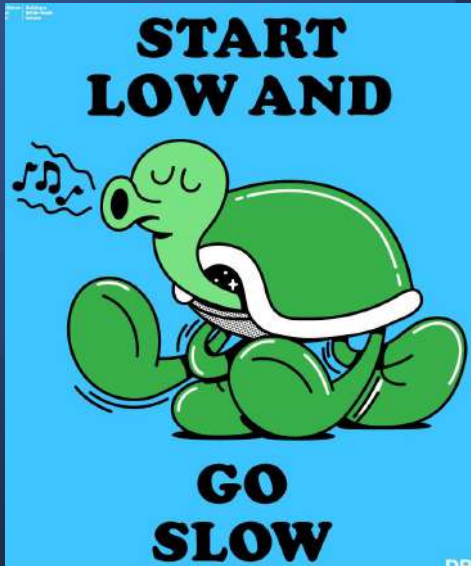
# Teaching how to support tolerance and **acceptance** of painful thoughts, feelings, and sensations

Photo credit:  
<https://www.sonia-jaeger.com/en/act-exercise-hands-and-thoughts/>

Photo by Anne Spratt



# Developing exposures



Graded exposure	Pacing
A planned, deliberate, step-by-step increase in activity	A strategy of energy conservation to ensure adequate rest when doing activities
Imagine stairs, not a slope. You check to see if step is solid and secure before proceeding. Each activity increase in very small.	You have a baseline level of activity that allows you to function comfortably, and with periods of rest and relaxation. You do not push yourself to any discomfort.
Steps are not directed by your symptoms. You keep going even with mild-moderate symptoms.	Steps depend on fluctuation in symptoms. You judge your capacities and avoid triggering symptoms.

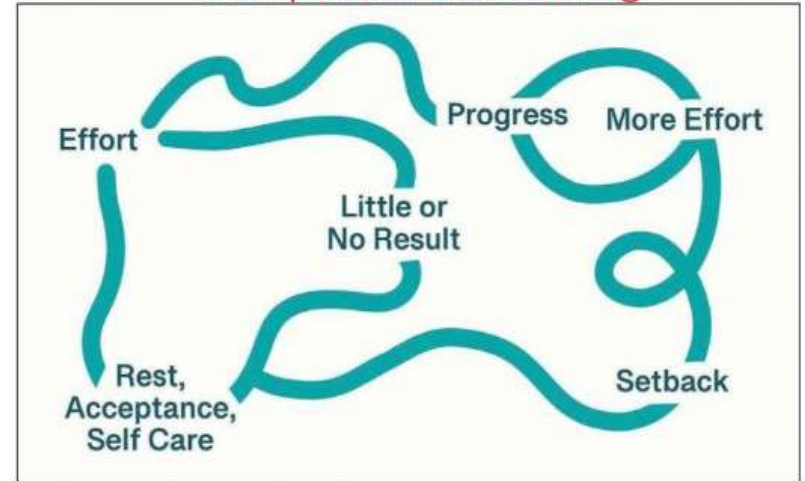
# Ensuring **consistency** in exposures to prevent burnout

Reference: Curable Health App

## All or Nothing Healing



## Compassionate Healing





# Graded Exposure: the Start of a Plan



**Zara**  
(patient)



**Grace**  
(family doctor)

# Role Play

## Graded exposure

Key takeaways in this example:

- Validate distress caused by symptoms.
- Validate positive intentions and motivation.
- Plan activities (exposures): small steps on a weekly basis, varied time and location.
- Be flexible in functional goals (e.g. 50% online classes).
- Do not stop the activity even when symptoms are worse.
- Add in support to make the exposures successful.
- Elicit others to co-manage (primary provider, school staff, therapist, etc.).

# Role Play

**Zara:** I tried to go to school every morning last week and I made it twice.

**Grace:** Sounds like you put a lot of effort into going to school - your motivation is really high to get to school.

**Zara:** Yeah, catching up on school is really important to me

**Grace:** I wonder if we should look at whether the full morning is the right amount of time? What do you think about going to one class each day for now?

**Zara:** If I do that then I'll be really far behind, and I want to graduate with my friends.

**Grace:** Ok it's good for me to know your priorities. It sounds like you are working towards graduating with your friends which means a more full course load. I wonder if there is an in-between step. Some of my other patients have done part-time in person school and taken one or two online courses.

**Zara:** One of my friends does a lot of her courses on-line, I could look into that. I also want to be in person because I like getting to see my friends.

# Role Play

**Grace:** Even if you do some on-line classes, it sounds like it's really important for you to be in person at school too. What if you and I think about a plan for getting you back to school gradually.

**Zara:** Yeah it is.

**Grace:** Do you want to aim for one class a day or two? And remember the really important thing is that once you decide on when to go, you stick with it even when your symptoms are really strong.

**Zara:** I think I could do one class a day for now.

**Grace:** Okay, what is the best time of day for you? Mornings or afternoons?

**Zara:** I think it's hard to wake up because I'm not sleeping well, so maybe in the afternoon.

**Grace:** Some of my patients like doing the second class of the day – they can sleep in a bit, but they aren't waiting around all morning anticipating school. But it's also important to choose the class carefully. Do you have one class that you really want to do? Or that you have a friend in, so it's easier to be there even with your symptoms?

# Role Play

**Zara:** I like my biology class, my teacher is really understanding. That's in the afternoon, but I think that would work okay for me.

**Grace:** Okay – do you think it's realistic for you to go every day for the next two weeks? Then we can check in and see about adding another class. If it goes well the first few days, maybe you can add in lunch time to be with your friends. That could be optional – but being in class is something you should do everyday.

**Zara:** Yeah that would be okay.

**Grace:** It can really help to have a plan for how to manage your symptoms when you are at school. Could you work on this with your therapist or your school counselor?

