

Clinical Practice Guidelines for the Management of Pediatric Somatoform Disorders

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INTRODUCTION

Somatoform disorders are characterized by the repeated presentation of physical symptoms which are not explained by any physical disease. If the physical disease is present then the level of distress and impairment is much more than expected by the physical disease. These patients persistently request for investigations despite of repeated normal findings and reassurance by the doctors that nothing is physically wrong. The somatoform symptoms are not under voluntary control. These patients often have a degree of attention seeking behaviour. They are usually diagnosed by excluding organic causes for the physical complaints. Despite absence of any physiological abnormality these patients show considerable distress and impairment.

The group consists of several disorders. ICD-10 (WHO, 1992) included somatization disorder, undifferentiated somatoform disorder, hypochondriacal disorder, somatoform autonomic dysfunction, persistent somatoform pain disorder and other somatoform disorder under this category.

CLINICAL PICTURE

There are no systematic studies of these disorders in children and adolescents.

Commonly reported symptoms in community studies in children and adolescents are headache, abdominal pains, limb pain, fatigue, gastrointestinal symptoms and multiple symptoms (Eminson et al., 1996, Taylor 1996, Alfvén 1993, Garber et al., 1991). Somatoform disorders increase with age and are more common in females during adolescence (Eminson et al., 1996, Taylor 1996). Children and adolescents with somatoform disorders are more prone for other psychiatric disorders like depression, anxiety and school refusal (Campo and Fritsch, 1994, Egger et al., 1998, Campo et al., 1999).

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ETIOLOGY

Exact etiology is not known. However, psychological causes are judged to be present. Association of somatoform disorders has been seen with psychosocial stressors and the symptom severity also fluctuate with them. Patients with somatoform disorders are more likely to come from low socioeconomic status and broken or dysfunctional families (Campo et al., 1999). Anxiety and depression is more reported in families of somatoform children. Presence of chronic physical illness in family may be associated with increased somatic symptoms in children and adolescents. Childhood physical and sexual abuse may be associated with more somatic symptoms in children and adolescents (fritz et al., 1997).

DIFFERENTIAL DIAGNOSIS

Somatoform disorders should be differentiated from Dissociative disorders, malingering, factitious disorders and elaboration of physical symptoms for psychological reasons.

INDIAN STUDIES

Indian epidemiological studies in pediatric population also did not report somatoform disorders (Srinath et al., 2005, Hackett et al., 1999) although children with somatoform disorders are seen in Indian child psychiatric clinics. On PUBMED medline search using key words somatoform disorders, somatization disorder, body dysmorphic disorder, hypochondriachal disorder, children and adolescents, and management, we did not find any Indian study.

ASSESSMENT

These disorders are difficult to diagnose early because a pediatrician must rule out an organic basis for all somatic symptoms. Evolution of full clinical picture may take time. Pediatrician may refer a case without a complete assessment and without clearly telling the family that the 'symptoms' are non-organic and therefore neither dangerous / life threatening nor will become so in future. The child may be vaguely labeled 'mental', 'neuro' or 'psycho' and the pain ascribed to psychological reasons. Such labels are not acceptable to the family and cause resentment. The child and family have almost fixed beliefs that the child's problems are due to an undiagnosed serious physical disorder. Psychiatric work up to elicit a psychological cause for the physical symptoms is often resented and rejected by the child and family. Not doing physical investigations and not prescribing medication is taken as incompetence or negligence. Therefore, the pediatrician and the psychiatrist must liaise with each other. The diagnosis of these disorders should include the exclusion of organic causes as

well as elicitation of correlated positive psychological factors. One should look for the temporal correlation of physical symptoms with significant psychological stress, prior history of unexplained physical symptoms, social or familial reinforcement of symptoms, model for symptoms within the family or environment, and comorbid psychiatric disorder. One should assess responsiveness of the symptoms to placebo, suggestion, or psychological treatment. Information from the school can be very helpful, since school avoidance due to learning or other problems can be a reason of the psychological stress. Similarly, family dynamics and environment may be the underlying psychological factors, especially if there is a family model for disease or the child has separation fears. Exploring the family's understanding of and response to the child's symptoms is crucial to comprehending the factors maintaining and perpetuating the situation. One must assess concerns about appearance and body image to screen for body dysmorphic disorder (Dingle, 2005, Campo & Fritz, 2001).

