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Emily Foxen-Craft, Ph.D., is a pediatric pain psychologist with over 7 years of experience, and the enthusiastic owner of Pediatric Pain and Behavioral Health. She provides treatment to children, teens, and young adults with chronic pain, chronic illness, and anxiety. Common concerns include headaches, digestive symptoms, sports injuries, and stress, but she always personalizes care to help the individual and family learn to manage their symptoms, improve functioning, and develop resilience for life. Dr. Foxen-Craft is a licensed psychologist in the State of Michigan, but is also authorized to provide interjurisdictional telehealth to 40 states through PSYPACT. Prior to launching Pediatric Pain and Behavioral Health, she helped found the University of Michigan's pediatric chronic pain program as a postdoctoral fellow and then as a faculty member in the Departments of Pediatrics and Anesthesiology. She continues to conduct and publish research, and to educate psychology trainees as well as pediatricians in pediatric pain management. Welcome, Emily.

Allison Puryear (she/her): Welcome back to Not Boring CEs! I'm your host,

Allison Puryear. I'm here with Emily Foxen-Craft, and we are going to be talking about pediatric pain psychology. Which for me was an area I have a lot of experience in as a parent,

but absolutely none as a clinician. And so I'm so excited about this conversation, cause I feel like

Allison Puryear (she/her): it will help both those sides of my life. So thanks for being here.

Emily Foxen-Craft: thanks for having me,

and thanks for taking an interest in the subject. Yeah, absolutely. So

Allison Puryear (she/her): can we talk some about kids and pain?

Because I think when we think of kids and pain, my first thought,

at least, is usually acute pain like broke their arm on the playground, or

Allison Puryear (she/her): has scabby knees, or whatever but that's not the majority of

what we're gonna be talking about today. We're gonna be talking more about chronic pain, right?

Absolutely. So you hit on a number of great points that I would like to emphasize already.

So first of all, you're right. Most people don't think about kids and pain in the same sentence, except for maybe the exceptions of, you know, bumps and scrapes and

injuries like that. So I just wanted to take a moment to say thank you to anybody

who is clicking on this video to watch and for taking an interest in this subject,

because it is more common, then we appreciate and also more complex.

Then I think a lot of people think at first face value. But anybody who's a clinician who's maybe talked to somebody who's in pain has realized that. Wait. What in the world am I supposed to? How do I understand this? And how am I supposed to deal with this? So Emily Foxen-Craft: chronic pain and different kinds of pain conditions and pediatrics are actually quite common. And so, yes, we can kind of divide and classify pain in a number of ways, whether it's longevity of pain, acute to chronic or the ICD. The International Classification of Disorders diagnoses. Emily Foxen-Craft: it has started in the newest iteration has started to classify pain based on whether it's the primary condition or a secondary condition. Meaning is pain itself the condition and the diagnosis? Or is pain more? A result or an effect of something else.

And amongst those we also understand a lot of different pain mechanisms. So across the board,

pain is actually quite common in children. And so,

although we all are familiar with the acute or injury, kinda often prone our kids in our lives.

Chronic pain or pain that's actually lasting a long time

is also quite prevalent in kids just a little bit more under appreciated.

So depending how you capture it, or how you measure it, how often?

Emily Foxen-Craft: you're kinda how often in a week, for instance,

you're assuming pain has to occur to be a diagnosis or a condition

Emily Foxen-Craft: prevalence. Very estimates vary and range from, you know, something like 10%

to almost 40% of kids, which is a lot of kids! Think about the kids who are maybe struggling with

Emily Foxen-Craft: something like a stomach ache or a headache pretty significantly, maybe once a

week, all the way up to kids who may be struggling with one or more locations of pain multiple days,

a week, or maybe even all of the time, and so, whether the pain is coming from a bump or scrape.

Emily Foxen-Craft: or whether it is longer lasting. There are a lot of great psychological tools and ideas that we can bring into our work with children. But, as you mentioned there's usually a caregiver or somebody else in the picture. And so thinking about the child and the whole family together. Who are in distress and maybe in pain and trying to think about the child in their lives and also in their context.

Allison Puryear (she/her): That's so interesting to think about.

Allison Puryear (she/her): you know, for potentially heritable conditions, right? And how, if there is a child struggling with some chronic pain due to a heritable condition. Their parent might also have that in the

Allison Puryear (she/her): empathy or lack of empathy that maybe coming from the parent based on their own experience. Can really make a difference in how their child experiences pain.

Emily Foxen-Craft: Exactly so whether they see a lot of disability or a lot of dismissal and invalidation, any extreme or anywhere in between. They're gonna be observing and picking up on. Hmm! That's so interesting.

Allison Puryear (she/her): I'm thinking, too, about like the prevalence being so much higher than I would have guessed like up to 40% is so much higher than

Allison Puryear (she/her): my imaginings. And it's something that we don't talk about as therapists, as people, as parents. As if it is that much of a problem.

Allison Puryear (she/her): And how that also communicates something to kids.

Emily Foxen-Craft: exactly a lot of dismissal, a lot of dismissal, a lot of assumptions, of growing pains. Or this is normal or you're exaggerating. And so it's really complicated for both parents, caregivers.

Emily Foxen-Craft: pediatricians, clinicians to really distinguish what's what, in any given situation. On the one hand, we don't want to over medicalize or over pathologize things. But we also wanna make sure that the kids who are in pain are feeling heard

and getting into treatment. Because that's the exciting thing about working with kids.

Emily Foxen-Craft: whether it's young kids or adolescents is, we have a lot of opportunity to intervene early before they kind of go down the you know, disability trajectory and into adulthood where there are definitely long term, significant, adverse consequences of having chronic pain.

Allison Puryear (she/her): Hmm! I'm I'm thinking, too, about. I've got a stomach ache as a like excuse, so to speak, of getting out of school. And how like I mean, parents talk about that all the time, like

Allison Puryear (she/her): as kind of a trope kind of, and how do we distinguish when that is a stomach ache, when that is a stomachache caused by

Allison Puryear (she/her): like medical condition versus anxiety versus? Hmm! That's something you can't really verify. So throwing up or having diarrhea or something, and so it could just be an excuse like how.