**Zara:** I can check with him. My therapist also gave me a letter for the school and offered to talk to them with me.

**Grace:** That's great Zara. I think we are all on the same page!

# Developing a Symptom Management Plan

Is relevant and  
necessary  
across  
conditions

## Help develop a Symptom Management Plan

Determine how symptoms interfere with normal activities and how others respond

Develop physiological distress tolerance strategies

- Relaxation (deep breathing, PMR)
- Exercise activities
- Modifying diet or fluid intake

Plan for environment-specific strategies

- Where to go
- Who should be there for support

Suggest practicing strategies

# Example for GI symptoms

## Symptom Management

### *Zara's plan for stomach pain and nausea*

#### *Every day:*

- *take ginger tea to school ,stay hydrated*
- *eat small meals throughout day (protein bars)*

#### *When pain starts:*

- *do 5 4 3 2 1 activity*
- *listen to music, if possible*
- *use heating pack*

#### *After 15 min if needed:*

- *take a break from class (return in 10 min)*



# School planning for NES

## Symptom Management

*During a non-epileptic event Chris is not able to control the way his body moves, senses things, or thinks. These events are not life-threatening. Non-epileptic events can last for seconds, several minutes, or even longer. The length of time is not an indication of severity or medical emergency. If Chris has an event, he can be monitored in a calm and quiet manner.*

*Chris does not require 911 response and, in fact, calling 911 can increase the stress and perpetuate events. However, if Chris develops difficulty breathing or blueness around his mouth, or there is concern the episode is significantly different from his prior episodes, then 911 should be called.*

# Developing a Symptom Management Plan

## Important for School Functioning

## School Letter Template

Date \_\_\_\_\_

Dear School Team,

[Patient] has been diagnosed with provide details (e.g., *basal ganglia lesions which is a type of somatization, Majanovic with an element of somatization*).

**Information about somatization and the mind-body connection**

Somatization is the involuntary physical expression of emotional distress. Somatic symptoms are common and real. They include symptoms such as stomach aches, headache disorders, nausea, fatigue, and shaking episodes. Often somatic symptoms are persistent and interfere with functioning; they require treatment and may be diagnosed as Somatic Symptom Disorder or Functional Neurological Disorder. Somatization occurs because of the reciprocal communication between the brain, nervous system and body that involves many different body systems (the mind-body connection). Thoughts and feelings automatically affect our body, just as our body automatically affects our thoughts and feelings. We can think of our brain and body as one integrated system. See <https://schmeissmanlab.org/somatization> for family resources including videos, handbooks, and podcasts.

**School recommendations for [Patient]**

It is important for [Patient]'s recovery that they participate in an academic program regularly and learn how to cope with symptoms during academic time. Although [Patient]'s somatization symptoms are powerful and real, they are not life threatening or dangerous and can be managed safely in a school setting. School team members play an important role in the successful treatment of somatization. We encourage [Patient], the family, and the school team to work together to develop a detailed plan for school participation that addresses overall goals, school attendance, course load, and classroom accommodations. It is better to participate for a planned and short amount of time every day, than stay home or leave early because of symptoms.

Sometimes students with somatization are considered for designation by the Ministry of Education. Given [Patient]'s significant needs in academic/intellectual functioning, social-emotional functioning, self-determination/independence, and physical functioning which have affected and will continue to affect their learning and achievement, we strongly recommend that the school consider applying for a Ministry of Education Special Education Designation of "D" for Chronic Health.

A school plan for somatization should be as detailed as possible to the student's needs and what is available at the school. Here are some suggestions for the types of supports that might be helpful (add or delete):

- Totally eliminate or significantly minimize catch-up work, unless missed work is essential foundation for future work or is crucial for postsecondary outcomes. If missed work will be problematic moving forward with grade completion or graduation, consider options for online, and/or self-paced learning to support catching up.
- Determine the workload and courses for the following month/year. It may be important for [Patient] to have a reduced course load, a reduced number of course blocks, or the introduction of a support block during the work.
- Work with [Patient] to carefully balance and pace classes (academic, elective) and activities (social, extracurricular, athletics, etc.). Know that [Patient]'s symptoms are not medically dangerous.
- Consider preferences seating in any classroom. The best place to sit depends on the student. Some students prefer being near the front of the class, near the door, etc. For elementary students, it's usually helpful to sit near the teacher or provide opportunity for one-on-one interaction.

• If Nursing Support Services are already involved in this student's existing support plan, it should be given a copy of this plan.

**Develop a plan for somatization on symptoms at school:**

It is important to identify environmental, social, and emotional factors that may trigger or intensify physical symptoms. The school team should use their expertise and awareness of available resources to develop additional strategies. Consider creating a "Somatization Symptom Management Plan" for [Patient] that outlines strategies to help in coping with physical symptoms when they occur. For [Patient], strategies to consider include: add or delete

- [Patient] may use insert details (e.g., relaxation, breathing, visualization, distraction, grounding techniques) when having symptoms.
- [Patient] may try listening to music on headphones during work periods in class.
- [Patient] can sit in a quiet location to help cope with symptoms during school.
- When [Patient] has a somatization episode, a school team member may support [Patient] by insert details (e.g., sitting quietly beside [Patient]). The team member should calmly convey that [Patient]'s symptoms are real and powerful, but not a medical emergency.
- [Patient] should be allowed to leave the classroom to take a short break.
- If the symptom management plan for [Patient] includes the option to leave class for rest, it is very important to develop a plan for how [Patient] can return to class as soon as possible.
- Plan for transition between classes. [Patient] may leave class a little early or a little later to avoid transitioning between classes when the hallways are very crowded.

The school should be a ready response when peers or others have questions about [Patient]'s symptoms. If insert to be completed with [Patient] and family input here: OR See Pediatric Somatization Family Handbook, OR at <https://schmeissmanlab.org/somatization> for a sample script.

