Somatization disorders in children and adolescents

Dr Anita Tsang Department of Paediatrics & Adolescent Medicine Queen Mary Hospital The University of Hong Kong Somatization (體化症/身心症)

- 身心症就是一種以身體形式呈現心理問題的病症。
- Communication of emotional distress, troubled relationships and personal predicaments through bodily symptoms



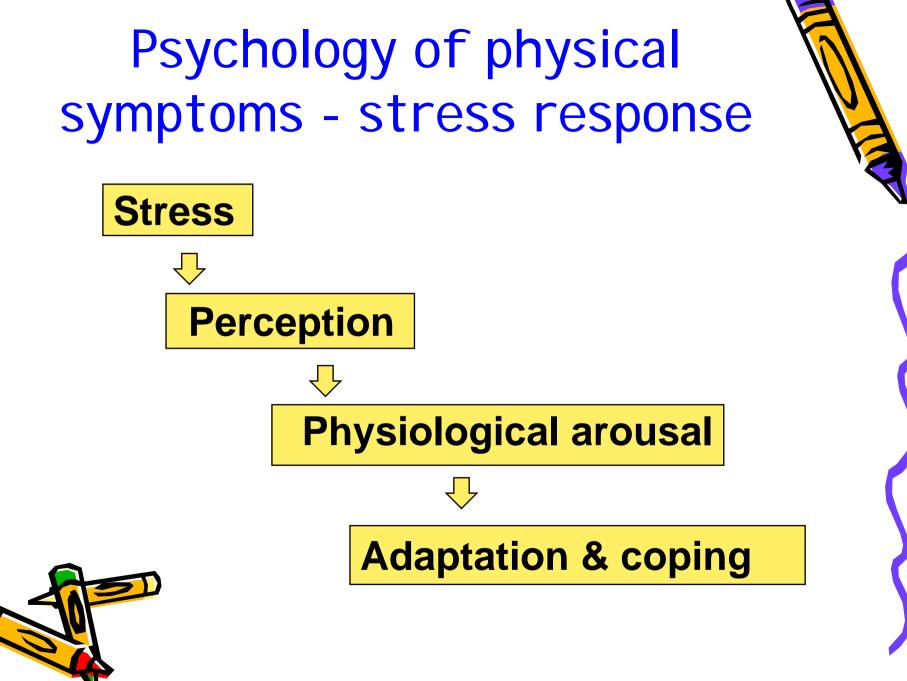
- 其症狀很類似身體疾病
- 1.它不是生物醫學、藥物使用或其他精神病症 所能解釋的;2.個人感到痛苦,社會、人際、 職業等功能受到影響;3.非人為因素刻意呈現 的。
- The physical symptoms
 - suggest an underlying medical condition but no organic cause can be found. "Medically unexplained symptoms"
 - cause distress or functional impairment
 - not under conscious control nor intentional



Case 1- A 11 year-old boy with abdominal pain

- F. 1 student with good past health
- Attended OPD for recurrent abdominal pain for 2 months (Oct – Nov)
 - Started off after an episode of gastroenteritis
 - Periumbilical, colicky, occurs every morning, so severe that he could not go to school. Has been absent from school for 1 month
 - Less severe attacks during weekends. No attacks during sleep.
 - Normal appetite. No weight loss.
- Normal physical examination.
- Satisfactory school performance. New school, few friends