Allison Puryear (she/her): how, as a clinician do we help parents

Allison Puryear (she/her): hear, listen, and ascertain which of those is going on?

Emily Foxen-Craft: That's a great question, and kind of my bread and butter, and what I do day in and day out. So certainly I just wanna remind everybody that luckily, as therapists, we have sometimes the luxury of sometime, although

Emily Foxen-Craft: although families are often in crisis and want a solution. Now, just thinking about taking things step by step, and that you may be able to figure out things in a moment. But

also this could be more of a process where we're learning and refining our approach as we go. So

I think, though regardless, there are a couple of principles that you might wanna keep in mind.

I think. Oh, going back to the dismissal and validation. I don't know how fruitful it always is to decide what is real pain and what's not. We really conceptualize pain, any experience of discomfort and pain, whether it's nausea, or you know more of the classic kind of form of pain.

Emily Foxen-Craft: Really, being at the quintessential bio psychosocial

phenomenon. It's gonna involve part, you know, brain. And it's gonna involve up parts of our body communicating within each other that are influenced by certain biological factors that are influenced by mental and psychological factors as well as the social context that we're in. So I don't know how fruitful it is to really say, Oh, that's just anxiety, or that's just, or that's or that's true pain.

Emily Foxen-Craft: It really can be both. Of course, it is important to figure out if there is an infection or a fever, or something like that going on, so that those might be some clues about the source of some stomach pain. But beyond that, first of all, just, you know.

Emily Foxen-Craft: not trying to label it or dismiss it is a really good first step of just taking that pressure off of yourself as a parent or a clinician that being said, moving forward, if we've ruled out acute illness.

Emily Foxen-Craft: and that's been ruled out either by, you know, a parent's professional opinion or a provider. The ideas to move forward with

Emily Foxen-Craft: a balance of empathy, of saying, we,

I hear you. This is what you're going through. This is tough, but also a real focus on functioning. So even if a child is really struggling with chronic abdominal pain, the goal is to gradually help them overcome that and help them still figure out a ways to maintain their functioning like going to school, hanging out with friends, participating in sports

Emily Foxen-Craft: with their pain. Of course, we also wanna include some strategies for helping

manage the symptoms, prevent the symptoms. Handle them in the moment, but also regardless.

The focus is on helping them get into school, get on with their lives. For a lot of reasons.

It's interesting. This feels slightly related, but maybe not entirely. But this is not pain.

But

Allison Puryear (she/her): having raised my kids, who were really young during Covid.

Allison Puryear (she/her): where, if you have a sniffle, you don't go to school like you are meant to stay home. And now, being in a place where you can have a full on cold and go to school again,

they. They don't have a sense of that. So they're like, Well, I have a sniffle and a half, so I can't go to school and as being like. No, you still have to function

Allison Puryear (she/her): like you don't feel your best, but you're you're feeling great enough to play and you're allowed to be at school now, so it's time to go, and it just being such an interesting schema shift for them

Emily Foxen-Craft: of what you do when you don't feel good.

Allison Puryear (she/her): not just stay home and hang out anymore. It's the way it was a couple of years ago.

Emily Foxen-Craft: Yeah, that is a great parallel to think about. That might be relatively universal right now. When you've been experiencing pain pretty recurrently or frequently, it does shift your mental set around what's typical. What's normal pain universally is a signal of our body being in distress. That's what it's meant to do. It's an adaptive response.

Emily Foxen-Craft: So you can imagine the quintessential more acute pain. You bump your arm, you burn your finger. That signal is, gonna be really strong and really distracting and make you focus on it. It's gonna be super unpleasant for the purpose of keeping your body safe so that you don't continue to do that, and you don't do it in the future. So it's a learning experience as well. And so when we have chronic pain, for whatever reason, that signal we kind of have to uncouple it from that from that message that that's a signal. That's a danger, and that's a threat. And that's something really hard to overcome and do, because it's primed. It's natural within us to make those assumptions and those cognitive leaps when we're in pain. And so you know, and when you have the pain recurring chronically, it definitely shifts your mental set and around

Allison Puryear (she/her): your interceptive signals.

Allison Puryear (she/her): How does it work for like either anecdotally? Or what does the data say about parents who experience the same kind of pain as their children. Do they tend to be

Allison Puryear (she/her): more empathetic or less?

Emily Foxen-Craft: I'll say clinically,

I've definitely seen both. I think there is a large degree of concordance between parents, mental set and children's mental set around pain. So there is a construct called catastrophizing, which is an exaggerated mental set around pain. I hate the word exaggerated, but regardless. It's one that's commonly used. Or it could just be framed as a negative mental set around pain, which again, most of us don't have the most positive experience or thoughts around pain.

Emily Foxen-Craft: But it's this, you know, this response about pain, and how negative or the degree to which the appraisal is occurring. And so there is a lot of interesting data out there about the concordance between parents and children, or sometimes the dis-concordance. And what does that mean when they have different views on pain?

Emily Foxen-Craft: What's interesting, though, is at least clinically. I think this is an area that is just emerging as an area of research in pediatric pain. Is this concept of resilience? And I think it's particularly interesting in kids, because there's so many factors about kids that are naturally resilient. They're, especially these days, are used to overcoming tremendous changes into their lives and disruptions.

Emily Foxen-Craft: But regardless kids are sometimes really motivated to, you know, although sometimes we're not so motivated to go to school, some very much are, are very motivated to live their normal lives and have fun with their friends and do their activities, and often clinically I see kids who are much more accepting and open to trying different strategies and working through their pain. And sometimes it's more the parents who are the more distressed ones, or the ones who feel that things have to be fixed at all costs. which is a totally understandable perspective.

We would do anything to protect and and save our kids from any pain. But it is interesting sometimes to see that that perspective. Yeah, that's really interesting.

Allison Puryear (she/her): Is there a correlation with the way parents model their own resilience for their kids like, what

Allison Puryear (she/her): what do you think

Allison Puryear (she/her): makes one kid or a group of kids more resilience focused and they still want to participate? Does it also have to do with the

Allison Puryear (she/her): severity of their pain like, if it's more severe pain

Allison Puryear (she/her): and they know it's going to be forever. Is it like they're more desperate for that connection, and they're more willing to bear it like.