Sometimes school counselors and other professionals can play an important role in supporting the following:

- emotional awareness and emotional expression skills
- the ability to detect stress and emotional triggers as early as possible
- stress and emotional coping skills

Each patient and school are unique. If it would be helpful, a member of our team can be available for a one-time school and family team meeting to help develop the specifics of the school plan. [Patient]'s family can contact us to join the meeting.

Sincerely,  
Insert Name and Contact Information

Insert Resource List if appropriate.

Supporting  
Parents to Give  
Children  
Autonomy and  
Agency...

...and **Reduce  
Overhelping**

*When a child is sick, we  
commonly find ourselves  
doing things for them.*

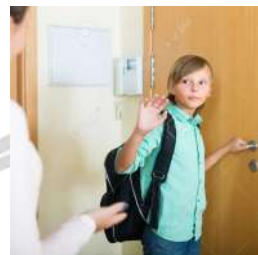
*When a child is trying to  
get better, the new  
challenge is letting them  
do things by themselves.*

Supporting  
Parents to Give  
Children  
Autonomy and  
Agency...

...and **Reduce  
Overhelping**



Secure base and  
safe haven



Exploring

## THE CIRCLE OF SECURITY

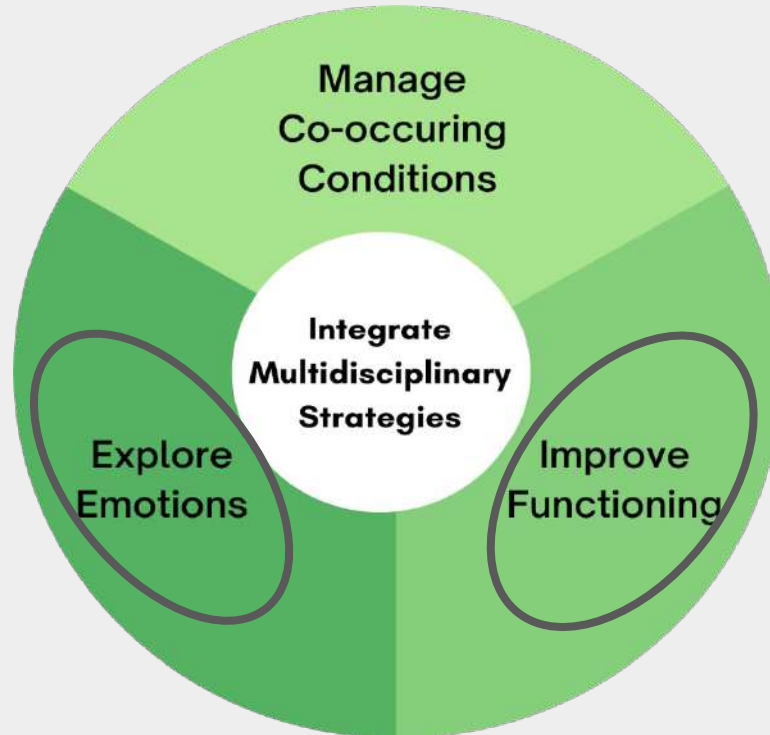


Check-in/support



Stretch  
limit

# Integrating Emotional + Functional Approaches



# Role Play

## Emotions + Functioning: The Balancing Act



**Pat**  
(Parent)



**Zara**  
(Child)



**Miriam**  
(Psychologist)

# Role Play

## Emotions and functioning - A balancing act

### Key takeaways:

- Validate distress experienced on both sides.
- Notice and articulate the positive intentions and motivation for both parent and child.
- Microslice the narrative: break down the interactions very specifically to see where things might be going sideways, or see what they don't know about the other.
- Support implementation of 'being with' strategies (validating the child's physical and emotional distress while also maintaining expectations of forward movement) to balance when to push and when to pull back. 'Being with' doesn't mean agreement.
- Empower the child to increase autonomy in their care; empower the parent to play a supportive role.



# Role Play

**Pat:** I've tried everything all the doctors have told us. Nothing is working.

**Zara:** I'm feeling so frustrated. Everyday I'm supposed to go to school and it's not working. The exposures are just disappointing. I do these little baby steps, and I need to get much further ahead. The symptoms keep staying the same. It feels really overwhelming

**Miriam:** The two of you are working really hard on getting better and just that is very disappointing when it doesn't get you to exactly where you need to be.

**Zara:** I feel like I've done everything everyone has told me to do. Mum's telling me to do stuff too. And everyone's getting so frustrated, and I feel so bad that I'm not doing things right.

**Miriam:** There's a lot on your shoulders, Zara. And Pat, I just want to check in with you - you might see things differently - but did you know that about Zara? That she's feeling frustrated that it's too much and that she's not doing it right, and I get the sense (Zara you can correct me) she doesn't want to let you down and doesn't want you to be frustrated with her?

# Role Play

**Pat:** I'm working really hard, I'm just trying to help her.

**Miriam:** But did you know what she just said?

**Pat:** What part?

**Miriam:** The part about her worrying about letting you down, and getting you frustrated.

**Pat:** I didn't realize she felt that she was letting me down. I can see that she's working really hard but I am just trying to get her to do the things that will get her better.

**Miriam:** You didn't know that part. And I think that's really common that kids want to do the best for themselves but also for their parents. I'm just going to map this together. Zara, you are pushing yourself very hard to get better - you're finding the exposure hard and it's disappointing when they don't pay off immediately. And then on top of that you are worrying about letting your mom down.

# Role Play

**Zara:** Yeah, and then I just end up feeling so overwhelmed that I shut down and can't do anything!

**Miriam:** Ok, so Pat, you see Zara shut down. That must be very hard to see. And that prompts you to help. You try doing some things - what are those things?