The Body and the Mind Body Mind

心理

肝火 、脾氣 、膽小 氣得我話都說不出來

這件事令人頭痛

生理

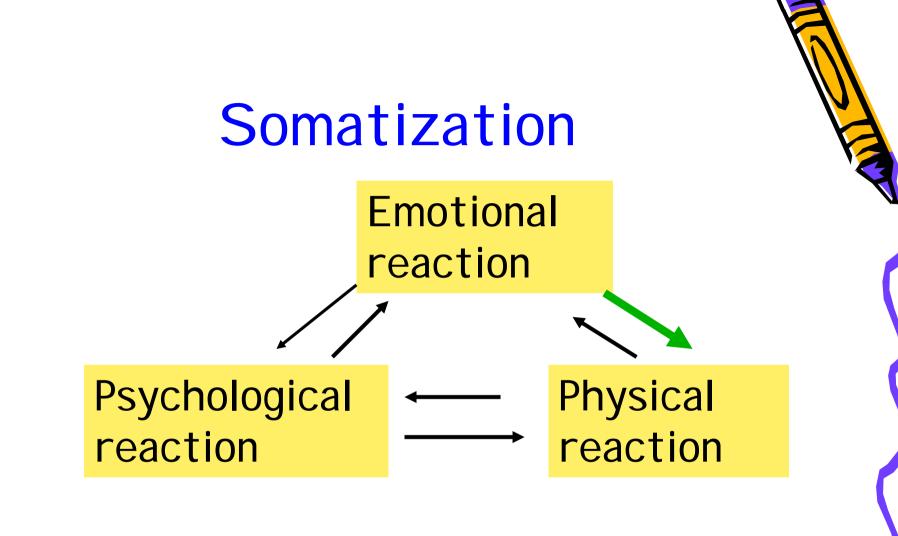
那人使我人嘔心

忙得我頭昏眼花



Common somatic symptoms

- 疼痛:頭、腹、背、胸、四肢、關節
- 呼吸困難或窒息感、 心悸、胸痛或胸悶
- 胃腸道症狀:噁心、脹氣等
- 假性神經學症狀:麻痺、失聲、目盲、耳聾、發抖或 類似癲癇發作等問題
- Pain: back pain, joint pain, limb pain, genital pain
- Heart & lung: difficulty in breathing, palpitation, chest pain
- Gut: abdominal pain, nausea, vomiting, poor appetite, diarrhoea
- Nervous system: headache, dizziness, difficulty in swallowing, visual problems, muscle weakness, tremor, convulsion

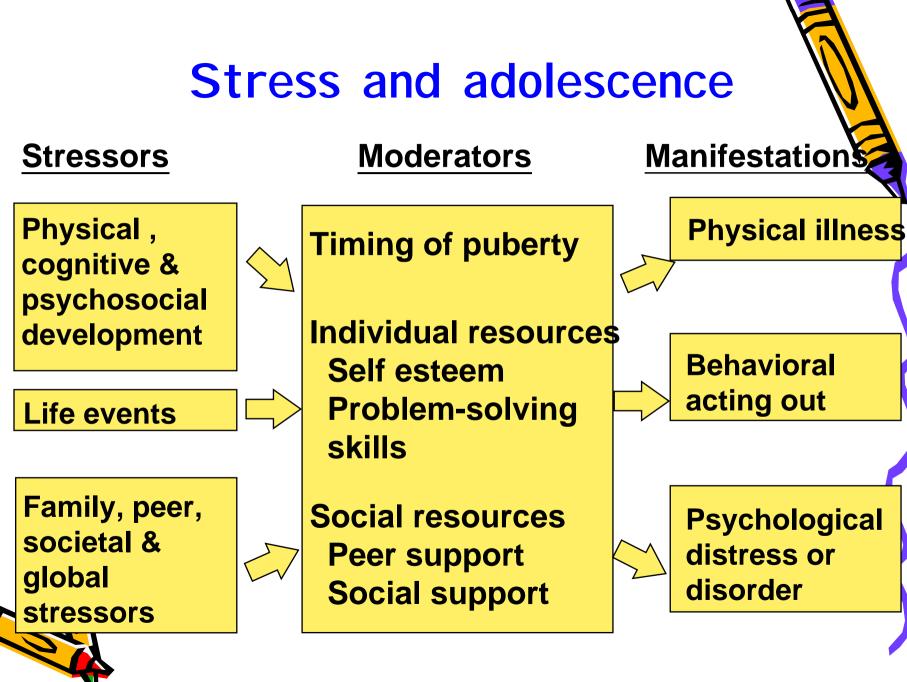




Which somatic symptoms to be manifested?

