
Somatising in children and adolescents.

2. Management and outcomes

D. Mary Eminson

In this paper I outline the assessment, engagement and management of children and adolescents with somatising conditions. The major diagnostic groups, in rough order of prevalence, are adjustment, dissociative (transient and chronic), somatoform and factitious disorders and chronic fatigue. See Eminson (2001) for more detailed descriptions and subtypes.

Which professional should manage somatising disorders?

The decision about the appropriate clinician to manage a somatising disorder should depend on who has the skills to maximise the chances of recovery to normal child or adolescent functioning. This depends on the severity of the presentation, its impact on the child's functioning and how long symptoms have lasted. Essentially, in the management of any conditions that are severe, handicapping, slow to recovery or where there are significant levels of psychiatric symptoms, child mental health expertise will help to attain appropriate goals, often using the skills of several different professionals.

Paediatric and primary care management

Paediatricians and general practitioners (GPs) undertake most of the management of many adjustment, dissociative and factitious disorders,

and mild relapses of any somatising conditions. The presentations are likely to be of children in middle childhood or early adolescence with single or multiple physical symptoms (abdominal and joint pains, headaches, pains), fatigue associated with obvious stresses of any kind, recent-onset losses of function and unexplained symptoms after a clear physical illness. Their management forms a routine part of primary care and paediatric practice: many clinical accounts of successful paediatric management are available (Dubowitz & Hersov, 1976; Lask & Fosson, 1989; McGrath & Reid, 1995; Murray *et al*, 2000). There is a much more limited literature about management of childhood somatisation in primary care.

Key elements of management in paediatric and primary care are listed in Box 1. Where there is a loss of function, involvement of physiotherapists in graded exercise programmes is reported to be

Box 1 Key elements of the management of child somatisation disorders

**Take a good history, which identifies stresses
and recent life events**

**Provide clear reassurance about negative
physical findings when the appropriate
investigations have been completed**

**Examine family beliefs about illness in order
to prepare for the step of encouraging a
return to a normal lifestyle**

**Provide a model to explain psychosomatic
symptoms to the family**

D. Mary Eminson is a consultant child and adolescent psychiatrist at Bolton Hospitals NHS Trust (Royal Bolton Hospital, Minerva Road, Bolton BL4 0JR; tel: 01204 390663; fax: 01204 390660; e-mail: Mary.Eminson@boltonh-tr.nwest.nhs.uk). She has a long-standing clinical and academic interest in all aspects of abnormal illness behaviour in children and parents, and in parents who fabricate illness in their children.

helpful. Child and adolescent mental health services (CAMHS) should become involved if primary care intervention is unsuccessful, or where there are significant psychiatric symptoms at the outset.

CAMHS or joint management

Paediatricians, surgical specialists and GPs are usually the first professionals approached in the assessment of the remainder of this group of conditions: all the somatoform disorders, chronic dissociative presentations and chronic fatigue. In the management of these more handicapping disorders, the involvement of CAMHS professionals should be considered from the outset. For this to be achieved, paediatric medical, surgical and associated specialists (e.g. physiotherapists) must recognise the nature of the presentation, be able to categorise somatising disorders, acknowledge the importance of a biopsychosocial formulation and be able to recognise other likely psychiatric symptoms in the patients. There must also be an available CAMHS service, with sufficient resources in time and skill, to which patients may be referred. Joint management between physical and mental health clinicians is helpful for a significant proportion, especially where there is an element of organic illness. Increasingly, service reorganisation (such as the creation of fully multi-disciplinary clinics) creates a setting in which mental and physical health professionals work together, which facilitates effective management and avoids the arousal of strong family prejudices against overtly psychological interventions and services.

Paediatric–primary care–CAMHS long-term liaison

A third kind of management is liaison between CAMHS professionals and other medical and non-medical staff, without direct CAMHS involvement: clinical responsibility remains solely with the physical medicine team. This is appropriate for patients who meet criteria for CAMHS referral or joint management in the paragraph above, but who reject such input. It is discussed further in Management by liaison, below.

CAMHS assessment and management

Referral of children and adolescents with somatising disorders to a CAMHS service is a crucial task that

may make the difference between successful rehabilitation and treatment and continued searching for physical explanations. A tendency to search for physical as opposed to psychological explanations for the symptoms is, almost by definition, a feature of the disorders, and reluctance to accept the input of any mental health professional or service may be persistent and strong. A positive, unapologetic attitude to the referral by the paediatrician or GP is essential, conveying a clear message that the CAMHS service is uniquely well placed to deliver a set of effective treatments that will speed the recovery of the young person. Stressing all professionals' belief in the child's experience of the symptoms is essential: he or she is not "putting it on".