**Pat:** I'm getting her up in the mornings so she's not spending the day in bed, trying to keep her on schedule, and reminding her throughout the day about what she needs to do to stay on top of school

**Miriam:** You are doing a lot! You're doing those things because you care. But then something happens. Zara, what's it like when mom does all those specific things throughout the day?

**Zara:** It makes me feel like I can't do them myself.

# Role Play

**Miriam:** Wow - so let me piece this together. The more mom tries to do things, the less you feel like you can do them. It leads you to shut down. And then Pat, you see the shut down and you try to help do things. The more you see her shut down, the more you try to do things. You guys are stuck in this loop.

**Pat:** Yes, that's how it feels. We are stuck. But what am I supposed to do. Just sit back? Nothing would get accomplished.

**Zara:** I do need your help mom, but I want to feel like I can do things too.

**Miriam:** It sounds like you don't want your mom to give up - you do want her support. But it sounds like you want her to salute your OWN motivation.

**Pat:** I'm just trying to help. She is my daughter, I love her and don't want her to feel disappointed or frustrated.

**Miriam:** Zara, did you know that - mom wants to help you?

**Zara:** I don't think so, I think she just wants me to be able to do everything I used to do so our family gets back to normal. I feel like a screw-up.

# Role Play

**Miriam:** But mom said she doesn't want you to feel bad, disappointed, or frustrated. I think that's news to you then.

**Zara:** Yes...

**Miriam:** So when you are shutting down...?

**Zara:** . . . mom should let me rest so I don't feel worse. I need to be left alone.

**Miriam:** So then what happens is that even though you want to rest and be alone, I remember there is this other part of you that also wants to see your friends and get back to school.

**Zara:** That's true.

**Miriam:** Pat, that must be your conundrum - that she wants to rest and move forward at the same time.

**Pat:** I don't know when to push and when to pull back. I tried "being with" like we talked about. But like I said, nothing happens. I end up accepting that she is going to rest, I call work and cancel my day.

# Role Play

**Miriam:** To you, does “being with” mean accepting or agreeing with Zara?

**Pat:** I guess.

**Miriam:** So you seem to see two choices...either to get her to do things, or then to give up.

**Pat:** Yep.

**Miriam:** “Being with” is actually very hard to do in moments like you’re describing. Being with the emotions of frustration, exhaustion, and overwhelm (while also feeling all those things yourself). And then at the same time, keeping your foot on the gas, and getting her moving forward. In those moments of shut down, have you ever told Zara that you can see she’s feeling frustrated and overwhelmed?

**Pat:** No I haven’t tried that. I thought she knew.

**Zara:** I didn’t.

# Role Play

**Miriam:** So it sounds like, if I'm paying attention to both of your voices, one thing you haven't tried in these moments of shut down is for Mom to take a beat and let you know she sees what you're feeling, see it from your eyes. That can be very calming and empowering. That might help you both keep your foot on the gas for you so you don't slip backwards into more shut down.

**Zara:** I would like to feel empowered.

**Pat:** I'd like to try doing something like that. It seems complicated - can I spend some more time learning about what you mean?



# Resources



# Treatment Template

## Treatment Recommendations Template

This document offers recommendations for community-based treatment and directs you to key resources. Families should keep this plan for their own information and may provide it to community care providers. This document has also been included on [Patient's] health care chart.

**Introduction to [Patient]**  
Brief identifying information about patient, include personal strengths.

**Medical Summary**  
Summary of admission or consultation, MDP and teams involved, tests and results, diagnoses provided (narrativized +/- medical), further investigations, pending results, specialist referrals, and follow-up appointments.

**Information about somatization and the mind-body connection**  
Somatization is the involuntary physical expression of emotional distress. Somatic symptoms are common and real. Examples include stomach aches, headaches, dizziness, rashes, fatigue, body pain and shaking episodes. When somatic symptoms are persistent and interfere with functioning, they require treatment and may be diagnosed as a Somatic Symptom Disorder or a Functional Neurological Disorder. Somatization can be caused by many different things, for example, having anxiety, the stress of a medical condition, being bullied, etc. Sometimes somatization starts off because of one cause (e.g., a medical condition) but then persists for a different reason (e.g., the impact of having chronic symptoms). Somatization occurs because of the integrated communication between the brain, nervous system, and body that involves many different body systems (the mind-body connection). Thoughts and feelings automatically affect our body, just as our body automatically affects our thoughts and feelings. Think of our brain and body as one integrated system. See <https://bcchildrens.ca/healthcare/for-parents/understanding-somatoform-disorders> for more family resources and see <https://compassbc.ca/resources> for professional resources.

Treatment for somatization focuses on 1) functional recovery (participating in activities, working towards goals) and 2) emotional regulation.

**Recommendations for [Patient's] somatization**  
Now that we know from the medical team that [Patient] has a somatic symptom disorder, we can work together to manage [Patient's] symptoms. It may take some time to set up a plan, but it is normal to experience some ups and downs. Don't be discouraged if things aren't going well.

**What if symptoms get worse or new symptoms appear?**  
It is not uncommon to experience flare-ups of symptoms. If symptoms worsen or new symptoms develop, [Patient] may want to arrange a consultation with their primary care provider. If [Patient] requires urgent medical attention, please seek medical care (e.g., urgent care centre, emergency room).

**How can [Patient] manage physical symptoms at home and when out in the community?**  
There are many tools and coping strategies that [Patient] can use to manage symptoms. [Patient's] specific plan includes:

- Specific strategies e.g., stretching, breathing, walks, exercise, mindfulness, medication, ice/heat packs, etc.

This symptom management plan is a "work in progress" and should be updated or changed as needed. See Pediatric Somatization: Family Handbook at <https://bcchildrens.ca/healthcare> for suggestions about symptom management strategies.