- Varies with individual
- Each individual may have his/her own specific symptoms
 - Anxious stomach ache, diarrhoea, exacerbation of asthma or ezcema
 - Depressed loss of appetite, chest pain

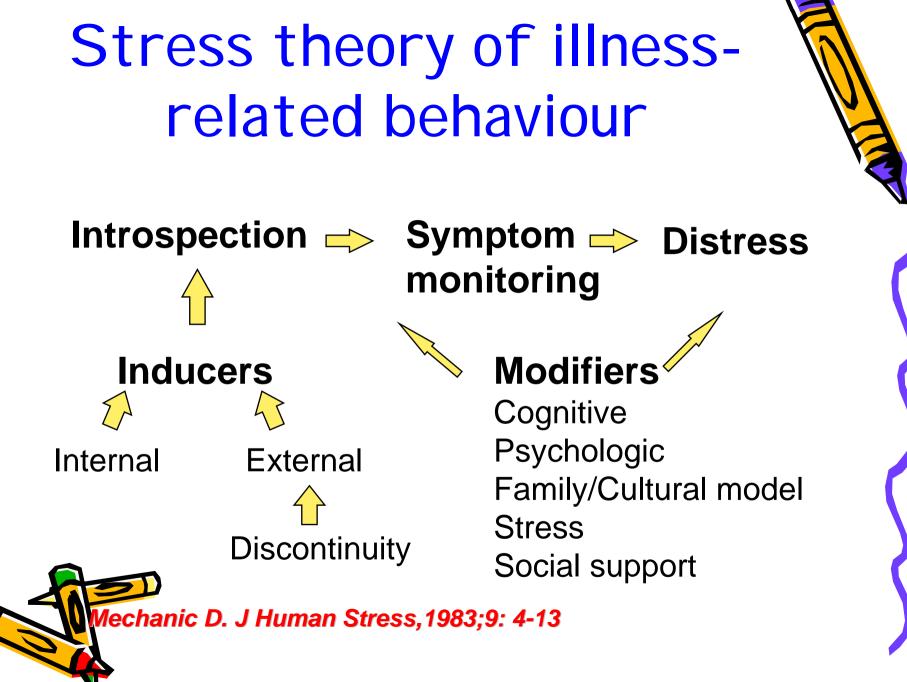




Vulnerability of adolescents

- Increased self-concern
- Greater sensitivity to body changes





Psychological component of illness

Primary psychiatric disorder

 \leftrightarrow

"Psychosomatic disorder"

 \leftrightarrow

Chronic disease with major psychological component

Anxiety Depression Eating disorder Panic Psychosis Tension headache Chronic abdominal pain Chronic chest pain Hyperventilation

Asthma Chronic fatigue Migraine



How common?

- Recurrent abdominal pain : 10 25%
- Headache : 10 30%
- Chest pain : 7 15%



How Common?

Somatization symptoms in a community sample of children and adolescents

- 540 children in grades 3 to 12
- 50% reporting at least 1 physical symptom during the preceding 2 weeks
- Most commonly reported symptoms: headaches(25%), low energy(23%), sore muscles(21%) and abdominal discomfort(17%) Garber et al (1991)

Development of somatization - demographic factors

- Female predominance
- Peak in late childhood or early adolescence
- Low socioeconomic, rural and poor educational backgrounds

Symptoms

- Recurrent abdominal pain
- Headache
 - Pseudoneurological symptoms

12 adolescence

Peak age

9



Development of somatization - the family

- Somatizing parents, somatizing child
- Using somatic symptoms as a means of communicating emotions
- Transactional characteristics of psychosomatic families (Minuchin, 1975)
 - enmeshment
 - overprotectiveness
 - -rigidity
 - lack of conflict resolution



Development of somatization - the family

- Somatization serves a special "function" within the family system
- Provides a role model
- Association : family members with anxiety and depression; chronic physical illness or disability



Development of somatization - the adolescent

- Negative life events
- Childhood sexual abuse
- Physical illness
- Associated psychiatric disorders : anxiety and depression



Development of somatization - the physician

- Uncertainty of diagnosis
- Unnecessary medical investigations and procedures



Somatically fixated physicianpatient interaction

Physician withdraws or refers to specialist Patient doctor-shops

Patient feels misunderstood & requests more tests. Physician becomes irritated.

Physician looks for psychosocial "stress". Patient denies, becomes angry.

Patient experiences symptoms & requests help Physician orders tests, prescribes medications Patient reports no relief. Tests are negative.

Physician relieved, patient perplexed.