The 'engagement' interview

Although comprehensive assessment of somatising disorders has ingredients similar to those used for other child or adolescent disorders, one difference is the level of attention that must be paid to engagement of these patients and their families with psychiatric services. The first interview has engagement as its primary purpose, often best established through a careful narrative approach to the history of the illness, its impact and management. Understanding family illness beliefs, the level of conviction that the illness has a physical cause, the level of satisfaction with physical investigations and explanations and views about the psychiatric referral is critical for success in this engagement process. Garralda (1999) details the ingredients of assessment, including physical examination if this has not been completed elsewhere.

After this narrative is established, the normal personal and family history are obtained. Attention should be paid to the extent of the risk factors described both for somatisation itself and for illness behaviour, and relevant factors in the individual child, the family and the relationships between them should be looked for (Box 2).

It may be necessary to canvass the family medical history over quite a wide area of the genogram to establish whether other family members have had similar physical symptoms, whether serious illness was the cause or the symptoms remained unexplained and the extent to which family members have been handicapped by ill health (physical and mental) of all kinds. The apparent failure of doctors to find the cause of a family member's complaints (sometimes with serious consequences) may undermine parental confidence in medical opinions and become a source of repeated uncertainty. It also

seems on occasion that the memory for medical 'mistakes' is particularly long and vivid in such families.

The individual assessment of the child or adolescent is a relatively routine one, taking into account current physical symptoms, physical state

and functional mobility, mental state and ability to relate and engage. Current functioning in terms of sleep, appetite, peer relationships, school attendance and ability to perform any academic work is reviewed. It is important to find the young person's views of the cause of the illness, although these usually mirror parental views quite closely. Questionnaire measures of somatic symptoms (e.g. the Somatic Symptom Questionnaire (Eminson *et al*, 1996) or Children's Somatisation Inventory (Garber *et al*, 1991)), pain, illness attitudes, depression and anxiety are often a useful baseline measurement, together with a global functioning measure such as HONOSCA (Gowers *et al*, 1999).

The engagement interview is the place to establish an explanation of psychosomatic relationships: how physical symptoms, including fatigue, may genuinely be present, even when currently there is no physical abnormality. Analogies are useful, for example, the tension headache experienced at some time by most adults and acknowledged by the sufferer to have a psychological aetiology but to be extremely physically painful. If other examples of physical discomfort affected by psychosocial factors can be found from within the family's own experience (e.g. asthma worsened by emotional distress) these usually carry the most weight.

During this interview the clinician tries to establish a formulation of the illness that incorporates pre-existing vulnerabilities, precipitating ('triggering') events or illness and maintaining ('secondary gain') factors. The formulation will rarely be complete at this stage. Sometimes this is because the family's view of the pre-illness functioning is so positive, compared with the present, that earlier difficulties are hard to see. Any suggestion of earlier problems may be perceived as criticism and rejected. Sometimes, especially in perfectionist, striving children who have achieved highly but at significant personal cost (Lask, 1986), the premorbid functioning really did appear to be effortlessly successful, until a physical illness supervened and it became clear that resuming previous activities was too demanding. Nevertheless, tentative hypotheses will be established at this initial stage, with a need to clarify areas of uncertainty in future.

It is usually helpful to share this 'predisposing, precipitating, maintaining' approach to analysis with the family and to stress that recovery through rehabilitation can be achieved without an initial understanding of all the aetiological factors. This is the next step in counteracting 'either/or', 'physical v. psychological' thinking. Parents may begin to think of triggers themselves. A mistake often made by families is to assume that the final precipitant for a somatising disorder must be a substantial stress in its own right. On the contrary, an apparently trivial

Box 2 Somatising disorders

Predisposing factors

Family:

- Many somatic symptoms experienced (genetic component?)**
- Limited in verbal communication about emotional issues, including conflict**
- 'Conditional caretaking'**
- Suspicious attitude to medical expertise**
- Parental history of somatoform illness, anxiety or depression**
- Problems with boundary setting for children**

Child:

- Temperamental factors, including conscientiousness, emotional lability, vulnerability and worthlessness**
- Earlier emotional abuse**
- Low IQ**
- Social-relating difficulties**

Precipitating factors

Child:

- Anxiety, depression**
- Life stresses of all types – overt and covert**
- Physical illness**
- Peer group problems**
- Academic problems and cognitive limitations**
- Low self-esteem**

Parent:

- Life events/crises**

Maintaining factors

Child,* parent and professional:

- Current family relationship difficulties**
- *Predicament is resolved by symptoms**
- Family model of serious illness**
- Current parental mental ill health, particularly anxiety and somatisation**
- *School problems**
- Models of sickness and conflict avoidance**
- Benefits of sick role**
- Professional behaviour that reinforces anxieties and sick role**

Cultural factors may be relevant in any category

physical or psychological stress in a young person with substantial predisposing factors may be sufficient to provoke a conversion (dissociative) disorder or the beginning of an episode of severe fatigue.

