Mental health care in the pediatric clinic

Conceptual Framework

Objectives

By the end of this chapter, you will be able to:

- Understand the cognitive-behavioral model of mental health
- Describe contextual factors in mental health problems
- Use cognitive, behavioral, and contextual factors as leverage to treat (and prevent) mental health problems

Mental Health

The capacity to keep functioning in an imperfect world.

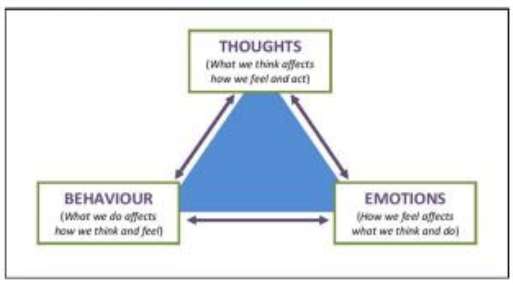
For kids, includes:

- Learning to regulate feelings and behavior, and tolerate distress
- Being able to form and maintain relationships
- Developing a sense of right and wrong
- Being able to play and attain developmental milestones

Mental health problems are

Feelings
Behaviors
Thoughts
which impair a child's ability to meet his or her developmental goals and/or interact with others.

The cognitive triangle



The cognitive behavioral model highlights the dynamic relationship among behaviors, thoughts, and feelings. Each tends to drive and reinforce the other. The direction of the drive can be toward more positive or negative thoughts, feelings, or behaviors.

The model in context of the child

We want to put the symptoms that the child has- the thoughts, feelings, and behaviors, into the context of who the child is. As with any diagnosis, we take into consideration the family history, past medical history, social, and developmental history. We consider the child's temperament: is she generally fearful, risk-averse, difficult to console, or upset by change? We also recognize that behavioral symptoms exist in a dynamic relationship with the child's environment, specifically with the ways in which family, friends, school personnel and others respond to the child's symptoms.

Who is the child?

Genetic predisposition/family history
Medical history
Social history
Developmental history – strengths and weaknesses
Temperament

What symptoms/disorder does the child have?

Thoughts, feelings, and behaviors

How does the world respond to the child?

Behaviors of family and others that reinforce or mitigate symptoms

Case: Tim

Tim is 9 years old, here for a well child check. You ask about any emotional concerns, and mother states that Tim is afraid of storms. That sounds pretty normal for a 9-year-old, but after some probing, you find that Tim's fear of storms is causing problems in the family. Tim is checking the weather on the phone up to 20 times per day. He says he is afraid that a storm could wash him down a culvert (he saw that on TV). He constantly seeks reassurance from his parents that it won't rain, and he won't leave the house if there is thunder. His parents have been taking turns staying home with him in these situations.

Tim, continued

Who is the child?

Family history: mom and aunts- anxiety
Medical history: ALTE at 2 months, hospitalized 2 days
Social history: parents married, Tim is an only child
Developmental history: highly verbal, does well in school
Temperament: slow to warm up

What symptoms/disorder does the child have?

Fear of storms generalizing to all bad weather, tries to avoid going out, becomes distraught if pushed to do so

How does the world respond to the child?

Parents shape their lives around Tim's fears because he explodes when they try make him go out in the rain.

Why understand the model as a pediatrician?

Understanding the thoughts, feelings and behaviors associated with mental health disorders in the context of who the child is and how the world responds may help you:

- Identify symptoms early
- Employ brief interventions that may relieve symptoms

- Recognize impediments to improvement in medication treatment
- Understand what your patients may be working on in cognitive behavioral therapy

Here are some of the feelings, behaviors and thoughts associated with depression.

Depression: feelings

- sadness
- pain
- anger
- loneliness
- despair
- emptiness
- helplessness

Depression: behaviors

- isolate
- reduce activities
- lash out
- take risks
- sleep
- self-harm
- use drugs or alcohol

Depression: thoughts

- I'm no good.
- I'm a failure, doomed to fail.
- I'm unlovable, and unloved.
- I am a burden to everyone. They'd be better off without me.
- There is no meaning, no reason, no argument to go on living.
- I'll die eventually, why not now?
- I can't live with this pain.

A major component of depression is an internal monologue of intensely negative thoughts that plays in the background of the mind and gets particularly loud when the person meets with disappointment or frustration. This is why a seemingly small event can trigger a marked reaction in a child or teen who is depressed.