Allison Puryear (she/her): Explain the world to me. Sure. Sure, you know, that's what I love about

pain. There's so many different offshoots that we can explore and think about. It is a relatively newer field, and especially in pediatrics. Once we layer that concept of development onto everything. Is, you know, the child pain research is definitely sometimes behind.

In some ways the adult research, because so much more is able to be done in adults due to numbers

and due to a funding. But there's some really innovative and thoughtful research being done in pediatrics. So I'm so excited to continue to keep up in the literature. Regardless,

I think the question was about behaviors and modeling. And what do we see, or what are some of the factors that help kids be resilient? And again, I think there we

Emily Foxen-Craft: we can think a little bit about the Bronfenbrenner model of kids being in their ecological context. So there's definitely internal factors that maybe predispose or help kids be more resilient. And there's definitely a lot in their social contexts and their development through time

that affect how resilient they are. So there's lots of great internal psychological constructs that we see correlated with resilience things like optimism and skills and self care and

Emily Foxen-Craft: you know, certain mental sets and patterns and adaptive coping patterns.

Emily Foxen-Craft: there's a lot about, you know, internal locus of control and and things like that. But there's definitely lots of psychosocial concepts that we see being

Emily Foxen-Craft: being related. So I'm sure a lot of you have heard of adverse childhood experiences, and that we've also that

some research has started to explore positive childhood experiences. So

Emily Foxen-Craft: it's not just the lack of ACEs, but the experience of these PCEs in children's lives. That also seems to be related to better outcomes with pain. That may be indicators of resilience. So the things that some researchers have looked at with PCEs, although it's not as well defined sometimes, universally, as ACEs are

Emily Foxen-Craft: for things like having a resilient mindset in the family, but also living in a safe neighborhood, having a other positive adult mentors in someone's life, giving back to the community and volunteering are amongst a a set of different psychosocial factors that might help a child be more resilient in the face of pain. And then, once we start looking at the characteristics of the pain itself.

Emily Foxen-Craft: There's a number of different factors that we look at so certainly the intensity, certainly also the duration. So you can imagine, like an 18 year old, who's been really struggling with pain since

Emily Foxen-Craft: maybe middle school may have a different experience than somebody who's starting to get weekly headaches.

Emily Foxen-Craft: and they're 10 years old.

so that might affect things too. But also we look at things like the widespreadness of pain is an interesting concept that I and some of my colleagues have looked at. So that's the concept

of thinking about whether the pain is in one place like your head, your stomach, your arm, or whether you have pain in multiple parts of your body, or even all over your body, can definitely

that and that level. That distinction has been shown to be highly correlated with a lot of the outcomes that we're interested in. Like, how functional are are these children? How much are they living their lives on their levels of anxiety and depression, sleep problems, fatigue. So a lot of those things, as well. Hmm.

Allison Puryear (she/her): got it.

Allison Puryear (she/her): Yeah. Oh, there's so many questions in my head all at once.

Allison Puryear (she/her): I think about children

who are developmentally not in a place where they have a lot of language yet.

Allison Puryear (she/her): And how they communicate pain and what what gets missed and caught later like, how does the communication of pain when you don't yet have those skills.

Allison Puryear (she/her): How's that..,how does that work?

Emily Foxen-Craft: So you can think about age, you can think about different developmental trajectories and diagnoses impacting a person's ability to communicate about pain. So there's first the under the internal understanding about pain, and then there's the ability to express it as well.

Emily Foxen-Craft: So some of the most common measures of pain that you might see are definitely focused on the intensity of pain. How bad is it? And so you usually see that 1 to 10 scale or 0 to 10 scale

Emily Foxen-Craft: that might work for some children don't underestimate them. They've been asked that question before. If you're the provider, the therapist seeing them, someone's asked them that before on the flip side it can be a very abstract concept for them. So first of all,

if they are able to give you some response to the one to or 0 to 10 scale, I like to. I frame it to families like that is, that's not an objective criteria. It does not mean that your 5 is

Emily Foxen-Craft: better or worse than somebody else's 7 or 3, but we can use that as a frame of reference for saying, are things getting better? Are things getting worse?

Emily Foxen-Craft: So just kind of taking the that pressure off, but really focusing on the person themselves. Kinda making a person centered measurement system. And that's the creative approach I like to take with children, or even young adults who may be struggling with communication. Is really taking a personal approach, trying a few different things and seeing what clicks. So one great tool that works, especially with younger children, is bringing in familiar metaphors like a stoplight. So a lot of kids are familiar with the whole stoplight system,

whether it's from learning about rules of the road, or sometimes there's some games that involve around that and so I've helped kids kind of come up with a system of Emily Foxen-Craft: you know, red means it's really bad. Green means I'm feeling good, and yellow is somewhere in between, and that seems to work some well for some kids. You might even take out the yellow, if that's too much to add. And the nice thing about that tool is that we can also layer on to it Emily Foxen-Craft: plan. So if I say, I'm green,

this is what I'm gonna this is what my mom or dad are gonna do

Emily Foxen-Craft: if I say I'm red, this is what's gonna happen. And so it creates that sense of predictability. And and also some communication around that. So that's one kind of

tool I like to use. Cause I'm sometimes bringing in something that already has some meaning.

Emily Foxen-Craft: When we talk about pain location rather than just relying on verbal. You can have them point to their body. Point to a picture that's one that's been studied and validated. There's a map, a body map called the Super Kids Body Map, developed by a consensus group, I think, related to the

Emily Foxen-Craft: college of rheumatologists, arthritis and rheumatologists.

Emily Foxen-Craft: sorry bungled that one. But it is validated for kids as young as 8. So use it with clinical judgment around younger kids. That that's one great tool. That can be used as well. And certainly there are some.

There's the faces, scales, and there's also observational tools.

That you can be trained in and learn more about.

They're a little bit more intense, but they involve looking at facial, facial reactions, and different kind of utterances and body language as well.

Allison Puryear (she/her): I'm wondering. Is there a correlation between like age of onset and

Allison Puryear (she/her): resilience?

Emily Foxen-Craft: Hmm! That's a great question.