The final stage of the engagement interview is to establish whether there is a contract for further work with the CAMHS service. This may be agreed directly and is assisted by details of treatment and evidence that the service has successfully treated other young people with similar conditions. For some, clarification of physical investigations and their meaning must be undertaken because significant doubts remain and will resurface unless addressed. Such clarification interviews are often best conducted in a joint paediatric/psychiatric/family session: this leaves less room for confusion or different nuances in interpretation. For others, it is clear that engagement has not been achieved. Anecdotally, this

is noted most frequently where parental difficulty in developing trust is high for whatever reason (parental belief in a physical cause, or significant parental illness behaviour). This is best acknowledged openly, with an invitation to revisit the treatment options later. This most challenging group may be best managed by continued liaison with paediatricians.

If a family is engaged, the principles of management (Box 3) are similar for all the disorders. However, at different ages and developmental stages and with disorders of varying severity, a variety of techniques and approaches may be used to achieve the same goals. The emphasis that needs to be placed on the different aspects, including the extent to which the child requires individual treatment away from joint sessions and the pace of progress that can be achieved, will depend on the nature and chronicity of the presentation.

Box 3 Principles of managing somatising disorders in children and adolescents

Encouragement to express feelings, emotional distress, underlying worries or fears through direct, verbal means rather than through physical complaints. (This step may not be essential for mild and brief presentations in families without strong beliefs.)

Skills and support to alter attitudes to physical symptoms: exploration of the child's and parent's current attributions of serious physical causes to symptoms, followed by rehearsal of alternative beliefs and cognitions, introducing new ideas with more optimistic beliefs about the possibility of recovery

Managing the physical symptom(s) with a variety of physical and/or psychological methods, depending on type and illness stage: physical methods include analgesics, transcutaneous electrical nerve stimulation (TENS) machines, monitoring using diaries or pain charts, distraction with activity; psychological methods include cognitive-behavioural techniques

A strategy to resume gradually, rather than avoid, activities normal for the developmental stage, with attention to any areas of functioning that have become disrupted, such as sleep patterns, exercise and study

Attention to treatment for any concurrent psychiatric symptoms such as depression or anxiety: this may include appropriate medication or other psychological approaches

Attention to all possible maintaining factors in child or family: problems of learning, temperament, peer relations, other family relationship issues

Consideration of parental capacity to encourage recovery through activity, and, if there is continued persistent pursuit of abnormal illness behaviour by parents, exploration of the reasons so that these can be addressed

Prevention of unnecessary medical investigation and interventions through paediatric and primary care liaison, with agreement about gatekeeping of referrals to other medical and surgical specialists. In other words, if the family cannot contain their urge to seek more physical investigations, the professionals must provide this boundary and a clear medical rationale must be agreed with the family and all professionals if new opinions are sought

Maintenance of a systemic perspective throughout, so that the pace of change in child, family and professional network does not become unsynchronised. Other professionals with input to the family (health service, educational, self-help group or others) may have very different beliefs about management and outcome, and unless the family (and professionals) are helped to resolve conflicts of opinion between sources of advice, through clarification and discussion, they may find it difficult to maintain their support of an active rehabilitation programme

Setting for therapeutic work

The setting for the work (out-patient, day or in-patient) depends on the degree of chronicity, level of impairment and previous progress, especially the extent and nature of family difficulties, as does the decision about the appropriate professional to undertake the intervention. It is evident that for severe and complex cases, and depending on the relative importance of individual and family factors in each case, input will be needed from more than one person and that a team approach will be required to integrate the interventions. This is particularly true where day or in-patient management is undertaken, and in these cases a psychiatrist is best placed to coordinate. Integrated rehabilitative approaches to management have been described most thoroughly in relation to chronic fatigue, but are widely applicable to the severe disorders (Vereker, 1992; Wright *et al*, 2000). Often a combination of child, family and systemic interventions will be most effective. The issue of engagement does not, of course, disappear after the initial assessment, and 'milieu' interventions are rarely successful if the patient or family are antagonistic to the approach.

The length of treatment also varies a great deal. A series of out-patient appointments over 4–6 months may be sufficient. The more chronic and incapacitating sicknesses may require input over 1–2 years, of which several months may be in-patient or day patient care. Even longer support may occasionally be necessary to maintain relatively healthy functioning.

Individual treatments

A wide range of techniques may be used, although the strength of the evidence base is limited. Undoubtedly, there is a need to define more precisely the reasons why a particular approach is chosen and to measure progress on goals relevant to the treatment approach and the target symptom within the disorder. Not all target symptoms are physical, and functional goals such as better peer relations and school attendance may be as important as reduction in physical complaints.

Psychodynamically informed approaches

Very regressed and withdrawn children, those with extreme denial of emotional distress of any kind and

those with a limited vocabulary to describe emotions, may be helped as a first step by non-directive techniques, the aim of which is to increase the integration of psyche and soma. Non-verbal or other indirect techniques (art, play or drama therapy) are effective and psychodynamically informed approaches in which the input of a child psychotherapist may provide an opportunity to reach the young person and begin to help him or her to acknowledge distress.

