Somatoform, somatization and psychosomatic disorders in children and adolescents

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Somatoform disorders

- Somatoform conditions DSM IV
- Conversion disorder
- Hypochondriasis
- Pain disorder
- Somatization disorder
- Body dysmorphic disorder
- Undifferentiated somatoform disorder
- Icd 10: Neurasthenia
Somatoform disorders

- A FORM OF COMMUNICATION
  - Of personal distress
  - Disturbed interpersonal relationships
  - Or being in a predicament (Taylor and Garralda, 2003)
Prevalence

- More often diagnosed in medical settings
- Not all children referred to mental health professionals
- Lifetime prevalence in adolescents of 12% in German study (Taylor and Garralda, 2003)
- Of 7% (12 month incidence) at a certain point
- Roughly 10% of children
Epidemiology

- Survey 5 Nordic European countries
- 3760 representative school children
- 25% one somatic symptom weekly or biweekly (most common headache, abdominal pain)
- Mild 16%, moderate 7%, severe 0.8%
- A little more common in girls
- Reduced social competence in boys and girls
- Lower socioeconomical status
- Poorer health in mother


Epidemiology

- United Kingdom MRC, National Survey of Health and Development, cohort born in 1946
- Persistent abdominal pain in childhood (at points 6 years old, 11 and 15 year old)
- Associated with “maternal neuroticism” and family health problems
- At age 36, if multiple unexplained symptoms, hospital admissions for unexplained conditions: associated with persistent symptoms in childhood and parental poor health

What is psycho-somatic?

- The Cartesian dichotomy between body and mind
- Probably it should be abandoned
- Mind influences body and body influences mind
- Mind is intertwined (and is part of ) with the body, and vice versa
Mind body interactions

The MIND
(THOUGHTS, EMOTIONS, FEELINGS, EXPERIENCES)

THE BODY
Neurotransmitters
Hormones (e.g. stress)
Immune system
Organ systems
(e.g. musculoskeletal, digestive, Respirat.)
Old conceptions

- Conditions “were caused” by emotions and feelings:
- E.g. asthma “caused’ by separation anxiety
- Eczema caused by “maternal rejection”
- Arthritis, irritable colon, peptic ulcer, migraine, etc.
Newer conception

- “diseases” are multifactorial in their causation and course
- Interplay between “host” (the person) and “the illness” (infection, imbalance, structural disorder, etc.)
- The illness affects state of mind and state of mind affects the illness.
Psychosomatic

- Interaction between emotions, thoughts, reactions to a condition or diagnosis
- Influence of emotions in “etiology”, clinical course, prognosis, adherence to treatment, response to treatment
- Illness affects emotions and thoughts, directly and through indirect repercussions
Some conditions are “highly psychosomatic”

- Migraine. Influence of strong emotions, changes in routine, levels of stimulation, fatigue, diet, etc.)
- Episodes of migraine can be brought on by strong emotions or changes in the above
- Emotional response of the child to the migraine headaches, limitations on everyday activities, etc.
Psychosomatic

- Gastritis and peptic ulcer in children
- Anxiety is related to higher levels of gastric secretion
- Causes pain, irritation, feeling of hunger, heartburn
- Causes limitations, e.g. re school attendance
- The consequences of the gastritis may be worsened by parental or school response.
Psychosomatic

- Chronic fatigue in childhood
- Correlation with a viral infection in the past
- Correlation with depressive symptoms
- Correlation with stressors and life circumstances
- (previously “neurasthenia” ?)
What are “conversion” disorders?

- Transformation of a strong emotion or emotional conflict into physical symptoms
- Conversion indicates the condition has been transformed, now it resembles or “takes the shape” of a “physical” illness, e.g. paralysis, blindness, seizure, etc.
Symptoms

- One or more sensory or motor symptoms, deficits: suggest a neurological disorder or a general medical condition
- Association with psychological factors, or stressors, preceded it at times
- Not intentionally produced nor feigned
- Produces dysfunction and distress
- Not exclusively a part of somatization disorder
Conversion disorder

- The complain resembles a “medical” illness
- On investigation, the typical medical illness is not found
- The symptoms resemble the medical condition, often in the ‘folkloric’ view of the illness by persons of that culture
Common symptoms of conversion