**What about school?**  
[Patient] should be involved in an academic program of some kind. However, their involvement needs to be planned with flexibility. School staff can't be a great resource. It is helpful to identify one member of the school team who is the main point person for developing and supporting [Patient] with the school plan. Work with (e.g., school counsellor, alternative school programs). See Pediatric Somatization: Family Handbook at <https://compassbc.ca/resources> for suggestions about school. If [Patient] has not been attending school, [Patient's] family should meet with school (e.g., school counsellor, resource teacher, counsellor) before they return to school.

With [Patient's] help, [Patient] can take the next steps to be involved in activities (e.g., family and friends, community groups, sports, work, chores, etc.) and should keep going once started. However, [Patient] should be supported to take breaks. Specifically, for [Patient] we suggest:

- [Patient] should be encouraged to take breaks (e.g., modifications to participation in activities, building on small steps, breaking recovery goals into small steps, engaging in regular exercise)
- [Patient] should be encouraged to take breaks (e.g., managing symptoms, returning to activities, developing self-regulation skills)

Working with a variety of professionals can be very helpful. For example, mental health clinicians (e.g., counsellors, psychologists, psychiatrists) can help with making plans to manage symptoms and help plan to return to activities. They can also help with the important skills of identifying, labelling, expressing and managing difficult emotions and stress associated with somatization. Physiotherapists can help with re-conditioning. Specifically, we suggest:

- Working with [community counsellor, psychologist]
- Working with [physiotherapist, massage therapist, personal trainer]
- Engaging in [group therapy, family therapy, etc.]

**How does [Patient] explain their physical symptoms to others?**  
It is common for other people to have questions about a person's somatic symptoms. It can help to have a ready response. See the Pediatric Somatization: Family Handbook at <https://bcchildrens.ca/healthcare/for-parents/understanding-somatoform-disorders> for suggestions about what to say to others. If a script has been developed, meet here.

**Can [Patient] continue to be seen at BC Children's Hospital?**  
We do not provide ongoing individual treatment for somatization at BC Children's Hospital. We do offer indirect consultation to primary health care providers, community mental health clinicians, community therapists (e.g., physiotherapists) and school teams. To arrange a consultation phone call, [Patient's] family can provide our contact information to the community provider. The best way to contact us is by calling [name and position at phone number].

**Next steps**  
There are a lot of steps towards recovery, and they don't have to be done all at once. Getting better will take time. We recommend getting started with:

- Specific suggestion
- Specific suggestion

# School Letter Template

# School Letter Template

**INDEX**

Dear School Teams,

[Patient] has been diagnosed with provide details (e.g., Non-Epileptic Seizures which is a type of somatization. Migraines with an element of somatization).

Information about somatization and the mind/body connection

Somatization is the involuntary physical expression of emotional distress. Somatic symptoms are common and may include symptoms such as stomach aches, headaches, dizziness, nausea, fatigue, and shaking palpitations. When somatic symptoms are persistent and interfere with functioning, they require treatment and may be diagnosed as Somatic Symptom Disorder or Functional Neurological Disorder. Somatization occurs because of the reciprocal communication between the brain, nervous system and body that involves many different body systems (the mind-body connection). Thoughts and feelings automatically affect our body, just as our body automatically affects our thoughts and feelings. We can think of our brain and body as one integrated system. See <http://behavioralhealth.usfca.com/education> for family resources including videos, handouts, and podcasts.

## School recommendations for [Patient]

It is important for [Patient's] recovery that they participate in an academic program regularly and learn how to cope with symptoms during academic time. Although [Patient's] accommodation symptoms are powerful and real, they are not life threatening or dangerous and can be managed safely in a school setting. School team members play an important role in the successful treatment of amnesia. We encourage [Patient], the family, and the school team to work together to develop a detailed plan for school participation that addresses overall goals, school attendance, course load, and classroom accommodations. It is better to participate for a planned and short amount of time every day, than stay home or leave early because of symptoms.

Sometimes students with somatization are considered for designation with the Ministry of Education. If [Patient]'s significant needs in academic/intellectual functioning, socio-emotional functioning, self-determination/independence, and physical functioning which have affected and will continue to affect learning and achievement, we strongly recommend that the school consider applying for Special Education Designation of "D" for Chronic Health.

A school plan for socialization should be as detailed as possible, specifying available at the school. Here are some suggestions for the types of

- Only fully educated (or significantly experienced) teachers can provide the best support for students with special needs. Consider the possibility of hiring a teacher with a background in special education to provide support during the competition or graduation, consider options for students with special needs to receive support during the competition or graduation.
- Determine the workload and courses for the students with special needs. Consider the possibility of hiring a teacher with a background in special education to provide support during the competition or graduation.
- Work with (parents) to carefully balance and provide support for students with special needs. Consider the possibility of hiring a teacher with a background in special education to provide support during the competition or graduation.

- If Nursing Support Services is already involved in this student's existing school plan, they should be given a copy of this letter.

### Dealing with somatization symptoms at school

It is important to identify environmental, social, and emotional factors that may trigger or intensify physical symptoms. The school team should use their expertise and awareness of available resources to develop additional strategies. Consider creating a "Somatization Symptom Management Plan" for [Patient] that outlines strategies to help in coping with physical symptoms when they occur. For [Patient], strategies to consider include: ~~add or delete~~

- [illegible]

body response when peers or others have questions about [Patient]'s symptoms. If completed, [click here](#) to be notified with [Patient] and family input here. OR See Pediatric Sematization: Family Handbook pg. 18 [Click here](#) to be notified with [easematization](#) for a sample script.

Sometimes school counselors and other support team members play an important role in supporting the following:

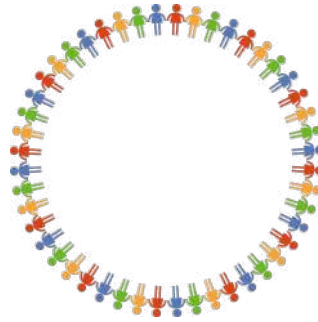
- the ability to detect stress and emotional triggers as early as possible
- stress and emotional coping skills

Each patient and school are unique. If it would be helpful, a member of our team can be available for a one-time school and family team meeting to help develop the specifics of the school plan. [Patient's] family can contact us to plan the meeting.