For less severely affected or younger children this work to increase emotional recognition and communication may be undertaken less formally and may use techniques (e.g. 'feely faces', 'feelings trees') that are also used as the beginnings of the cognitive approach discussed below.

The objective of all these approaches is to encourage more direct expression of feelings and verbal expression rather than somatisation.

In adults, formal psychotherapy has been shown to be efficacious in irritable bowel syndrome (Guthrie *et al*, 1993), and this may therefore be appropriate with older adolescents, on the same principles and having the same objectives.

Behaviourism and cognitive-behavioural approaches

In relatively well-functioning children and families where the level of impairment is limited, behavioural management of specific single symptoms (such as headache) and or multiple symptoms has been shown to be successful in both children and adolescents (Larsson, 1992; McGrath & Reid, 1995). In such adjustment disorders or somatoform disorders with minor levels of handicap, this may be the only treatment required and can be delivered on an out-patient basis. Externalising behavioural approaches, such as that described by White (1984) to manage a variety of symptoms in children up to the age of about 12 years, are effective in providing a model of symptom management both to the child and the parent, of altering attitudes to symptoms, and encouraging return to normal activities. Unfortunately, although clinically useful, these techniques have not been studied for systematic evidence of efficacy. Cognitive-behavioural treatments of recurrent abdominal pain have greater empirical support than other treatments; Janicke & Finney (1999) have reviewed these approaches and the limitations of studies using them.

There is also evidence (Chalder, 1999) that quite formal cognitive work is efficacious with older children and adolescents. Such approaches are effective for those with many symptoms, pains and hypochondriacal concerns, as well as those with

chronic fatigue. As suggested above, modifications may be made to enable parts of the cognitive approach to be used with younger and less able children and to be combined with behavioural approaches to integrate work with parents and child.

Management of other symptoms

Sleep

Careful attention to sleep hygiene will be the first step in many chronic or severe illnesses. This uses routine techniques to ensure that the young person is awake during the day and asleep at night, through the gradual reduction of day sleep and introduction of normal night-time sleep routines. It is important to identify the secondary gains of a disturbed routine, which may include opportunities for close relationship with a parent or avoidance of school attendance or academic work.

Medication may occasionally be used briefly as an adjunct to behavioural techniques.

Pain

The use of physical interventions to manage pain (e.g. analgesics, TENS machines) will need to be considered, and it is important to integrate this with any other approaches to the management of symptoms. The advice of a pain clinic may be helpful. Integrating the work of mental health clinicians with that of physiotherapists and any other specialists, such as rheumatologists, is essential to ensure a shared formulation and management plan, for example where there are physical problems secondary to immobility of whatever cause, as is found in reflex sympathetic dystrophy.

Inactivity

In all the somatoform disorders and in chronic fatigue, if normal activities have ceased the planning of a return to a more appropriate lifestyle requires great care and attention to timing. It may be important to discourage hasty overactivity and (apparently paradoxically) to encourage regular rest. There are three reasons for this. First, it is a pragmatic strategy to enforce an appropriate pace and prevent collapse. Second, it gives a clear message to the family that the professional takes seriously their own statements about the seriousness

of the illness and the time required to recover. Third, it may be used skilfully to remove any inappropriate secondary gains that are occurring.

Case vignette

Elizabeth's somatoform pain disorder meant she was not at school but could spend hours in her grandparents' heated swimming pool. Instituting 20 minutes of complete rest every hour, in a darkened room with no distraction, introduced change to this comfortable regime, which was not producing recovery. Reduction in rest periods was made contingent on coping better with other activities, e.g. getting up in the morning and coping with a home tuition lesson.

School attendance, learning and peer group problems

The approach to management of these difficulties is no different from that for any other young person; the difficulty is usually in establishing the extent of the problem and of helping the young person and family recognise its relevance in aiding recovery from the symptomatic presentation. The approach to peer group interaction problems will depend on the young person and his or her pre-existing skills, and may be individual (using cognitive-behavioural didactic social skills or problem-solving techniques) or through group processes. Liaison with education professionals is essential.

Systemic and family approaches

The importance of a systemic perspective in somatising disorders has already been emphasised: there is obvious potential for difficulties consequent upon the involvement of numerous individuals and groups with different beliefs and practices. There is a role for a systemic practitioner in helping these family and professional systems to work together successfully for the benefit of the young person; a medical background may increase the power to convene relevant meetings. Systemic work may also be undertaken within the more limited arena of the day or in-patient psychiatric unit, or with paediatric and CAMHS staff working together. The rationale is that in all these circumstances there is potential for conflicting views and beliefs and that these potential conflicts may be amplified and hinder progress if (as is usual) the young person's presentation itself has conflicting aspects (acknowledging/denying difficulties; wanting to recover/fearing activity; experiencing psychological pain somatically/elaborating symptoms).