Depression in context of the child

Who is the child?

Genetic predisposition/family history (mood disorders)
Medical history (chronic illness)
Social history (trauma, loss, bullying)
Developmental history – strengths and weaknesses
Temperament – internalizing, externalizing

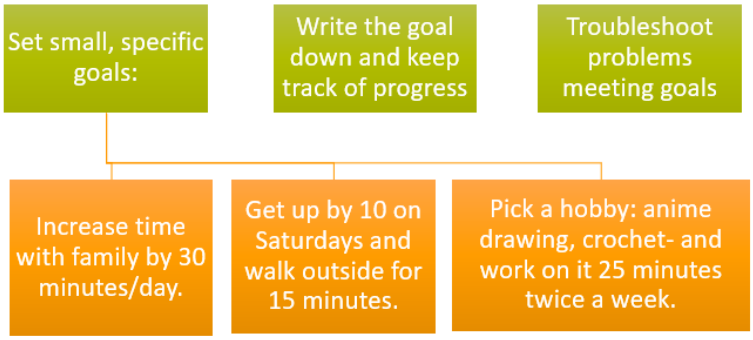
What symptoms/disorder does the child have?

Thoughts, feelings, and behaviors

How does the world respond to the child?

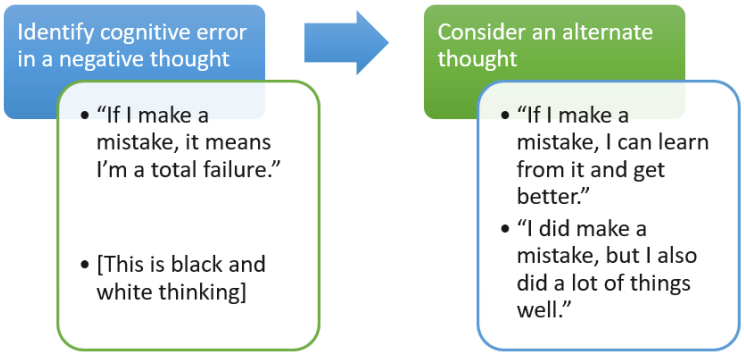
Behaviors of family and others that reinforce or mitigate symptoms- criticism, unmet expectations, recurrent conflict

Behavioral Activation



A primary and very effective strategy in cognitive behavioral therapy is called behavioral activation. This is the idea that if you get going a little and do something, you will feel better. The problem is that depression creates a terrible inertia, so getting going is hard. You have to start with very small, measurable steps and troubleshoot barriers to taking them. The best activating behaviors are those that are pleasurable and those that involve mastery (practicing a sport, learning a skill).

Challenging Negative Thoughts



Another key CBT strategy is challenging negative thoughts. All negative thoughts contain what we call a thinking error. These errors are the cognitive lens that depression puts between our thinking and the world. I will often point out these errors and say, "that's your depression talking, and depression does not tell the truth. Is there any other way to think about this?".

Here is a list cognitive errors we see in depression- and in our everyday lives. They are self-reinforcing because they leave no room for critical thinking. While you are not going to engage your patients in extended therapy, you can nudge them toward seeing these thinking errors as distortions of reality. One strategy: "If your best friend said what you just said, what would you tell him?"

Cognitive distortions or thinking errors

All or nothing thinking	• I see things in black and white categories • "If I don't score perfectly, I am a failure"
Overgeneralization	• I see a single negative event as an overall pattern • "I have put on 2 pounds; I'm fat and always will be"
Fortune telling	• I can tell what the future holds and it's not good • "Nobody will ever love me"
Emotional reasoning	• How I feel is how things are • "I feel hopeless, so things are hopeless"
Personalization	• It's about me • "If somebody else is angry, it's clearly my fault"

What about context in strategies for depression?