Sincerely,  
Insert Name and Contact Information

Insert Resin: List if appropriate

# BCCH Mind and Body Together Group



- Psychoeducational and Supportive
- No individual direct therapy or care
- 4 groups/year
  - Youth group (13 - 19)
  - Parent group (any child/youth age)
- No waitlist
- Must attend MBT Group Information Session
- Anyone can refer

<http://www.bcchildrens.ca/health-professionals/refer-a-patient/outpatient-psychiatry-referral>

# Treating Somatization

OXFORD

### When feelings hurt: Learning how to talk with families about the role of emotions in physical symptoms

School of Population and Public Health, University of British Columbia, Vancouver, BC, Canada

## ABSTRACT

Introspection is at the core of all human experiences, but talking about emotions is challenging, particularly in the context of medical encounters focused on somatic symptoms. Transparent, normalizing, and validating communication about the mind-body connection opens the door for respectful, open dialogue between the family and members of the care team, acknowledging the lived experiences of what is brought to the table in understanding the problem and co-creating a solution.

Emotions represent complex states of mind, intertwined with our circumstances, motivations, moods, bodily sensations, relationships, and so much more. Emotional difficulties with patients are often complex, and the challenge for the clinician is to identify the target emotion, but much more difficult to talk about how involuntary physical symptoms are affected by emotions and ideas (and/or symptoms). Somatic symptoms are a complex, experienced phenomenon that encompasses a wide range of physical and psychological manifestations of emotional (e.g., fear) to clinically significant symptoms that impair functioning (e.g., non-specific somatic signs related to a somatization disorder). The challenge for the clinician is to understand the complex experience in the clinical encounter, in the research literature, may often arise around the definition of emotions influencing symptoms, and in some cases completely repressing the term emotion to mean certain parts of the experience (e.g., 23). Notice the emphasis on the data and analyses during the therapeutic encounter to vividly address all of the somatic symptoms, what follows are some suggestions for working with children and adolescents in this complex experience.

Physical symptoms that are associated with and influenced by emotional experiences are common. (1) Chronic stress increases susceptibility to illness; distress can occur in response to an unpleasant symptom, and symptoms can be brought on by strong emotions (e.g., heart racing during panic). Genetics, illness and injury, trauma, social positions, individual and cultural identity and psychological factors (e.g., attention and learning) may set up a vulnerability that interacts with emotions to heighten somatic sensations (2).

Although somatization is often acknowledged among clinicians, talking about it is difficult, sometimes due to the confusion, stigma, and the fear that patients may feel blamed (4). Concepts such as Occults rater, where one should account for an observed phenomenon in the simplest way possible and not look for multiple explanations (5), do not account for the spectrum whereby somatic symptoms can constitute a component of acid-related with all medical conditions. New diagnostic categories such as primary pain disorders in ICD-11 begin to reflect a more nuanced understanding that acknowledges multiple interactive attributes

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## Developing a Clinical Pathway for Somatic Symptom and Related Disorders in Pediatric Hospital Settings

## ABSTRACT

settings. There is, however, a lack of standardization of care across treatments for youths with these disorders. These patients are diagnostically and psychosocially complex, posing significant challenges for medical and behavioral health care providers. SSFDs are associated with significant health care use, cost to families and hospitals, and risk for iatrogenic interventions and missed diagnosis. With its sponsorship from the American Academy of Child and Adolescent Psychiatry and support from multidisciplinary stakeholders, we describe the first attempt to develop a clinical pathway and standardize the care of patients with SSFDs in outpatient, hospital settings by a working group of experts from centers across the United States.

The authors of the SSFD clinical pathway outline 3 key steps from admission to discharge and include practical, evidence-informed approaches to the assessment and management of children and adolescents who are medically hospitalized with SSFDs.

[www.hogrefeonline.com](http://www.hogrefeonline.com)

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and critically reviewed and revised the manuscript, and all authors approved the final manuscript as submitted.

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10



# Consensus Recommendations – PT, OT, SLP

## Rehab Resources

**Neuropsychiatry**

**VIEWPOINT**  
**Physiotherapy for functional motor disorders: a consensus recommendation**

Glenn Nielsen,<sup>1,2</sup> Jon Stone,<sup>3</sup> Audrey Matthews,<sup>4</sup> Melanie Brown,<sup>5</sup> Clare Ross Farmer,<sup>6</sup> Lindsay Masterton,<sup>7</sup> Linsey Duncan,<sup>8</sup> Alisa Winters,<sup>9</sup> Laetitia Lumsden,<sup>10</sup> Alan Carson,<sup>11</sup> Anthony S Davis,<sup>12</sup> Mark Edwards<sup>13</sup>

**ABSTRACT**  
**Background:** Intervents with functional motor disorders (FMD) including weakness and tremors are commonly referred to physiotherapists. There is growing evidence that physiotherapy is an effective treatment, but the existing literature has limited indications of what physiotherapy should consist of and how one can deliver it to produce evidence-based guidelines. We aim to address this issue by generating recommendations for physiotherapy treatment.

**Methods:** A meeting with 16 physiotherapists, neurologists, and neurophysiologists, with extensive experience in treating FMD, a list of consensus recommendations were produced based on existing evidence and experience.

**Results:** We recommend that physiotherapy treatment is based on a biopsychosocial approach. Treatment should address physical, self-reported, emotional, and cognitive functional impairments through a process of education, movement training, and self-management strategies with a positive and empathetic attitude. The specific goals and content of treatment should be tailored to the individual patient's needs. This is a new synthesis of direct and descriptive evidence of current practice across of FMD. FMD is a complex disorder with a broad range of clinical presentations and a wide range of functional impairments. The current evidence base is limited and heterogeneous. The current evidence base is limited and heterogeneous. The current evidence base is limited and heterogeneous.