More specific tasks may also be undertaken with the family: psycho-educational work to introduce a

carefully paced rehabilitation and explain the nature of the illness and its treatment (Chalder, 1999); exploration of family illness beliefs and alternatives; helping parents to manage physical symptoms and other kinds of behaviour; enabling recovering children to negotiate differently and more directly with their parents.

However, evidence of the utility of systemic approaches, used either as an adjunct to other interventions or alone, is lacking and research will be hard to undertake.

Management of factitious disorders

Management of factitious disorders follows the same principles as for any other somatising presentation, but special care should be taken to engage the parents, lest they become extremely punitive when the factitious nature of the symptom becomes apparent. Unfortunately, young people whose factitious presentations are severe and intractable are more likely to come from families in which problems with open and trusting relationships are also evident, making work with all the family difficult.

Somatisation management in severely disturbed, disrupted or broken families

In circumstances where physical, sexual and emotional abuse and attachment disorder have constituted a part of the aetiology, where there are many other psychological symptoms, including conduct problems and self-harm, where parents themselves have somatisation disorders or there is other major social dysfunction, management is rarely able to take place in the organised way described for most families. The child may be in a substitute family or there may be major difficulties in engaging parents if relationships remain ambivalent or negative. If possible, the principles and practice of management described above should be employed. But in some cases damage limitation may have to be the main objective: responding to crises and periods of emotional distress with an intervention relevant to the mood disorder or self-harming phase, or helping to find an appropriate educational or substitute home environment. Preventing unnecessary medical interventions is important for young people with

severe disruption of social circumstances and relationships; even this may be difficult if the young person is moved to a different part of the country.

Management by liaison

The CAMHS contribution to the management of disrupted families has much in common with that of those who decline or abandon 'psychological' involvement from the outset (see Paediatric-primary care –CAMHS long-term liaison, above). Some of the most severe difficulties, in terms of their impact on the patient's lifestyle, may be included here, and it is this that justifies efforts at indirect work. All the major diagnostic categories of ICD-10 (World Health Organization, 1992) will be represented: young people with severe fatigue and/or withdrawal (chronic fatigue syndrome), severe 'disuse' symptoms with secondary physical problems, dissociative and factitious disorders and somatisation disorders, including those with antisocial and personality difficulties.

In dealing with this group, the CAMHS professional plays the following three roles (summarised in Box 4). The first is to support the professionals already involved and enable them to provide limited interventions, for example by advising on sleep hygiene and the prescription of antidepressants, or supporting the work of a paediatric play worker or practice counsellor who is able to spend time with the young person. The purpose is not to encourage delivery of interventions by those without appropriate training but to monitor the situation, to work on principles of management in key areas and to provide an opportunity for the development of trust in an accepting, emotionally congruent and sympathetic professional. This person can also encourage the family to consider engagement with CAMHS for more intensive and appropriate treatment in the future. Another aspect of this

Box 4 Liaison roles of the child and adolescent mental health services in the management of problem families

Support Advise and enable professionals to make optimum interventions and keep psychosomatic formulation in mind
Containment Help professionals prevent unnecessary investigations and treatment
Prevention of avoidable impairment Overview effect on the patient of the disorder and the family's response to it

supportive liaison role is to help the paediatrician (and others) to retain the psychosomatic formulation in mind, rather than seeing a puzzling physical problem. Naturally, a chronic, severe and untreated problem is unlikely to make a quick recovery, but without help the urge to reinvestigate without good reason may become overwhelming.

The second role is to help the paediatrician to contain the situation, to prevent harm from unnecessary investigations and unproven or superfluous treatments. Some families repeatedly seek new specialists and interventions, and professionals, including the GP, may need help to resist pressure to make referrals for yet more opinions. (The exception to this reluctance to endorse further referral should be the involvement of pain clinics. By focusing on a single type of symptom these may enable more holistic and psychologically informed approaches to be used without 'mental health' labelling or invasive treatments.) It is important that children and families are not prevented from receiving necessary advice from experts but, in principle, such experts should be approached by the first specialist for second opinions where necessary, rather by the family, who may involve professionals not fully informed about the background and previous investigations.

The third role is to keep under review the extent to which the somatising disorder and the family's management may be causing avoidable impairment to the young person's development, considered in the broadest sense in terms of physical, emotional, social and educational milestones. The intensity of the parents' drive for an invalid lifestyle or surgical interventions for their child may occasionally be so extreme that professionals consider invoking child protection legislation, in which case a meeting of all relevant professionals with local authority social workers is appropriate.