Daniel S et al. Family Systems Medicine 1989;1:5-16

Diagnostic approach - keys

- Establish a trusting relationship
- Balance investigations for both organic and psychosocial causes
- A collaborative healthcare team psychosocial specialist an integral member



Never say

- "I can't find anything wrong. It must be psychological."
- "Your symptoms are in your head."



 Acknowledge patient suffering and family concerns

- Explore prior assessment and treatment experiences
 - Feel dismissed? Not taken seriously?
 - Bad past experience with medical professionals generating mistrust



- Investigate patient and family fears provoked by the symptoms
 - Separation fears, parental overprotection
 - "vulnerable" child
- Remain alert to the possibility of unrecognized physical disease. Avoid prejudging the etiology of the symptom.



- Avoid excess and unnecessary tests and procedures
 - Professional anxiety about unrecognized disease, family anxiety, risks of medical tests and procedures, costs





- Avoid diagnosis by exclusion
 - Identify clues to diagnosis:
 - Temporal relationship of symptoms with psychosocial stressors
 - Presence of comorbid anxiety, depression, or other psychiatric disorders
 - Prior personal or family history of somatization
 - Evidence of social or familial reinforcement of the symptom
 - A model for the symptom in the family or social milieu
 - Symptom violation of known anatomic or physiologic patterns
 - Response to psychological treatment, suggestion or placebo





- Explore symptom timing, context and characteristics
 - What maintains the sick role?
 - Any secondary gain?
 - Disease provides a ready explanation for not performing up to expectation



Diagnosis

- State the diagnostic impression clearly, frankly and directly
- Build a foundation for intervention
 - Educate patient and family





- Be honest and direct
 - Emphasize "working together"
 - Focus on functional improvement rather than "cure"
- Reassurance
 - No serious medical disease

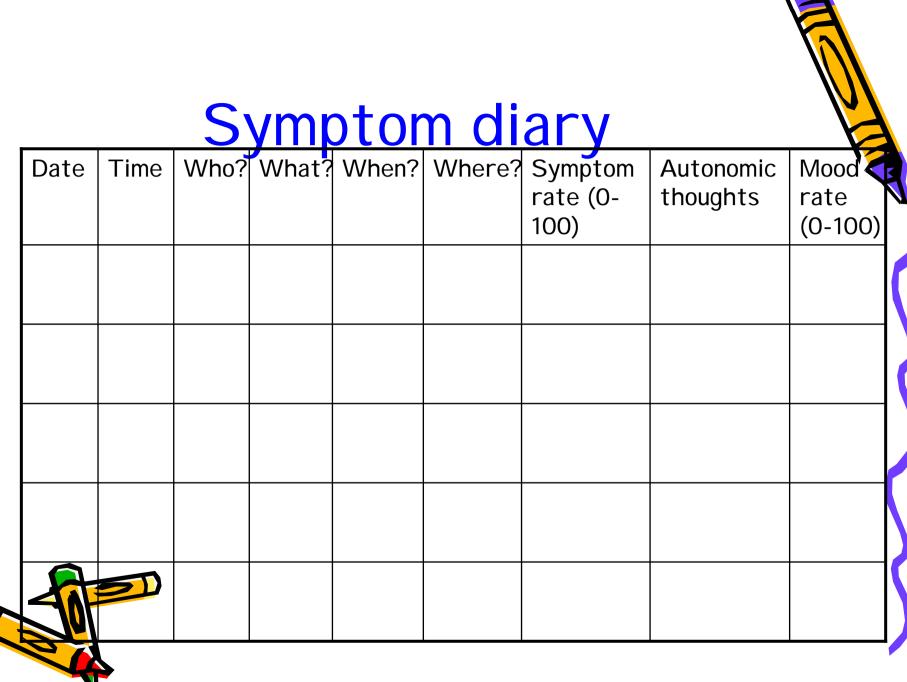


- Cognitive-behavioural interventions
 - Successful in treating recurrent abdominal pain
 - Self monitoring of symptoms
 - Limit parental reinforcement of illness behaviour
 - Relaxation training
- Rehabilitative approach
 - Encourage patient to return to usual activities and responsibilities prior to definitive symptomatic relief
 - Shift from "finding a cure" to " coping with and overcoming a distressing physical problem"
 - Empower the patient to overcome the problem: improvement = personal success
 - Expect the patient to function in spite of the illness is not cruel, but therapeutic