**INTRODUCTION**  
 Many people experience the functional motor disorder (FMD) as a sudden onset of weakness and there is increasing evidence for an underlying neurological condition.<sup>1-3</sup> There is, however, very little evidence on what physiotherapy should consist of and how one can deliver it to produce evidence-based guidelines. We aim to address this issue by generating recommendations for physiotherapy treatment.

**DEVELOPMENT OF RECOMMENDATIONS**  
 In 2015, an international meeting of 16 physiotherapists, neurologists, and neurophysiologists, with extensive experience in treating FMD, a list of consensus recommendations were produced based on existing evidence and experience.

**Occupational therapy consensus recommendations for functional neurological disorder**

Clare Nielsen,<sup>1,2</sup> Mark J Edwards,<sup>3</sup> Alan J Carson,<sup>4</sup> Paula Gardiner,<sup>5</sup> Nicholas Goller,<sup>6</sup> Kate Hayward,<sup>7</sup> Susan Hambrook,<sup>8</sup> Helen Jinks,<sup>9</sup> Julie Macgregor,<sup>10</sup> Lynne Mann,<sup>11</sup> Lindsey Macgregor,<sup>12</sup> Glenn Nielsen,<sup>13</sup> Jason Price,<sup>14</sup> Jessica Ranford,<sup>15</sup> Isobel Renu,<sup>16</sup> Ed Sam,<sup>17</sup> Jon Stone

**ABSTRACT**  
**Background:** People with functional neurological disorder (FND) are commonly seen by occupational therapists. However, there are limited guidelines in the literature about the type of interventions for an FND. The purpose of this document is to address this issue by providing consensus recommendations for occupational therapy assessment and intervention.

**Methods:** The recommendations were developed in four stages. Stage 1: an initial scoping session to establish the scope of the project. Stage 2: a literature review to identify current practice. Stage 3: a survey of occupational therapists to identify current practice. Stage 4: a consensus meeting to develop the recommendations.

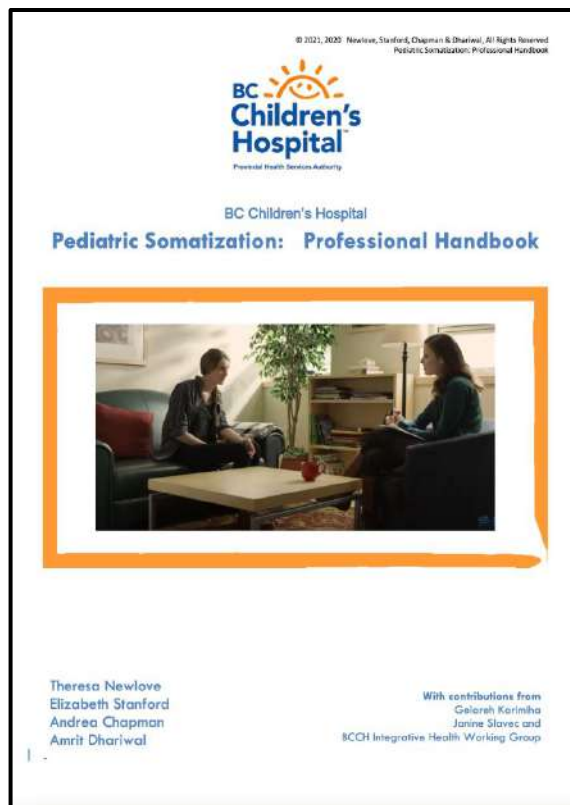
**INTRODUCTION**  
 Occupational therapists (OTs) are people with physical and mental health difficulties who are skilled in enabling people to live their lives to the fullest. They are skilled in enabling people to live their lives to the fullest. They are skilled in enabling people to live their lives to the fullest.

**General neurology**

**Management of functional communication, swallowing, cough and related disorders: consensus recommendations for speech and language therapy**

Janet Baker,<sup>1,2</sup> Caroline Barrett,<sup>3</sup> Lesley Cavanagh,<sup>4,5</sup> Maria Dietrich,<sup>6</sup> Lorna Dixon,<sup>7</sup> Joseph R Duffy,<sup>8</sup> Anne Elyas,<sup>9</sup> Diane E Fraser,<sup>10</sup> Jennifer L Fiebert,<sup>11</sup> Catherine Gregory,<sup>12</sup> Kristy McGee,<sup>13</sup> Nick Miles,<sup>14</sup> Jo Patterson,<sup>15</sup> Carole Ridd,<sup>16</sup> Nathan Roy,<sup>17</sup> Alison Smith,<sup>18</sup> Anne Williams,<sup>19</sup> Anne Williams,<sup>20</sup> Alison Smith,<sup>21</sup> Anne Williams,<sup>22</sup> Alison Smith,<sup>23</sup> Anne Williams,<sup>24</sup> Alison Smith,<sup>25</sup> Anne Williams,<sup>26</sup> Alison Smith,<sup>27</sup> Anne Williams,<sup>28</sup> Alison Smith,<sup>29</sup> Anne Williams,<sup>30</sup> Alison Smith,<sup>31</sup> Anne Williams,<sup>32</sup> Alison Smith,<sup>33</sup> Anne Williams,<sup>34</sup> Alison Smith,<sup>35</sup> Anne Williams,<sup>36</sup> Alison Smith,<sup>37</sup> Anne Williams,<sup>38</sup> 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# Pediatric Resources