Outcomes and continuities

The range of disorders described in this paper is wide and the treatment interventions equally broad in variety. Although there is a wealth of clinical studies from the 1950s onwards, they are often from selected secondary and tertiary paediatric populations, and the earlier ones do not meet modern levels of precision in categorisation and measurement. These outcome studies have been strengthened recently by a series of papers examining the 33-year follow-up of the 1946 birth cohort (Hotopf *et al*, 1998, 2000; Fearon & Hotopf, 2001). The categorisations and measurements of symptoms and outcomes used

in the earlier epidemiological studies are also relatively unsophisticated. We do not know what proportion of the children received any form of treatment intervention. Hence, it is not surprising that it is difficult to make robust predictions of outcome of the somatising disorders at different ages and that the literature appears to give inconsistent results. This problem is compounded by the existence of a group of sufferers and families who appear to seek out practitioners predicting continued invalidity as the outcome and who find it difficult to engage with active treatment approaches. Nevertheless, despite the longstanding and severe nature of many of the disorders, there are substantial gains to be made from mental health treatments in relieving physical symptoms, improving management and reducing handicap and in remediating functional impairment in terms of lifestyle, independence and relationships. Although engagement remains the single most important determining factor, those who work closely with paediatricians and others in this area are able to maximise such opportunities. This is an argument for early involvement of specialist expertise in dealing with the more handicapping disorders: chronic dissociative and somatoform disorders and chronic fatigue.

Outcomes may be considered in relation to the future risk of (a) psychiatric disorders or symptoms, (b) continuing unexplained physical symptoms and (c) more widespread somatoform problems. It has become increasingly clear that the experience of excess or chronic physical symptoms in childhood and adolescence is associated with psychiatric disorders (especially depression and anxiety) and in adulthood with excess unexplained hospitalisations (Hotopf *et al*, 1998; Zwaigenbaum *et al*, 1999; Fearon & Hotopf, 2001). This is the case even when psychiatric symptoms were not apparently present in childhood. We do not yet know which young people will, as they develop, acquire the ability to express emotional distress through verbal means and whether (as one suspects) they differ from those who continue to present somatising disorders, either with or without other psychological symptoms. The results of different studies and also outcomes in boys and girls are inconsistent, reinforcing the need for more research and greater specificity in the comparisons made.

There are also conflicting results in longitudinal clinical studies that examine whether children continue to experience the same physical symptoms when they grow up, but there are clearly many continuities in vulnerabilities to certain physical symptom constellations. Christensen & Mortensen (1975), Walker & Greene (1989) and Hotopf *et al* (2000) suggest that the continuities between somatising presentations in childhood and in later

adolescence and early adulthood are not invariable, but that disorders characterised by antisocial difficulties and aggression tend to be consistent (Verhulst *et al*, 1999).

Papers examining outcomes for specific disorders are becoming more common but still often relate to specialist services rather than diagnostic groups. Adjustment disorders characterised by physical and emotional symptoms are by definition short-lived, as are transient dissociative reactions. In general, these disorders show poor continuity with adult presentations. The picture for more chronic dissociative disorders is less straightforward. Clinical accounts suggest that most recover from the initial episode, the loss of function disappearing quickly once reassurance is given and investigations completed (Goodyer & Taylor, 1985; Grattan-Smith *et al*, 1988), although relapse is not uncommon. More long-lasting dissociative disorders are often associated with ongoing difficulties in areas such as school and peer relationships (Wynick *et al*, 1997). Factitious disorders often have a similar clinical course: the index episode usually resolves completely, but the underlying difficulties remain and are associated with other psychiatric presentations later.

The long-term outcomes of well-defined somatoform disorders in childhood and adolescence are rarely reported, although symptom-specific groups (e.g. reflex sympathetic dystrophy, usually seen as a form of somatoform pain disorder) are presented in clinical series. A typical study (Murray *et al*, 2000) describes recovery times following diagnosis (itself sometimes more than 2 years after symptom onset) of between 0 and 140 weeks (median 7 weeks), but 27.5% of patients relapsed. Clinically, any of the long-lasting severe somatoform disorders may show continuities into adulthood. This is consistent with the results of studies of adults with somatoform disorders that suggest that many begin in adolescence or even earlier. The late onset of hypochondriasis, barely represented within child and adolescent populations, has been commented upon above. Perhaps there are those among the somatoform disorders that are in effect developmental disorders, as has recently been discussed in relation to personality development and somatisation (Bass & Murphy, 1995).

Chronic fatigue is a better researched area for both treatment and outcome, with studies of adults, adolescents and children providing information about positive factors for recovery: engagement with psychiatric services (Vereker, 1992), clear physical precipitants of the illness, onset at the start of a new school year, ongoing immunological abnormalities, better maternal health and socio-economic status (Rangel *et al*, 1999). In a relatively small study

persistent symptoms were predicted by strong maternal belief (at the outset) in a physical cause for the illness and by personality difficulties and disorder in the adolescents (Rangel *et al*, 2000). Most series with children and adolescents are small and highly selected, but typically, two-thirds of sufferers make a good recovery.

Conclusions

With the exception of the burgeoning literature on chronic fatigue, somatising disorders remain one of the most neglected areas in child and adolescent psychiatry. Recognition of these disorders and their responsiveness to vigorous treatment are a continuing major problem. The challenges continue once recognition has occurred: a non-pejorative terminology is needed, to be shared with paediatricians; existing categorisation systems must be reviewed to take account of child development; and treatment research using rigorous definitions must approach the strength level of randomised controlled trials. More theoretical research on mechanisms of somatisation and more longitudinal studies with robust measures of symptom and function are also urgently required.