I'm not sure if I just haven't read it, or if that has not yet been studied,

the most kind of common age of onset, for chronic pain, at least in kids.

is more of the adolescent years or early adolescents kind of timed around puberty.

So there is kind of a somewhat lack of research, in even younger children, because it's hard to get sample sizes at all in pediatric chronic pain. And so much of the research is set at around those

adolescent years when we can at least get some reasonable sample sizes into a research study.

Emily Foxen-Craft: So I think that's one of the main reasons. I'm sure that's not the only reason,

but it's one of the main reasons there is a little bit of when you look up pediatric chronic pain research. You'll also look at and realize those kids are teenagers, and there's not a lot being done on the adolescent at the pre adolescent, school age, or even preschool years. So

Emily Foxen-Craft: I think that would be an extremely interesting question to study. Hmm.

Allison Puryear (she/her): Does most of the pain that kids feel? Is it? Most of it

Allison Puryear (she/her): have, like a diagnosable etiology? Or is it more nonspecific?

Emily Foxen-Craft: That's a that's a great question. So a lot of kids come into clinics.

Emily Foxen-Craft: Usually, by the time they come into a pain clinic they have collected a number of diagnoses because no one diagnosis is really capturing everything that they've been

through. I think the field is continuing to revise diagnoses and clarify things.

So the ICD-11, I think, like I mentioned earlier, came out with some new classifications around pain, which I think was really powerful, because previously it kind of been shuttled under other chronic pain.

Emily Foxen-Craft: and so including it as a valid diagnosis. That primary pain can be a valid diagnosis. I think, is a really really powerful first step. But some researchers have started to analyze the codes that are included in that. And I've realized that they it may not entirely map onto the pediatric experience. But this is very new.

So I think in the coming years there'll be some research into

understanding what maps onto pediatrics, and maybe what are some gaps, or maybe some additional diagnoses that they should create potentially for pediatric populations.

Emily Foxen-Craft: But luckily, I think there are a few common ones that you might see in your clinic, or that something might come in with. So there are certainly a number of migraine and headache diagnoses that somebody might have. There's kind of something called

functional abdominal pain, which I'm not sure has a code. Might be just other abdominal pain.

Emily Foxen-Craft: But that's a common, a diagnosis that's given when the pain is kind of idiopathic, or that there's no IBD going on

Emily Foxen-Craft: similarly, there's some more muscular skeletal pain conditions that are pretty

common in pediatrics. There's something called CRPS. Complex Regional Pain, Syndrome, Chronic

Regional Pain Syndrome. There's a couple of types of that one it used to be called RSD, so if you

have any people coming in with that diagnosis that is, that maps on and there's something called.

Emily Foxen-Craft: There's some debate in the field about what

it should be called and that's called Amplified Musculoskeletal Pain Syndrome,

or AMPS. I always tell that one to kids. And because it's a mouthful other parallel

diagnoses that you might see to that one are like juvenile fibromyalgia. So there's some

debate about whether it's true fibromyalgia when it present similarly in kids. So hence

Emily Foxen-Craft: hence the need why, somebody you could see might accumulate a lot of these

different diagnoses depending on where their pain is presenting which specialists they've seen. So if you go to a GI, you're gonna get a certain diagnosis versus. If you see

Emily Foxen-Craft: a headache specialist - a neurologist,

you can get a certain diagnosis. And some of these clinicians either aren't considering

the person holistically or don't even ask "Where else are you experiencing pain?" They're focusing on

their specialty. And so that's why we have the opportunity to think really broadly,

think about a whole person, and work with providers to help kids get the best diagnoses and the best

Emily Foxen-Craft: understanding of their pain.

Emily Foxen-Craft: And so sometimes, you know, if they see a specialist. They get one diagnosis,

but then you're talking to them in your life, and they have pain in so many different parts of their body. Maybe there's something more holistic going on your whole central nervous system kind of condition rather than just having to do with this one body part.

Allison Puryear (she/her): Huh? How much collaboration do you end up doing with physicians like per client?

Emily Foxen-Craft: Sure, that's a great question. So up until recently, I've been having the luxury of working at a tertiary care Medical Center. So

Emily Foxen-Craft: I was working directly in clinics with other providers. We were all on the same electronics system. So that was really fluid and really easy, and a lot of collaboration, and since I've been in private practice, I've been making an effort to keep up at a good degree of that collaboration. Although it's certainly harder to have to get releases. And it's not as easy just to catch people on the fly. But I think

Emily Foxen-Craft: I think it's really a great idea to continue collaboration, because it is ultimately what's best for the patient or the family or client. There, as we kind of talked about at the beginning, there's so much dismissal and validation

Emily Foxen-Craft: cross messages, different messages. And it can be really overwhelming for a family to try to navigate all the different messages, the ideas and potentially even contrary recommendations. So I think it's really critical to be collaborating.

Emily Foxen-Craft: I'm thinking I kind of want to go back to the ACEs and the like PCEs.

Allison Puryear (she/her): When a child has pain and maybe a lot of ACEs as well

Allison Puryear (she/her): does increasing their PCEs help?

Allison Puryear (she/her): Is that ever a part of treatment?

Emily Foxen-Craft: That's a great question. I read some of that research, and it was done in community samples. So it wasn't a treatment study per se or clinical study. But it did seem like in the context of ACEs having some PCEs mitigated or buffered some of those negative effects. So I certainly think that some of those things may not be in our control as therapists where patient lives or family lives

Emily Foxen-Craft: may or may not have a good degree of flexibility, but I think there's a lot that we are in our control, or you know, it is in a family's control that we can empower them to work on. And I think it is a really empowering message of, because sometimes

Emily Foxen-Craft: ACEs I think it's so sensitive, you know, so important for us to be so informed and so sensitive to those things, but it can sometimes feel a little defeating like I had this thing happen to me. And now my whole life, you know, is gonna revolve around that experience.

And I can't change it because it happened. But thinking about well, what can we add in

Emily Foxen-Craft: to change long term outcomes? And I still have a, you know, a sense of empowerment about about my life, I think, is a huge, hugely impactful message to share with children and families.

Allison Puryear (she/her): So just thinking about like treatment modalities, and kids with chronic pain. What modalities do you see used with the most success? Are there any sort of alterations that need to be made for this population.

