# Behavioral Challenges in Pediatric Urology

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# PUNS

- Where are you from?
- Work with pediatric psychologists?
- Do you have access to child or pediatric psychology currently?
- What kinds of questions do you have?
- What can I help you with?

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# Objectives

- Establish interactive adult learning environment.
- Define pediatric psychology.
- Explain how pediatric urology and pediatric psychology overlap through case presentations provided by presenter and attendees.
- Illustrate how to collaborate with pediatric psychology and provide resources.

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# What is Pediatric Psychology?

- Interface of medical care and psychological, behavioral care
  - Subspecialty within child & adolescent psychology
  - Typically available in children's hospitals
  - Multidisciplinary teams
- Selected principles of behavior
  - Avoidance of pain, discomfort
  - Immediate Reinforcement and delayed reinforcement
  - Shaping
- Evidence-based practices

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# Potential areas of collaboration

- Behavioral versus structural enuresis
- Constipation affects urinary incontinence
- Children and parents don't follow the structured voiding
- Encopresis causing UTIs
- Comorbid conditions (e.g., autism spectrum disorders, cognitive impairment, attachment disorders)
- Additions?

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# Strategies

- Medical approach
- Behavioral
  - Urine alarm
  - Dry-bed training
  - Preventative (i.e., limit fluids)
  - Enuresis behavioral plan

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# Case 1: Comorbid ADHD diagnosis

- 10 y.o. female with ADHD
- Medical showed no structural enuresis
- Concern regarding possible neglect in biological mother's home
- Concern regarding possible sexual abuse by uncle, half brothers

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# Case 1: Comorbid ADHD Assessment

- No evidence of abuse or neglect
- Inconsistent use of methylphenidate
- Harsh consequences for pee accidents
- Bullying resulting in depressive symptoms

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# Case 1: Comorbid ADHD Treatment

- Evidence-based treatment components
  - ADHD medication compliance
  - Family therapy
  - Individual therapy for compliance and depressive symptoms
  - Behavioral toileting plan with scheduled follow-up

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# Case 2: Comorbid diagnosis

- Child with ASD with cognitive impairments (ADHD, sensory and enuresis), possible bipolar
  - Medications –lithium, propanolol, risperidone, trazodone
    - Possible polyuria, polydipsia due to lithium (but no accidents at home)
    - Recheck with psychiatry
  - Contained classroom
    - Token economy (school cash) wherein child are allowed to go to the bathroom at certain times
    - Penalty of $50 school dollars to use toilet at non-program times

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# Case 2: Comorbid Diagnosis Treatment

- Treatment components
  - Psychiatry review of medication side-effects
  - Allow access to bathroom without penalty!
  - Scheduled sits/stands with reinforcement ($)
  - Evidence-based behavioral plan for toileting ( )

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# Case 3: Interstitial Cystitis

Case 1: Interstitial cystitis

- 12 y.o. female
- Unable to complete medical test, attend school so likely anxiety component
- Urgent need to pee multiple times/hour
- Parents divorced, shared custody, 9 y.o. female sibling
- Lives in southwest Michigan area

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# Case 3: IC History

- Verbally combative relationships between mother and father, between father and step-father (e.g., altercations on soccer field)
- Parental histories positive for anxiety, medicated with sertraline
- Competitiveness between 2 female siblings to "win," "fairness issues"
- Previous individual therapy

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# Case 3: IC Assessment

- School issues
  - Teacher disallowing toilet breaks
  - Secondary gain balanced with anxiety
- Anxiety presentation
- Concern regarding possible sexual abuse
- Beck Youth showed high level of anger, anxiety

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# Case 3: IC Medical

- TENS unit
- Low dose sertraline

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# Case 3: IC Evidence-based Treatment

- Family therapy (Brock & Barnard 2009; Nichols, 2009)
  - Second divorce
  - Verbally combative biological parent relationship
  - Differing parenting (grandparenting) styles
  - Differing parenting RE: IC
  - Sibling competition
- Individual therapy
  - CBT— Fairness" (Christophersen & Mortsweet, 2003)
  - Anxiety treatment—Coping CAT (Kendall, 2006)

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# Other examples

- The child in foster care, adoptive home, reactive attachment, sexual abuse
- Major problem:
  - Is it a parenting issue?  Compliance?
  - Children do the best they can and they can do better.
  - Beware:  rarely a child has a psychological issue, much more often a child has a primary or residual behavioral issue
- Toileting can be carved out

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# Compliance

- "What is in your way? "
- "Maybe this problem isn't a high priority."

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# If there is no pediatric psychologist what do I do?

- Work with someone specializing in child work
- Find behavioral psychologists
- Be clear on referral issue
- Bend the system to patient needs (M.A., Admin support)
  - Referrals
  - Follow-up with family (leverage your relationship wit family, status as medical provider)
  - Follow-up with behavioral health

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# If there is no child psychiatry, what do I do?

- Limited availability of child psychiatry
  - Community mental health
  - University consultation programs

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# Resources


- Cunningham & Banez (2006). Pediatric gastrointestinal disorders: Biopsychosocial assessment and treatment. New York: Springer.
- Rapoff, M. A. (2010). Adherence to pediatric medical regimens. New York: Springer.
- Roberts, M. C., & Steele, R. G. (Eds.). (2010). Handbook of pediatric psychology (4th ed.). New York: Guilford Press.
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American Psychological Association, Division 54, Society for Pediatric Psychology

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# Resources

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