Pediatric Somatization: Professional Handbook

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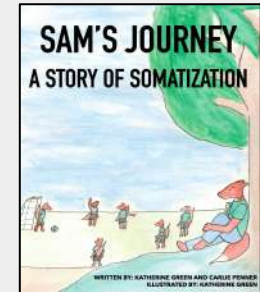
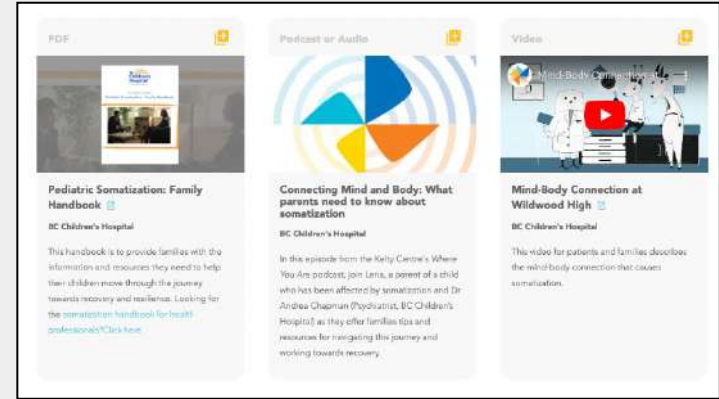
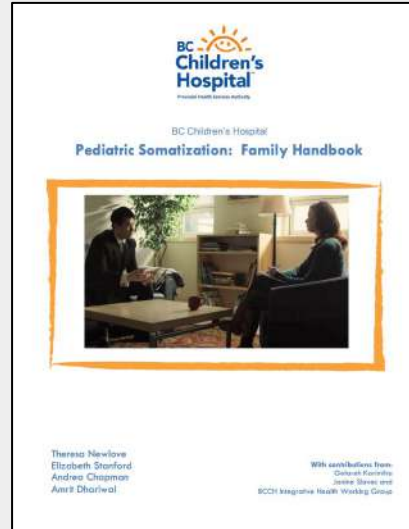
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# Family Resources

## Kelty Mental Health Website <https://keltymentalhealth.ca/somatization>



# Adult Resources

neurosymptoms.org

**FND Guide**  
neurosymptoms.org

Search

Save Items / Recommend

Home Symptoms Causes Treatment Stories Media FAQ About Fact Sheets

### Functional Neurological Disorder (FND):

FND describes neurological symptoms like limb weakness, tremor, numbness or blackouts, related to the movement and sensation parts of the nervous system....

- ✓ Caused by a **PROBLEM** with the **FUNCTIONING** of the nervous system
- ✓ A "software" issue of the brain, not the hardware (as in stroke or MS)
- ✓ With positive diagnostic features typical of FND
- ✓ Cause day to day difficulties for the person who experiences them

### Functional Neurological Symptoms are:

Troublesome symptoms that someone wishes to understand without necessarily having a 'disorder' are called functional neurological symptoms, and this site is for you too.

FND and functional neurological symptoms are surprisingly common but can be difficult for patients and health professionals to understand.

**Download FND app**

GET IT ON Google Play | Download on the App Store

This website, written by a neurologist with a special interest in these problems, aims to...

fndhope.org

**FND HOPE**  
Empowering Patients to Better Health

English

What is FND Managing FND What We Do How To Help FND Research Who We Are #FNDandUS

## MANAGING FND

FND TECHNIQUES AND SELF-CARE

# Resources for Professionals

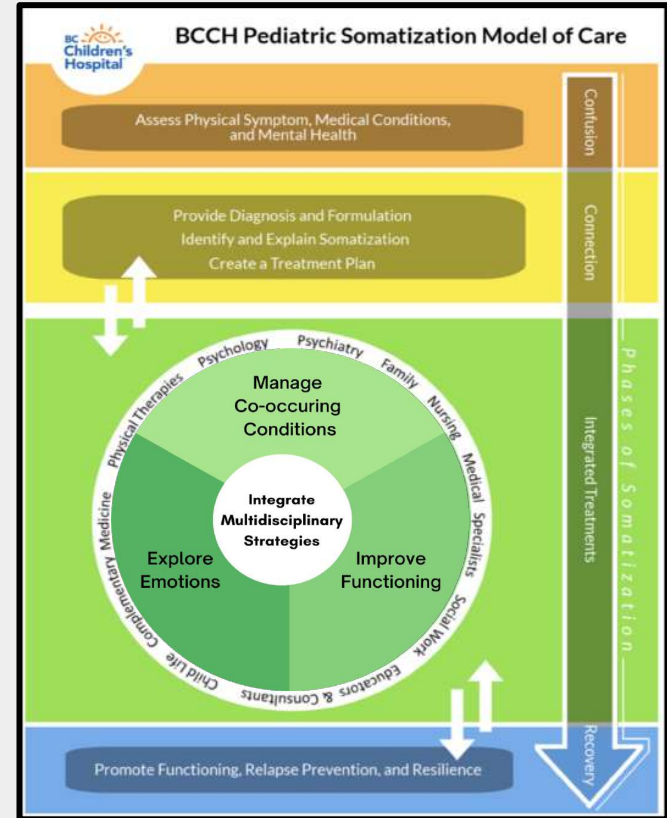
1. Pediatric Somatization: Professional Handbook, BC Children's Hospital:  
<https://compassbc.ca/resources>
2. Stay tuned for the Somatization Toolkit! Compass Toolkits:  
<https://compassbc.ca/toolkits>
3. Mind and Body Together Group Referral  
<http://www.bcchildrens.ca/health-professionals/refer-a-patient/outpatient-psychiatry-referral>

# 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](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: Somatization How to Help Your Child or Teen at Home  
<https://www.aboutkidshealth.ca/article?contentid=3770&language=english>

# In Summary

1. Make a diagnosis
2. Explain and normalize somatization
3. Increase trust and decrease confusion
4. **Co-management is key**
5. **Attend to emotional regulation and**
6. **Improve functioning**



# Thank you!

All of the recordings and slides from this webinar series will be posted on [compassbc.ca](https://compassbc.ca)