Nevertheless, the wealth of clinical material in the literature remains a strength of this area, and the development of collaborations between centres and between disciplines to achieve a better evidence base forms an exciting prospect for future research and treatment of these handicapping disorders.

References

- Bass, C. & Murphy, M. (1995) Somatoform and personality disorders: syndromal co-morbidity and overlapping developmental pathways. *Journal of Psychosomatic Research*, **39**, 403–427.
- Chalder, T. (1999) Family oriented cognitive behavioural treatment for adolescents with chronic fatigue syndrome. In: *Association for Child Psychology and Psychiatry Occasional Papers No. 16* (ed. E. Garralda), 19–23.
- Christensen, M. F. & Mortensen, O. (1975) Long-term prognosis in children with recurrent abdominal pain. *Archives of Disease in Childhood*, **59**, 110–114.
- Dubowitz, V. & Hersov, L. (1976) Management of children with non-organic (hysterical) disorders of motor function. *Developmental Medicine and Child Neurology*, **18**, 358–368.
- Eminson, D. M. (2001) Somatising in children and adolescents. 1. Clinical presentations and aetiological factors. *Advances in Psychiatric Treatment*, **7**, 266–274.
- , Benjamin, S., Shortall, A., *et al* (1996) Physical symptoms and illness attitudes in adolescents: an epidemiological study. *Journal of Child Psychology and Psychiatry*, **37**, 519–528.
- Fearon, P. & Hotopf, M. (2001) Relation between headache in childhood and physical and psychiatric symptoms in adulthood: national birth cohort study. *BMJ*, **322**, 1145–1148.

- Garber, J., Walker, S. L. & Zeman, J. (1991) Somatising symptoms in a community sample of children and adolescents: further validation of the Children's Somatization Inventory. *Journal of Consulting and Clinical Psychology*, **3**, 588–595.
- Garralda, M. E. (ed.) (1999) Practitioner review: assessment and management of somatisation in childhood and adolescence: a practical perspective. *Journal of Child Psychology and Psychiatry*, **40**, 1159–1167.
- Goodyer, I. & Taylor, D. C. (1985) Hysteria. *Archives of Disease in Childhood*, **60**, 680–681.
- Gowers, S. G., Harrington, R. C., Whitton, A., et al (1999) Brief scale for measuring the outcomes of emotional and behavioural disorders in children. Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA). *British Journal of Psychiatry*, **174**, 413–416.
- Grattan-Smith, P., Fairley, M. & Procopis, P. (1988) Clinical features of conversion disorder. *Archives of Disease in Childhood*, **63**, 408–414.
- Guthrie, E., Creed, F., Dawson, D., et al (1993) A randomised controlled trial of psychotherapy in patients with refractory irritable bowel syndrome. *British Journal of Psychiatry*, **163**, 315–321.
- Hotopf, M., Mayou, R., Wadsworth, M., et al (1998) Temporal relationships between physical symptoms and psychiatric disorder. Results from a national birth cohort. *British Journal of Psychiatry*, **173**, 255–261.
- , Wilson-Jones, C., Mayou, R., et al (2000) Childhood predictors of adult medically unexplained hospitalisations. Results from a national birth cohort study. *British Journal of Psychiatry*, **176**, 273–280.
- Janicke, D. M. & Finney, J. W. (1999) Empirically supported treatments in pediatric psychology: recurrent abdominal pain. *Journal of Pediatric Psychology*, **24**, 115–127.
- Larsson, B. (1992) Behavioural treatment of somatic disorders in children and adolescents. *European Child and Adolescent Psychiatry*, **1**, 82–88.
- Lask, B. (1986) The high-achieving child. *Postgraduate Medical Journal*, **62**, 143–145.
- & Fosson, A. (1989) *Childhood Illness: The Psychosomatic Approach*. Chichester: John Wiley & Sons.
- McGrath, P. J. & Reid, G. J. (1995) Behavioral treatment of pediatric headache. *Pediatric Annals*, **24**, 486–491.
- Murray, C. S., Cohen, A., Perkins, T., et al (2000) Morbidity in reflex sympathetic dystrophy. *Archives of Disease in Childhood*, **82**, 231–233.
- Rangel, L., Garralda, E., Levin, M., et al (1999) Psychiatric adjustment in adolescents with a history of chronic fatigue syndrome. *Journal of the American Academy of Child Psychiatry*, **38**, 1515–1521.
- , ---, ---, et al (2000) Personality in adolescents with chronic fatigue syndrome. *European Child and Adolescent Psychiatry*, **9**, 39–45.
- Verhulst, F. C., Visser, J. H., Ende, J., et al (1999) Continuity of psychopathology in youths referred to mental health services. *Journal of the American Academy of Child and Adolescent Psychiatry*, **38**, 1560–1568.
- Vereker, M. (1992) Chronic fatigue syndrome: a joint paediatric-psychiatric approach. *Archives of Disease in Childhood*, **67**, 505–555.
- Walker, L. S. & Greene, J. W. (1989) Children with recurrent abdominal pain and their parents: more somatic complaints, anxiety and depression than other patient families? *Journal of Pediatric Psychology*, **14**, 231–243.
- White, M. (1984) Fear busting and monster taming: an approach to the fears of young children. *Dulwich Centre Review*, 29–34.
- Wright, B., Partridge, I. & Williams, C. (2000) Management of chronic fatigue syndrome in children. *Advances in Psychiatric Treatment*, **6**, 145–152.
- World Health Organization (1992) *Tenth Revision of the International Classification of Diseases and Related Health Problems (ICD-10)*. Geneva: WHO.
- Wynick, S., Hobson, R. P. & Jones, R. B. (1997) Psychogenic disorders of vision in childhood (“visual conversion reactions”): perspectives from adolescence: a research note. *Journal of Child Psychology and Psychiatry*, **38**, 375–379.
- Zwaigenbaum, L., Szatmari, P., Boyle, M. H., et al (1999) Highly somatizing young adolescents and the risk of depression. *Paediatrics*, **103**, 1203–1209.