Emily Foxen-Craft: It's a great question. So the most commonly studied or and described in the research pop form of treatment is called cognitive behavioral therapy or CBT. And luckily there have been books and manuals published on this subject. So there have been people who've studied how to adapt CBT for pain and specifically for children. Of course, when you're working within a specific child, you wanna take it as still a personalized approach. And think about where their priorities might be. Here, what's a good fit for them?

Emily Foxen-Craft: There's some really common core elements included in a pediatric pain CBT approach that could be useful, I think, for most children, regardless of their diagnosis or particular etiology of pain or duration of pain. So that's the most commonly described one for children, and like really young children, there may be adaptation of more behavioral principles.

Emily Foxen-Craft: focusing on parent management and then teaching some more behavioral coping as

children develop. You stop really thinking about 7, 8 years old, we might again, on average, be able to incorporate some more of those cognitive strategies, and as children even develop further into adolescence, I think it's really exciting to be able to bring some ACT principles into. There's a lot that we can do with cognitive diffusion and acceptance and values based living. That, I think, is very applicable.

Emily Foxen-Craft: So I think there's a lot of great move to incorporate some of these different techniques. And there is some emerging literature around more positive psychology around this resilience building. So not just fixing a problem, but developing positive resilience and growth. Is, are some of the exciting things that I've seen. There's some new stuff about pain reprocessing, which I think is just an application of CBT principles.

That we've seen pop out, and then those are the ones that are, I think you know, are more directly

related to most children with chronic pain. But you know, I think it's important to take

a lens on what is going on with a child's life, so are they. Do they have coming? Are they coming

in with a history of trauma? Are they also, very depressed or very anxious and develop some GAD

Emily Foxen-Craft: maybe part of it's related to their pain. Part of it's not. And so, thinking broadly about the treatment and what components of treatment are relevant for a particular individual. You may be thinking just because they have pain. You may still need to be thinking a little bit more broadly.

Got it.

Allison Puryear (she/her): I'm thinking about like therapists who are already working with kids for,

like other presenting concerns, and then find out. This child has some chronic pain that's been going on that either has or hasn't been disclosed to parents.

Allison Puryear (she/her): What would you tell this therapist, who isn't as well researched as you doesn't have the clinical experience with pain like, is this some? Is this a child that should be referred to a specialist? Is this a child that can be handled by this clinician with some consultation or some extra learning. What would you recommend?

Emily Foxen-Craft: Sure. So I think all of the above options are on the table.

And so maybe here are just some things to think about. And some options to, you know. Consider or wait, or our framework of thinking about this. So first of all, you know, validate the fact that they're bringing it to your attention and say, Hey, this sounds like it's really important. Assess a little bit more. What's going on?

Emily Foxen-Craft: If it hasn't been shared with anybody else, why is that the case? Is it just new. What's the reason going on there? And also really, try to assess the impact on functioning. So is this, maybe one of the reasons that we're not going to school, or that we're nervous about going out in public or things like that. So kind of getting a sense of how.

Emily Foxen-Craft: if you think about a person as a whole. To what extent is the pain, part of their experience and part of what's affecting their lives, and that might guide you a little bit in your treatment. So if they, if this is a portion of what they're dealing with. But it seems very related to the work that you're already doing with them. I think there's so much that therapists

don't realize that they can do to help with pain that is in your tool kit that you can use to help

Emily Foxen-Craft: if, for whatever reason, either, it feels completely out of left field.

If it feels like you're already trying to tackle so much. And pain just doesn't feel like something it can that can fit in with your treatment plan. Or maybe if it's impacting, functioning more, and you've tried a few things, and it's just not clicking or going anywhere. You feel you and the family feel a little bit out of your depth. That's a great time to reach out for either consultation

and some guidance.

Emily Foxen-Craft: or maybe to work refer, and it could be a collaborative treatment approach.

So I think all options are on the table. So there's a lot of things that therapists like,

I said can do that are probably already in your tool kit. That you can use to help. So if we think about CBT, for instance, if that's an approach that you're comfortable and familiar with.

Emily Foxen-Craft: Just taking a moment reading through a treatment

manual or reading some articles online. I think I've linked,

or where we might be linking a few resources in to this session. Today.

Emily Foxen-Craft: that may be able to guide you into saying, oh, I didn't realize like

that. That's how I could just tweak that one or apply that one skill. So some common things are working on behavior change. That's all thing a lot of us do and so sometimes there's things

like sleep management, activity pacing, thinking about someone's time management and schedules.

And

Emily Foxen-Craft: that might really play a role goal setting

solving problems. Those are skills that a lot of us help clients with all the time,

and then our thoughts and it to add changing our reactions to uncontrollable circumstances

is definitely something many of us do and so if you're comfortable working with children, there's

probably a lot that you're comfortable with doing when it comes to pain. Okay, that's good to know.

Allison Puryear (she/her): I'm wondering about unsupportive parents,

and how clinically you manage that.

Emily Foxen-Craft: Yeah, that's the toughie for any any challenge that any of us are facing.

I was wondering if you could add, Tell me a little bit more about what you're envisioning,

or or maybe a hypothetical. Yeah. So maybe I'm imagining parents who are like, oh,

it's just anxiety. Like, if you stop focusing so much on the pain it they'll stop acting

like they're in pain all the time, like that kind of idea. I'm thinking about

Allison Puryear (she/her): a family that I've I've known of,
just like just don't pay any attention to it. It'll go away. That kind of a mindset.

Emily Foxen-Craft: Yeah. So one modality of treatment that I have not really
brought up so much, yet is motivational interviewing, and that might play a role
in something like this in combination with some education. So first of all, you know,
there may be kernels of what somebody saying that are true. Right? So maybe there's a kernel
of what this parent is saying that, hey? You know the attention that we pay to pain

Emily Foxen-Craft: does factor in right and then the more we do avoid doing things,
the bigger they seem. That's all true for sure. And I'm so glad that you recognize that the mind
and brain play a role in our perception of pain. So many parents don't realize that.