Who the child is:

work with strengths and weaknesses

- intellectual
- social
- developmental

How others respond: essential to shape response of others:

- decrease criticism
- manage expectations
- listen without judgement

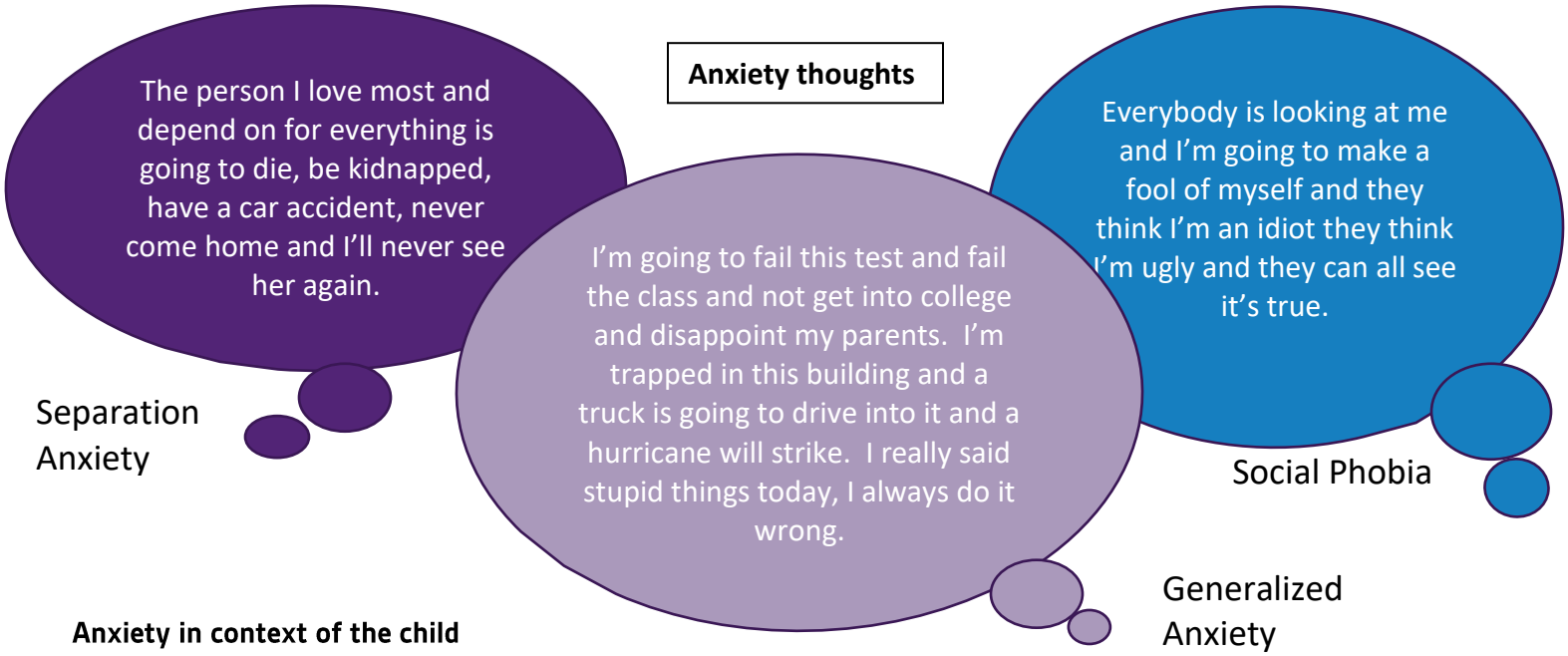
Anxiety: feelings

- fear
- terror
- embarrassment
- panic
- worry
- anger
- shame

Anxiety: behaviors

- avoid
- avoid
- cling
- seek reassurance
- perseverate
- lash out
- use alcohol or drugs

Avoidance is the cardinal behavior associated with anxiety and is the most important behavior to change. Avoidance is a powerfully self-reinforcing behavior because it provides immediate relief from the distress of the anxiety-provoking stimulus. If a child who fears separation from his mother can prevent separation by clinging, crying, barring the door, and hyperventilating, and the mother relents, the child has avoided the feared separation and trained himself and his mother as to how to avoid distress in the future.



Anxiety in context of the child

Who is the child?

Genetic predisposition/family history (anxious relatives)
Medical history (often asthma, GI symptoms, headaches)
Social history (trauma, loss, bullying)
Developmental history – strengths and weaknesses
Temperament (often fearful, risk averse, startles easily)

What symptoms/disorder does the child have?

Thoughts, feelings, and behaviors of anxiety

How does the world respond to the child?

Behaviors of family and others that reinforce or mitigate symptoms – especially accommodation of symptoms

Behavioral techniques for anxiety are centered around ending avoidance and will be discussed in a minute. Many of the same cognitive distortions discussed previously for depression are present in anxiety, with catastrophic thinking being the most salient. Mindfulness practice can be helpful here, training oneself that anxious thoughts are simply thoughts and do not require analysis or action.