Multiple choice questions

- In the management of somatoform disorders in adolescents:
 - increasing emotional recognition and expression through non-verbal and verbal techniques is often helpful
 - Selective serotonin reuptake inhibitors are almost invariably useful
 - psychiatric in-patient admission is rarely appropriate
 - disruption of normal sleep patterns usually resolves spontaneously
 - adolescents may benefit from cognitive approaches to their physical symptoms and fatigue.
- When families reject CAMHS intervention for somatoform disorders:
 - subsequent paediatric/psychiatric efforts at engagement are normally fruitless
 - continued liaison with paediatricians is indicated to reduce unnecessary medical interventions
 - liaison with professionals in education, health and social services may help to reduce the adverse impact on emotional, social and educational functioning
 - child protection procedures are never indicated
 - longer duration of illness may be anticipated.
- Regarding severe somatoform disorders and chronic fatigue syndrome in childhood and adolescence:
 - the prognosis is well established
 - specific and generalised learning difficulties are associated with poorer outcomes
 - there is often overlap with other somatising disorders
 - the prognosis is affected by parental beliefs and expectations
 - the prognosis is better for boys than for girls.
- Long-standing multiple pains in children and adolescents:
 - are not associated with increased rates depression and anxiety in the long term
 - may be associated with increased sensitivity to pain of all kinds

- c require full assessment to establish the extent of coexisting peer group and academic difficulties
- d respond best when multi-disciplinary management integrates paediatric and CAMHS inputs
- e do not correlate with increased rates of physical symptoms in parents.
5. As regards factitious disorders:
- a the presenting fabrication usually resolves
- b the earlier the difficulties present, the more likely are long-term problems of somatisation
- c acknowledgement of fabrication is essential for therapeutic work to proceed
- d relapse or a representation with different symptom are not uncommon
- e these be associated with social and relationship difficulties.

MCQ answers

1	2	3	4	5
a T	a F	a F	a F	a T
b F	b T	b T	b T	b F
c T	c T	c T	c T	c F
d F	d F	d T	d F	d T
e T	e T	e F	e F	e T

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Guidance for researchers and for ethics committees on psychiatric research involving human participants

Council Report CR82

Ethical issues in relation to research have come increasingly to the fore in recent years. This has happened as a result of both a growing public and professional awareness of the need to protect people (both patients and volunteers) who agree to participate in research, and a realization that research developments have raised new issues that have to be addressed. It is in everyone's interest that high quality research should be fostered and supported, but it is essential that this be conducted ethically in the context of appropriate risk-benefit analysis.

It was against this background that the Royal College of Psychiatrists set up an interdisciplinary working party to undertake a thorough reconsideration of the key issues with a special focus on concerns that apply particularly to psychiatry. Members of the working party reflected expertise in the different branches in psychiatry (including its subspecialties), and in neurology, neurosurgery, psychology, social work, nursing, law, philosophy and consumer concerns.

The topics covered in the report include: ethical responsibilities; the scope of ethics committees and varieties of research; research governance and clinical care; informed consent, capacity and competence; and the operation of ethics committees. The report notes the present state of the law but seeks to derive principles and to put forward practical guidelines for good practice.

An executive summary indicates the specifics of these guidelines, the body of the report provides a fuller background on the reasons for them, and appendices give more detailed considerations with respect to children's understanding of medical decisions; decision making and assessment of competence in individuals with a learning disability; and waived consent for research into acute grave illness, including unconscious patients, under emergency conditions.

The target audience for the report includes both researchers, with respect to their ethical and clinical responsibilities, and ethics committees, with respect to guidance on the issues that may be relevant in relation to applications dealing with mental health and illness issues.

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