Emily Foxen-Craft: But I also want to think about the biopsychosocial phenomena and
recognizing that

this is a 2 way communication between the brain and body. And there's something off
here that it keeps perpetuating. So why don't we work together to help get your
child to your goals of getting to school and not avoiding things, but take things step by step,
in a way that helps them get there, because what we've been doing so far hasn't.

Allison Puryear (she/her): Yeah. I love. How like empowering you are to
the parent in that conversation. Cause, I'm sure, like internally, I would be feeling
some frustration as the clinician of like trust your kid. Believe your kid, you know.

Allison Puryear (she/her): yeah, I'm thinking about how you were talking about. The onset
is often around puberty. Basically, when so many other changes are going on emotionally,
physically, all of it. Hormones are wild.

Allison Puryear (she/her): Our parents sometimes late to the game and realizing something
needs

to be addressed because there's it's like chaos already. And they were waiting for it to settle
down, or it was just a growth spurt, or whatever is there sometimes some some delay that
happens.

Yeah, there's there's definitely delays to treatment or delays to diagnosis that we see
in the literature. And I see clinically. And I think some factors are right related to.

Emily Foxen-Craft: you know, if it doesn't seem super intense, super urgent. We kind of wait and see

Emily Foxen-Craft: which is not a bad approach for a lot of things. So there's that component.

And then there's the component of working your way through a medical system that just takes unfortunately, so much time. So you get into. See your pediatrician, the pediatrician says like, Okay, let's wait a few weeks and and come back and see what happens. And then they see that it's not going away. And so then maybe you refer to a specialist, and that takes forever. And then they say, Oh, maybe now you need to go to a pain clinic. Because you know,

to get some rehabilitation or some education around it. And in that interval

Allison Puryear (she/her): it could be years. And the pain could have gotten worse. So I think there's so much that we can do if we're on the front lines of working directly with families. And you know, partnering. And, you know, serving as educators as well to our colleagues and different disciplines absolutely. And I think, like about pain meds and kids and adolescents talk to me about that.

Emily Foxen-Craft: yeah. So I I'm not a prescriber. So certainly. You know. Listen

to people who who know a lot more than me on the subject, but I'll touch on it just for a moment.

Luckily, I think for the most part the education has gotten out there, and most prescribers

Emily Foxen-Craft: are wary of Provi providing narcotics to

children. There's a lot of regulation, even around things like post surgical

Emily Foxen-Craft: prescriptions. So I think parents, providers are certainly wary,

but at the same time a parent will do anything at all costs to help their child. And sometimes there

is some very understandable medication seeking, and certainly a provider too,

who either is not as educated or is desperate to try to find something that helps

Emily Foxen-Craft: will try different things, maybe thinking at first it's going to be

a short term thing. However, the consequences of opioid type medications for children are

pretty extreme, and especially with the kind of pain that we've been focusing on so far today, which is chronic pain. Opioid medications have been typically shown to be actually more aversive, more have more adverse consequences than benefits.

Emily Foxen-Craft: And in fact, I think this is the one thing that's surprising to some people. It can actually cause hyperaladenia, which is more pain. Body, kinda I think, becomes a little tolerant of it, and the signals just become amplified, so it can actually have much more unintended consequences. And even make things worse than they were before. So I think that in terms of what we commonly think of as pain medications, opioid

medications. There's a huge move to move away from that for most children in most circumstances. And if you have questions about that, these are great times to be teaming up with a prescriber to ask these questions learn more and work together for the well being. That being said, there are some new nonopioid medications to help with different pain complaints.

Emily Foxen-Craft: Hate that word complaints. but regardless, some of them may be focused on the global body pains focusing on central nervous system. Some may be focused or prescribed more specifically for different kinds of presentations of pain. So

Emily Foxen-Craft: some, you know, there's some migraine and headache focused medications, and there's some

Emily Foxen-Craft: Gaebergic related medications. And sometimes SSRIs are used as well, and so there's no one chronic pain medication. But several have been used.

In pediatrics. But also sometimes. There's some really great data that show that the combined the combined power of psychology and medications can sometimes be greater than the individual

components. So I think there's some work that's been done in headaches and some works that's

been done in headaches that show that none of the commonly prescribed medications were

better than placebo. So I think there's a lot psychology offers in combination with the medical approach. That could be helpful for children. And there's been a lot of calls to have Emily Foxen-Craft: CBT to have psychology therapy be a frontline treatment as opposed to. Let's try medications, and if that doesn't work, then let's go to therapy. And it's kind of our last resort. So I think I appreciate when people are able to push that out that this is not stigmatized. We're not saying it's all in your head, although if it's a headache, it probably is.

Emily Foxen-Craft: but but yeah, I think they're, you know, educating yourself. If somebody comes in and they're on a prescription learning about it, talking with the provider, doing some research, understanding how it affects a particular individual? Are there positive effects? Are there negative side effects that they're dealing with, too, and learning both those the individual in front of you.

Allison Puryear (she/her): I think, too, about the the difficulty with kids communicating and referred pain.

Emily Foxen-Craft: And how that can sometimes be

Allison Puryear (she/her): like where the pain shows up may be a bit of a red herring. For the family like I'll I'll share. I shared this with you when we first spoke with my my youngest daughter, or my oldest daughter. When she was 5

Allison Puryear (she/her): or 6 she was 6, and she was throwing up all the time, and we went to her neurologist, and we were like.

Allison Puryear (she/her): is it her seizure medication? And he's like she's throwing up like 8 h after she takes it. I don't think it's her seizure medication. I think she has migraines. but it never occurred to me

Allison Puryear (she/her): that a child that young could have migraines like it just wasn't on my radar. I thought maybe around puberty

Emily Foxen-Craft: and

Allison Puryear (she/her): because she was never complaining of a headache like not once. She just

had, like gastric migraines. And so we kept thinking it was some sort of gastrointestinal

issue until we had that conversation with him. And then just got on some like he'd suggested some

supplements, some vitamins, really, that were have helped keep them at bay. Which was wonderful, but

Allison Puryear (she/her): how those of us who don't know or understand the body, or what can happen or make assumptions like I did that developmentally, she wasn't there yet for a migraine

Allison Puryear (she/her): like we can miss big, important things.

Allison Puryear (she/her): Just because we don't have the experience or the information.

Allison Puryear (she/her): Yeah.