- Impaired coordination, balance
- Paralysis of localized weakness
- Difficulty swallowing, lump in throat
- Aphonia
Common symptoms of conversion

- Urinary retention
- Hallucinations
- Loss of touch sensation, loss of pain sensation
Common symptoms of conversion

- Loss of touch sensation, loss of pain sensation
- Double vision, blindness, deafness,
- Dissociative symptoms: amnesia, loss of consciousness (not fainting)
Conversion

- For instance, anesthesia of the hand or the foot (glove and sock) anesthesia that does not follow the neurologically known dermatomes.
- Astasia-abasia, lack of balance but without falling and getting hurt, not being able to walk.
Conversion

- “blindness” without any evidence of damage to the visual pathways, retina or brain
- “pervasive refusal”, weakness, inability to face everyday life
Conversion

- “la belle indifference” (Martin Charcot)
- The person does not display the emotion one would expect from the condition at hand
- Rather there is a sense of relief or absence of distress with the condition
Etiology(s) of conversion

- A psychological conflict (e.g. repressed aggression or disgust)
- Repressed anger
- Repressed disgust
- E.g. “paralysis”, psychogenic cough, “knot in the throat”, difficulty to catch enough air
Etiology(s) of conversion

- Need to avoid an impending situation or conflict or difficult situation
- But “saving face”
- The avoidance is “due to illness”
- The person is not aware of the avoidance or conflict
- The person “really” experiences the pain, paralysis, blindness, etc. not pretending
Contributing factors

- Co morbid conditions in child., e.g. anxiety
- FAMILY contributors
  - High rates of medical illness in family members
  - Family’s attitude toward physical symptoms and psychological distress, or emotions
Conversion

- E.g. “not going to school”
- Due to illness
- Avoid separation from parents
- Avoid embarrassing situations at school
- Avoid facing difficult examinations
- Focusing the attention on oneself, distracting from something else
Etiology conversion

- There is a causal inference about what is happening, or the reason for the symptoms
- An “etiological’ diagnosis, not only phenomenological
- Another person can see the relationship between cause and effect
Differential diagnosis

- Sometimes there is really a medical condition
- E.g. back pain
- Several children were found later to have spinal cord compression

(Grattan-Smith PJ, Ryan MM, Procopis PG. Persistent or severe back pain and stiffness are ominous symptoms requiring prompt attention. J Paediatr Child Health 2000; 36:208–212.)
Examples

- A young man developed suddenly asthasia abasia. Hospitalized for tests, all negative
- He was “the most popular in class”
- A peer had just joined the class a few weeks earlier
- He had “displaced” the patient in his position as “the best”
examples

A 14 year old girl developed weakness of the legs, unable to walk or support weight.

High pressure by family to always get excellent grades.

Difficulty with an upcoming examination for which patient was not prepared.

She “had to miss’ the test because of illness.
Differential diagnoses

- Distinguish conversion from
- Malingering
- Factitious disorder
- Munchausen syndrome by proxy
- Hypochondria
- Secondary gain associated with chronic illness
Pain disorder

- Psychological/emotional factors judged to play a role in the causation, appearance, severity of the pain, exacerbation of the pain, or its maintenance
- Subtypes:
  - Associated with psychological factors
  - Associated with both psychological factors and a medical condition
  - Associated with medical condition only
Hypochondriasis

- A “tendency to worry about the body”
- Hyper-alertness to small signs of dysfunction or changes in the body
- Preoccupation with being sick or developing a worse condition
- Often associated with history of losses and stressors
Hypochondriasis symptoms

- Preeoccupation one might have or has a serious medical condition
- Misinterpretation of bodily symptoms
- Preoccupation persists, despite reassurance and diagnostic examinations indicating the condition does not exist
- (not delusional belief, nor only about body image or appearance)
Hypochondriasis symptoms

- Preoccupation has lasted more than six months
- Causes significant distress or impairment of psychosocial functioning
- Not another somatoform disorder, nor accounted by OCD, Anxiety dis., generalized anxiety, major depression, or separation anxiety
Hypochondriasis in the parent

- The caregiver is worried about a medical condition in the child
- Cannot be reassured
- Seeks constant tests, examinations
- The perception of the symptoms is “real”, i.e. not lying
- The parent is extremely attentive to the smallest signs of dysfunction in the child
Hypochondriasis in the parent