TREATMENT

There is no consensus about the management of pediatric somatoform disorders. Treatment approaches should be individualized for each patient. However, for most of these disorders, a treatment plan should be devised that includes coordination between medical providers. Liaison and coordination between the primary care physician and a psychiatrist, either as a provider or consultant is suggested. These patients and families are often reluctant to be in psychiatric care. The primary care physician or the pediatrician should prepare the child and family for psychiatric consultation which may have to be a long-term goal.

It may be helpful to consider treatment in stages with having immediate, short-term, and long-term goals. Immediate goals can be cessation of inappropriate medical interventions, ensuring the safety of the child, engaging the family in treatment, and arranging ongoing care. Short-term goals can be preventing further unnecessary medical interventions, maintaining reasonable medical monitoring, symptom reduction, and steps to initiate age appropriate activities. Long-term goals can be appropriate use (not overuse) of medical care, resolution of symptoms, development of appropriate coping skills to deal with psychological and environmental stressors, and resumption of age-appropriate activities.

The pediatrician must clearly tell the child and the family that there is no serious, underlying physical disorder causing somatic symptoms. He should then prepare the child and family for psychiatric consultation. The psychiatrist should carry out a complete psychiatric assessment using a diagnostic interview schedule wherever possible and assess differential diagnosis of and impairment due to somatoform symptoms. The psychiatrist should then diagnose somatoform disorders using the current diagnostic criteria. Wherever standardized assessment tools are not available, the psychiatrist should carry out an unstructured assessment including the

clinical and diagnostic features of somatoform disorders and the differential diagnosis.

Psychoeducation about the disorder should be imparted to the child and the family in the simplest possible terms avoiding attempts to overpsychologize. If the above diagnosis is acceptable to the child and his family, further psychiatric management is continued. If not, the child is referred back to the pediatrician for his opinion about the nature of the symptoms.

For somatoform disorders the psychiatrist does not make any more physical assessments. He encourages the child to talk about his feelings, thoughts and stressors. The psychiatrist expresses his acceptance of the child and his symptoms. He assures the child and his family and encourages the child's return to normal daily activity and school. Anxiety, depression or other comorbidities are handled using cognitive behavior therapy, and medication if required. Regular contact is maintained. If new physical symptoms arise, the psychiatrist decides about their further assessment.

In addition to above one may also try expressive writing about emotional or neutral topic, aerobic exercises, drawing and painting or anything to encourage emotional and thought expression (Peters et al., 2002, Soliday et al., 2004). Although not systematically studied cognitive behaviour therapy including reattribution should also be tried in somatoform disorders wherever possible. Otherwise one may try individual supportive psychotherapy.

These patients and the families often arouse negative responses in medical professionals and hospital staff. The staff can feel frustrated and angry. There can be beliefs that these patients and families are abusing health care resources, wasting the professionals' time, and no intervention will help. The psychiatrist can help in these situations by providing education about these disorders and their management to the primary care providers. He may also help the staff in coping with their reactions (Dingle, 2005, Campo & Fritz, 2001).

SUMMARY MANAGEMENT

1. Pediatrician must rule out an organic basis for all somatic symptoms.
2. Pediatrician and the psychiatrist must liaise with each other.
3. Pediatrician should prepare the child and family for psychiatric consultation.
4. The diagnosis of these disorders should include the exclusion of organic causes as well as elicitation of

correlated psychological factors.

5. Systematically assess for psychosocial factors from multiple informants including school.
6. Treatment planning should include immediate, short-term, and long-term goals.
7. Encourages the child to talk about his feelings, thoughts and stressors.
8. Encourages the child to return to normal daily activity and school.
9. Somatoform disorders should be treated with cognitive behavior therapy that includes cognitive reattribution of cause of the somatoform symptoms.
10. Comorbid psychiatric disorders should be handled using cognitive behavior therapy and medication, if required.
11. Regular contact should be maintained.

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