Emily Foxen-Craft: yeah, that's complicated. It's why this field is so complicated. On the one hand there so many

avenues to try to come in and help on all these different angles. On the other hand, it could still continue to present mysteries to us. And so I think the biggest thing, I think, as a therapist is really being a partner and an advocate for the child and family that you're working with. Make sure they're getting connected with people to add and helping coach them. Okay, if I go to an appointment, this is these are the questions I should be asking and this is how I can monitor my symptoms to track progress. So be able to tell a physician or somebody like that, and working on the background in the in the back on the back end to talk with them and share with them while you're learning and

Emily Foxen-Craft: and and working together to try to help understand things. So you are not wrong in that situation, like we said, most chronic pain starts to occur around puberty and people don't often think migraine in younger children. I've seen, you know, photos and and ways of diagnosing children even in infancy and preschool. So it's it's rarer.

Emily Foxen-Craft: Certainly comes on. And then this, you know, either cyclical vomiting, syndrome or abdominal migraines as a whole.

Emily Foxen-Craft: It's a whole thing, too. but yeah,

it you're right. And where the person's having pain may not be

Emily Foxen-Craft: the complete story, at least.

Emily Foxen-Craft: And so I'll you know, just asking a lot of questions,

working together to try to understand somebody's entire presentation. I think

often we have the luxury of talking with children and families with a little bit less time pressure

and more frequently than pediatricians and physician partners. And so we can really help

Emily Foxen-Craft: even if we're not the ones ultimately make, you know better,

ultimately responsible for making an accurate medical diagnosis. We can be helpful in gathering

information, distilling it. Presenting it back to a family or back to a physician or partner. To

Allison Puryear (she/her): help work together as a team. Yeah. And I think,

like it really speaks to that holistic piece because we had gone to the pediatrician with

stomach pains, you know, and talked about diet and talked about, you know, like

Allison Puryear (she/her): like is it reflux. Is it this,

is it that? And it was just not on anybody's radar.

Allison Puryear (she/her): yeah, which can happen so easily, even with really

great providers. And and what's the role like? Let's say. we had come to you and

mentioned that as a therapist. Is it like within your scope to be able to say like,

you know, I think this may be potentially a migraine issue.

Talk to your doctor about that possibility. Like what's within scope. There.

Hmm. Great question. I think it is a delicate balance. So as a pain psychologist, and having had the experience of working in the clinics and in a pain specialty, pain clinic and embedded

in different specialty services. You know. I do feel like I have the language and the radar, and

Emily Foxen-Craft: know a lot of the questions that would be asked,

but I really try to gauge it on a family by family basis. Do. I feel like, if I share a

Emily Foxen-Craft: question about a diagnosis or a name of one, how's that gonna affect

this family? Are they gonna latch onto and be like. She diagnosed us with this.

Emily Foxen-Craft: Wait a minute. Do what I feel like. They would

understand that this is an approach as a way of asking a question

Emily Foxen-Craft: and either way of conceptualizing, even if it's not a firm diagnosis, or it's a way of taking that information and asking a medical provider who is qualified to make a diagnosis.

Emily Foxen-Craft: So I think those I would. I would kind of read the room essentially got it.

There, you know there are. Yeah, I think it's important to be a good partner. To a family.

Help them connect the dots, but also leave some leave the right words to the right person.

Allison Puryear (she/her): Got it. Are there ways in which

Allison Puryear (she/her): you see therapists sometimes? Overstep

Allison Puryear (she/her): when it comes to pain like something that we can all be really conscious of going forward so that we don't do that.

Emily Foxen-Craft: I think balance is a keyword. So if you are starting to notice, we're leaning into one extreme right, we're leaning into

Emily Foxen-Craft: pushing them to do everything, and it completely ignore their pain, and it feels really extreme and kind of boot campy. Alternatively, if we're leaning too far into oh, just rest.

Emily Foxen-Craft: It's your body, you know. It's, you know, completely don't do anything. You know. Stay at home. Don't go to school. Kind of completely withdrawing from life. Those might be indicators that we're missing something in our conceptualization,

missing something in our treatment approach. And so those would be kind of common errors, I see,

are not errors, but common tendencies I see that are have good intentions that sometimes end up back-firing a little bit.

Allison Puryear (she/her): I think about how

Allison Puryear (she/her): we we are a culture of dichotomies in the United States. And it's very much like, go hard and hustle,

or it's you know, self care and slow down. And I just want a slow life.

I feel like there's very little talk about the
in between and that balance that you just referred to.

Allison Puryear (she/her): And I'm guessing that,
and I'm curious if my guess is accurate, like the parents bent

Allison Puryear (she/her): is what they then pass on to the kid. And
how maybe the therapists bent might also be something to be
aware of. Is that accurate? Or do you see it sometimes going the opposite?

Emily Foxen-Craft: Yeah, I think sometimes we we try to do the opposite of what we've been
told or what we brought up with, that we more often than not end up living it out ourselves.

And so that's a good opportunity for, you know, any therapist to ask yourself what your own
pain

experiences like, what are your own beliefs and experiences and thoughts that you have
about pain, whether it's from a personal experience or somebody in your own life.

Emily Foxen-Craft: Maybe use this opportunity to educate yourself a little further on,
what's known ,what's still unknown out in the world about this field and try to bring in the
strengths

of your experience into into your therapy session as appropriate. But keep an open mind that
everybody's experiences are gonna be a little bit different and trying to keep the what's best for

Emily Foxen-Craft: your client or your the child in front of you. In mind. I like to always start
by asking, you know families, what's your goals? What are your values? And starting there?
Hmm.

Allison Puryear (she/her): yeah. And I think about as a parent like my knee
jerk reaction to that is like to make the pain stop forever. And so like clinically,
how do you work when families have unrealistic goals? Or how do you kind of

Allison Puryear (she/her): how do you break it to them that like this,
this is an ongoing thing that will be ongoing potentially forever.

Emily Foxen-Craft: That's that's a really hard

Emily Foxen-Craft: thing to hear. And it's hard because we don't have great

Emily Foxen-Craft: data on like exactly. This is gonna exactly what's gonna happen to your child. Are these the exact rates of of outcomes. Because with pain, we have so many different possible outcomes that we could look at that might matter. It's hard to narrow down certain percentages of like this many children get better because what is getting better? And so I try to help families put that out there. Hey? You know, we'd love for this to all go away.