- Behavioural and operant interventions
 - Positive reinforcement for healthy behaviour
 - Withdraw reinforcement where sick role is rewarded
- Self management and other individual strategies to encourage active coping
 - Self monitoring, training in coping and relaxation, hypnosis





- Family and group interventions
- Communicate
 - Between involved professionals esp school
- Consolidate care with a single doctor
- Aggressive treatment of comorbid psychiatric problems
- Monitor outcome



Case 1- A 11 year-old boy with abdominal pain

- F. 1 student with good past health
- Attended OPD for recurrent abdominal pain for 2 months (Oct – Nov)
 - Started off after an episode of gastroenteritis
 - Periumbilical, colicky, occurs every morning, so severe that he could not go to school. Has been absent from school for 1 month
 - Less severe attacks during weekends. No attacks during sleep.
 - Normal appetite. No weight loss.
- Normal physical examination.
- Satisfactory school performance. New school, few friends



Case 1- A 11 year-old boy with abdominal pain

- Management
 - Investigations: blood, stool and urine
 - Discuss on abdominal cramps as a manifestation of worries and anxiety.
 - Reassurance
 - Trial of gradual return to school



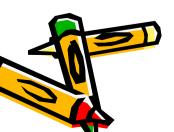
Case 2: A 14 year-old boy with shortness of breath

- F2 student in a band 1 school
- History of mild asthma in childhood, infrequent attacks.
- Since beginning of school term in F2, developed acute shortness of breath in the morning lessons at school, taken to A&E many times. Well in A&E.



Case 3: A 15 year old "blind" girl

- History of congenital hydrocephalus (先天性腦積水) with shunting operation performed at 3 months old.
- At 12 years old, developed headache during tests and examinations, normal physical findings, diagnosed to have tension headache. Reassurance.
- 9 months later, developed severe headache and blurred vision. Found to have swelling of optic discs. CT scan brain showed dilated ventricles suggestive of blocked shunt. Emergency operation was performed to put in a new shunt.
- Post-operatively, claimed to have persistent poor vision. Testing showed that she is legally blind and arrangement was made for her to study in the Ebenezer School for the Blind.





- Repeated admissions to hospital in the following year for attacks of severe headache – all normal CT scans brain.
- Parental fear of missing genuine medical problems
- Patient- physical illness a good reason for underachieving
- Case conference held



Case 4: A 10 year-old boy who still soils

- 1st child of family, 8 yr-old sister autistic
- Father technician, mother accounting clerk
- Started soiling at 5 years old when sent to Australia to stay with aunt
- Sent back to HK, studied in International School for 3 years, soiling improved
- Because of financial constraints, sent to Shenzhen International School, soiling worsened



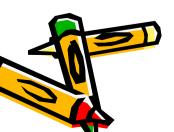
Case 5: A 15 year-old girl with stiff neck and back

- F4 top student, only child
- Father trading of Chinese herbs, frequent visits to China. Mother - clerk
- Presented with stiff neck and back and walks with an awkward posture
- Father took her back to China for medical consultation and stayed at aunt's place for 3 months. Very unhappy stay. Symptoms worsened.
- School stress



Case 6: A 15 year-old girl with anorexia nervosa

- Referred to us from another hospital for 2nd opinion as patient refused to stay there
- BW 30kg BH 162cm
- Initially presented with syncope and "slow motion and response". Weight loss of 15kg over 9 months.
- After staying with us for 1 week, mother requested discharge.



Management - considerations

- Biopsychosocial approach
- Goals :
 - –help adolescent cope with symptoms
 - -return to normal daily activities
- Reassurance : ongoing medical review
- Exploration of psychosocial issues

Referral to psychiatrist if not coping with the symptoms

Resources

- Adolescent Clinics of Paediatric Department of HA hospitals
 - PYNEH, QMH
 - QEH, PMH, UCH, TKOH, TMH
 - PWH, AHMLNH
- The HKU Family Institute
 - www.hkufamilyinstitute.hku.hk