Using context in strategies for anxiety:

Who the child is:

- increase awareness of and control over bodily reactions
- shifting attention from threat

How others respond:

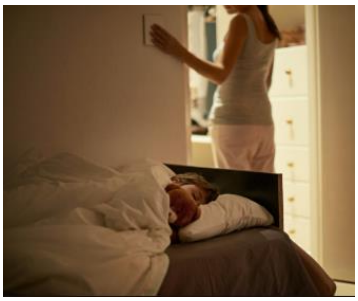
- decreasing accommodation and reassurance
- helping parents face their own anxiety

You know how to do this.

You have been working with anxious children and parents for years.

You have done graded exposures or fear ladders when you have explained a procedure, shown a child the instrument you will use, or demonstrated on a stuffed animal.

You have helped parents do graded reduction of accommodations when you coach them through getting their child to sleep without a parent at the bedside.



Case: Sarah

Sarah is 15 years old, a sophomore. She has always been a nervous child, but since she started high school has become increasingly socially anxious. She fears any situation in which attention is drawn to her. She won't volunteer answers in class and if called on shakes her head and blushes. She won't go to teachers for clarification or help, which is affecting her schoolwork. She cannot order food in a restaurant. She has only a few close friends and won't attend group activities. She wants to earn money but is afraid to go for a job interview.

Treatment: Exposure

Just as avoidance is the cardinal feature of anxiety, exposure is the cardinal element of treatment. Exposure means putting yourself in the anxiety-provoking situation over and over until you can tolerate it. In most situations, exposures are carried out in a graded manner, beginning with small, less threatening tasks and working one's way up to the most challenging. This hierarchy of exposure tasks is often represented as a fear ladder.

How to do exposures

Start small, manageable, and concrete

"I will say hi to 2 people in the hallway each day at school".

Identify level of anxiety immediately before and immediately after the exposure.

Do the exposure over and over until pre- and post-exposure anxiety decrease, then move a step up the ladder.

Reward for doing exposure, if needed.

Consider whether medication (an SSRI) is needed to control anxiety symptoms sufficiently to work on exposures.

Is the anxiety disorder a problem?

Who thinks it's a problem?

- How is it interfering with functioning?
- What sort of solutions are available?
- What sort of solutions are you willing to try?

In Sarah's case, Sarah had social anxiety that was keeping her from doing things she wanted to do. Both Sarah and her mom were interested in solutions, and Sarah was motivated to master her anxiety with her mom's support. This is not always the situation. Sometimes the child with symptoms is not going to be the main target of the intervention.

Case: Tim

Tim gets up every morning and checks the weather app. If there is any mention of rain, he frets and asks if there will be thunder. At school, if he knows it might rain, he leaves his work and is glued to the window, checking. If he is at a friend's house and it rains, he becomes distraught and calls his mom to get him back home. His parents estimate they spend 90 minutes daily providing reassurance or arguing about going out.

Tim's fear is taking up a big chunk of his time and energy, but it is also taking up a large amount of his parents' time and energy. Parents accommodate this type of anxiety because the child's reaction when they don't may be dramatic and upsetting for them, demanding more energy than the accommodation. Parents may have different thresholds for tolerating these reactions, which may put a strain on their relationship.

Is this a problem?

For parents?

Absolutely. It is taking over their lives and can be a source of conflict between them when one wants to handle it differently than does the other.

For Tim?

Objectively, yes. But for Tim, the fear is real: there are storms out there, and he did see a child swept down a culvert on TV. The system he has created is managing to protect him from them, so far.

What has to change?

The system.

In this case, exposure tasks on the fear ladder will involve parents withdrawing reassurance and withdrawing accommodations.

Crying, pleading, or aggression may follow.

Parents will need support to stay calm and firm.

> "You have 5 tokens for the day. You may trade these tokens to ask about the weather. When they are gone, you may not ask any more today. If you ask, we will not answer. We will offer to talk about something else."

Summary: conceptual framework

Mental health problems can be thought of as

- thoughts
- behaviors
- and feelings

which occur in the unique context of an individual child

which elicit responses from other people in the child's world.

Each element of this framework represents an opportunity to prevent, mitigate, or treat any mental health problem.