Emily Foxen-Craft: But then I kinda take it in 2 different directions that I say first of all, well, if you got better. What would be better about your life? Right, if your pain went away. Kind of that, you know. Magic question kind of thing. If the pain went away, what would be better?

Emily Foxen-Craft: Oh, well, we'd be going to school, and we'd have fun on family activities. And we'd live so carefree. And I say, Okay, these are the things that actually really matter. Right? We need to be going to school. We need to be having more family time and family activities. And we need to feel confident and prepared.

Emily Foxen-Craft: And while to a degree, maybe these don't exactly occur on the exact timeline that we want, or maybe we get part of the way. But those are the things that we, those, are also the targets that we really should really be keeping in mind. Another way of asking that is, you know, how can we look at either proximal goals? So okay, let's say the pain isn't gone by tomorrow or next week. What would be at least a step in the right direction. Right?

Emily Foxen-Craft: But also kind of to keep in mind. Well, what are mold, the more ways we can measure success, I think the better we can be. So I always try to do some exercises around some flexible thinking.

Emily Foxen-Craft: and include the child in that they probably have things that they care about, too, and trying to at least start with the common ground between those lists.

Emily Foxen-Craft: Sometimes there's some differences. But you know, the more we can include some functional goals in there. Often, the better we can be.

Allison Puryear (she/her): What if there's some sort of associated disability or something like that. Where, like, you're not going to be able to play baseball while you're in your wheelchair. That kind of a thing is there?

Allison Puryear (she/her): How do you manage that as a clinician while having that conversation about what do you want for your life?

Emily Foxen-Craft: Yeah, that's a hard one is being attached to certain timelines, so I'll often be faced with somebody being like, well, tryouts are in 2 weeks. Kinda having a timeline around that. So we always try, because I think the goal is to attach the goal to something

meaningful and important to somebody but also being realistic. And so maybe saying, Okay, well.

Emily Foxen-Craft: you know, is there a way to also do baseball for the joy of fun.

Emily Foxen-Craft: for the joy of baseball? What are some things that we can do in between now and then.

Can we, you know, play a little catch even in the wheelchair? What are the stepping stones to getting up and moving. In the clinic I used to work in I had the luxury of working with some amazing physical therapists. So I think those are also people that we haven't talked about so far in this talk that are really underrated and could be incredible

Emily Foxen-Craft: partners in helping with rehabilitation. And there's so much that goes on with the physical rehabilitation that goes on with the mental rehabilitation in parallel and so some of the most exciting partnerships

I've ever had, and I continue to to nurture. Hmm, yeah, I love that

and I think about OT's also as being part of that team and being able to just surround the family

Emily Foxen-Craft: appreciate and sensory things that start to happen,

sensory sensitivities that begin to happen with chronic pain. And so yeah, partnering with as many

people as you can get on board. There's a lot of CAM, complimentary and alternative medicine people that can be incredible. A little less research on some of those areas. So I always tell families when they ask me about that, that unfortunately, there's not a lot of literature.

Emily Foxen-Craft: not a ton, especially in pediatrics, that I can go to to make a strong recommendation. But if you have people that you like that, that you think are sensitive to families, won't do harm. Then those might be great people to have as part of your network to help refer, cross refer, and build a little team.

Allison Puryear (she/her): Yeah, I love it. I'm thinking, too, just like recognizing

Allison Puryear (she/her): your passion and working with pediatric pain. And it being a less researched field like, does that get frustrating sometimes. Is it more exciting? Like, what's the emotional experience for you as a therapist in this

Allison Puryear (she/her): kind of up and coming with knowledge field.

Emily Foxen-Craft: All of it? Okay, yes, I wish we all knew more, but it's an exciting field to be in,

because there's so many great questions that you can ask and that have yet to be asked so luckily, I think there's enough out there that we feel like we can start, right. There's enough out there. And there's so much great, amazing work that's been done by some really incredible dedicated researchers and clinicians that we can draw upon in our clinical practice.

Emily Foxen-Craft: but I think you know we should all always be paying it forward in doing what we can to help good questions get answered and push the field forward so that we can understand more things and

Emily Foxen-Craft: and help children more and more grow and thrive. So whether that means, you know. I continue to keep up some of my partnerships and research and write papers whether it's bringing up to date research back to children and families in the public.

Whether it means, you know, engaging in advocacy and research and some different avenues. Even in community health or private practice. I think there's a lot we can do

Amazing. Or doing CEs like this to help educate other therapists. There's so much that you already know that you can draw upon and help serve as community leaders.

Allison Puryear (she/her): Umhm. Is there anything else you really want therapists to

Allison Puryear (she/her): start to understand about pediatric pain that we haven't talked about yet.

Emily Foxen-Craft: I think we've thrown around the word "biopsychosocial" a few times. And I just really wanna emphasize that I don't take that word lightly. And I mean every single component of it, plus probably more cultural developmental factors. There's so much that goes into the experience of pain. And so truly is not a dichotomy. There's not

Emily Foxen-Craft: body pain and emotional pain. It's all intertwined. We know that on a neuroscience level, we know that on an experience level,

Emily Foxen-Craft: so I think, just really moving away from that dichotomy, or trying to label a pain and really understanding it deeply for yourself, and

being able to communicate that with confidence. To people that you may come across that pain

is a connection. Pain is a communication between the brain and the body. You can't have one without

the other to experience this phenomenon. It's you know, it's it's a phenomenon, a a sensory phenomenon. So it all goes into it. Maybe some experiences have more of one than the other. But

we all have a role to play with helping children with any form or mechanism of chronic pain.

Emily Foxen-Craft: But there's a lot of resources out there. A few of them are being shared today.

And you can always reach out to somebody. There's a lot of children's hospitals may have experts,

or just Googling and me would be happy to always help. Amazing. Thank you so much for talking with

us, Emily. For those of you watching or listening who are interested in pain. Emily has some others

that she is doing with us, so make sure you tune into those as well. And yeah, I will see you soon.

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