- Frequent calls to pediatrician
- Frequent visits to the emergency room
- Frequent checking of the child, fear she or he will die
- Often, history of losses, abandonment, death, separation from caregivers
- Other anxiety symptoms in the parent
Somatization disorder. Briquet’s syndrome

- Not seen in children, but relevant
- In terms of the frequent antecedents of maltreatment/abuse
- History of many physical complains
- Begin before age 30
- Have lasted several years
- Treatment sought or causes impairment
Somatization disorder

- FOUR pain symptoms
- At least four different sites or functions
- Head, abdomen, back, chest, joints, extremities. During menstruation, urination, rectal pain, or during intercourse (dyspareunia in women)
Somatization symptoms

- TWO gastrointestinal symptoms or a History of two of those
- OTHER than pain
- Nausea, vomiting (not during pregnancy), acidity, bloating, diarrhea, intolerance of several different foods
Somatization symptoms

- ONE sexual symptom
- Other than pain
- Sexual indifference
- Erectile dysfunction, ejaculatory dysfunction
- Irregular menses, excessive menstrual bleeding, vomiting throughout pregnancy
Somatization disorder symptoms

- ONE pseudoneurological symptom
- Not only pain. Symptom suggests neurological dysfunction
- Impaired coordination, balance
- Paralysis of localized weakness
- Difficulty swallowing, lump in throat
- Aphonia
- Urinary retention
- Hallucinations
- Loss of touch sensation, loss of pain sensation
- Double vision, blindness, deafness,
- Dissociative symptoms: amnesia, loss of consciousness (not fainting)
Factitious disorder

- Uncommon in children
- The patient him or herself misrepresents symptoms
- i.e. “fakes” or pretends to be sick
- There is no immediate or primary gain from “being sick” (disability income, indemnization, etc)
- Interest in having explorations and operations
Dysmorphic disorder

- Preoccupation with an imagined defect in appearance
- If a slight variance, the concern is out of proportion or markedly exaggerated
- Causes distress or impairment
Munchausen syndrome by proxy

- The caregiver (most commonly the mother) lies about the child’s symptoms.
- Fabrications regarding bleeding, fever, other symptoms,
- May damage the child in order to convince the doctor there is an illness (make bleed, make have diarrhea, choke, smother, etc.)
Munchausen syndrome by proxy

- The caregiver intends to deceive the physician
- Caregiver attempts to defeat the doctor, may be the underlying dynamic
- If necessary, doctor shopping or go to other hospitals
Intervention

- The first step is the diagnosis
- Caution. Some patients diagnosed with somatoform disorder turn out to have a medical condition in the long run
- Diagnosis in collaboration with an expert e.g. a child neurologist or other specialists
- Mostly a diagnosis of exclusion
Intervention

- Understand the dynamics of the situation
- i.e. the situation from the child’s point of view
- And from the family’s point of view
- Attempt to resolve the conflict or stressor that may be related to the symptom
Intervention

- Psychotherapeutic, expression of repressed feelings, reactions, anxieties, anger, etc.
- Allow alternative expression of feelings
- Allow the child to “save face”
- Avoid embarrassing child with diagnosis
- A “rehabilitation regime’ may be necessary which may assist the child to give up the symptom of conversion
- Relaxation techniques
- Cognitive and behavioral techniques
Intervention

- Address comorbidity, if any
- Family approach.
  - Empathy
  - Illness beliefs
  - Facilitation of recovery
  - Expectations and support
Intervention

- At times negative reinforcement
- E.g. strict bed rest
- The child is “ill” ergo cannot play certain games
- Consequences of “disability”
Form an alliance with the patient and family

- Be direct; avoid deception in explanations and treatments
- Offer reassurance when appropriate
- Use cognitive and behavioral interventions
Campo and Fritz Model

- Use a rehabilitative approach
- Use positive and negative reinforcement
- Teach self-monitoring techniques (eg, hypnosis, relaxation, biofeedback)
- Consider family and group therapies
- Improve communications between clinicians and school

Campo and Fritz Model

- Consolidate care when possible
- ● Aggressively treat comorbid psychiatric conditions
- ● Consider psychopharmacologic interventions
- ● Monitor outcome