SOMATIZATION DISORDER IN ADOLESCENTS
-CASE PRESENTATION-
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ABSTRACT

The common feature of somatoform disorders is the presence of physical symptoms that suggest a physical disorder that was either not found or does not match the level of functional impairment. Somatoform disorder studies are based on DSM criteria and apply mainly to adults, although some of these studies also investigated the presence of these disorders in children. In practice, attempts to use these criteria in child and adolescent mental health facilities were rather problematic, as many of these patients cannot meet strict criteria of admission even if the general range of symptoms is similar to those in adults. In practice it is found that, in most of them, somatoform disorders are a transient reaction in childhood and many of them resolve spontaneously. The most common somatoform disorders in children and adolescents are recurrent abdominal pain, headache, somatisation disorder, undifferentiated somatoform disorder, conversion disorder, hypochondriasis and dimorphic disorder. "Functional somatic symptoms" or "unexplained physical complaints" are now generally agreed terms that can be used for children with a more comprehensive scope. We will use this case presentation to illustrate that even though criteria are not always met, with the right support, for them and their families, from a multidisciplinary team, these children can have a good prognosis.

Keywords: somatoform disorders, child, adolescent

INTRODUCTION

Many clinicians consider somatisation to be a learned behaviour, which might begin from the experience that being physically ill is more acceptable for many caregivers than it is the expression of strong feelings. However, somatisation is seen in children who cannot get attention for emotional distress and who learn, in time, without purposefully doing so, that they may gain attention for the physical symptoms that often accompany the disturbed emotional state. Stress is the main triggering factor and the most common form of stress among children and adolescents is the pressure on the child to perform. The case presented here is very descriptive of how parents can expose children to mental health problems by having expectations that exceed young people’s possibilities, even if the parents always have their children's best interest in mind.

CASE PRESENTATION

We report on the case of a 14-year-old adolescent who was hospitalized after fainting during math class. The teacher said that the adolescent looked as if she was "hypnotised", with pale skin - especially facial pallor, without being accompanied by hypertonic or tonic-clonic manifestations, recounting that the episode lasted about a minute until the intervention of the school nurse who administered a vial of calcium i.v. After that, the patient partially recovered - she could hear but she could not speak. The ambulance was called and the patient taken to the local paediatric hospital for investigations and treatment.

The girl was abandoned in hospital at the age of two. Until then, she had lived with her birth parents who are no longer in contact with her. For this reason, we have no data about the mother or other members of the family, pregnancy, birth and early psychomotor development. After the age of two, she entered the Child Care Services and was sent to a foster care placement where she resided until the age of six years and eight months when she...
was sent to another caregiver. She has been in the Paediatric Mental Health evidence from the age of five when she presented difficulty adjusting to kindergarten, delay in cognitive development, micturition disorders and hyperactivity. After the neuropsychological and psychological evaluation, she was given a diagnosis of mild mental delay (mental age 3.6 years), simple dyslalia, attention deficit hyperactivity disorder, primary nocturnal micturition and she received treatment with neurotrophic substances. The caregiver was advised on how to offer more consistent educational and affective support.

At the age of almost 7 years old the patient was placed in another foster care and she was mentally and psychologically revaluated. She was given a similar diagnosis of mild mental delay (IQ = 57), dyslalia and attention deficit hyperactivity disorder and it was decided to postpone her going to school. The family was advised to enter the child into cognitive stimulation programme in order to assure a better future adaptation to school. It should be noted that the foster mother has two children of her own with very good professional results and showed an increased interest in the patient's school performance, trying to compensate for her deficiencies in the hope of a future school integration as close to normality as possible.

A month after the decision was taken, the patient presented with left hemicorp paraesthesia with functional deficit at the same level without loss of consciousness, lasting for a few minutes after playing in a swing in the park. The clinical and neurological examination, EEG and CT showed no changes at that time and the event did not repeat in the next years. She attended the first four school grades with special psychological and pedagogical support, adaptation was difficult, with poor school outcomes, with permanent support from the caregiver. Given the difficult adjustment and poor school results, at the time of the passage to middle school, she was recommended attending a special school. The caregiver insisted on her attending normal school with special adapted curriculum.

Until the seventh grade, benefitting from an adapted curriculum, with support from the caregiver and with specialized treatment and counselling no other special events occurred until the patient fainted during school classes. The clinical and neurological examination, laboratory tests, EEG and MRI did not show anything pathological. The psychological examination took place without difficulties as the patient was very communicative and was eager to speak about the event happping in the classroom: "I felt weak and then I don't know". She says she feels very well at school, with peers and teachers alike, and does not speak about whether it is difficult to prepare her homework or about how her colleagues view the adapted curriculum. She is discharged, with the caregiver being advised to be more careful about the academic pressure that she puts on the child in order to maintain a minimum pace of adjustment. It has to be mentioned that the caregiver has a new foster child, a six years old boy.

During the following months, more hospitalizations in various departments of the hospital for different symptoms follow: in the cardiology department for chest pain and respiratory distress, to neurology for liyotimic recurring events or trouble sleeping (episodes falling into a deep sleep with low reactivity), most of these events happen at school, during classes but also at home. All the investigations performed during this repeated hospitalization episodes showed no evidence that could explain the symptoms. High frequency of hospitalization and the recurrence of these events in school indicate low adaptation skills and high frustration towards teachers, the caregiver but especially towards colleagues. The difference between what she can do and what she would like to be able to do was more and more obvious, despite her attempts to deny and mask this. However, repeated hospitalization, in some case rather dramatic in nature (ICU) only confirms the inability to cope with both pressure from school and from the caregiver - who is perfectionist in nature and denying the obvious.

Counselling to change the school environment become a priority for both the patient and the caregiver, the perspective of a more relaxed programme and a good place in class hierarchy was approached at every meeting finally leading to the patient being moved to a special school. The adolescent says that in school she is bothered by "noise", which she "cannot stand" and because of that she "

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has headaches and gets sick”. The perspective of a new environment, where she could be valued and in which she would develop self-confidence and, even more so, self-acceptance, is regarding reluctantly, insisting on her attachment to teachers and fear of the new. Despite all these complaints, adaptation to the new school has been very good, now the patient is at the end of eighth grade, with the prospect of attending a vocational school. After being transferred to the special school there were no more neurological, cardiac, respiratory, gastrointestinal or other manifestations, this being a proof for a good integration. The following appointments included discussions about present and future plans. The psychological examination evaluation at that time (January 2014, 15.4 years old) revealed the following: personality development with a high degree of distractibility; the patient told stories with very expressive gestures, including less pleasant details about her life history and mentioning events which took place at a very early age when memories are usually faded, admitting that some were recounted by others: memories from the period spent with her first foster family where it seems she received an education based mainly on physical punishment. The patient’s cognitive acquisitions remained below average compared to her age and stage of development, confirming the diagnosis of mild mental retardation IQ = 58 (WISC). She described a balanced, supportive family climate, relatively good school adaptation; teachers state that there are no conflicts with colleagues. The adolescent has a perpetual state of inner conflict. She is frequently thinking about her life history. She would like to meet and live with their natural parents. Her expectations remain inconsistent with her cognitive possibilities. She wants to attend the Conservatory, to learn canto in order to become a music teacher. She is perpetually creating models out of the people she prefers: teachers, older brothers, acquaintances.

When talking about her wishes and troubles, she wants to go to a good college, have a career, have good school scores and stay with her foster family. She refuses to think about vocational school, which she considers beneath her aspirations and possibilities.

The Family Drawing: She drew herself first, near the mother, placed at the top left corner of the page, drew people with significant tangible details: large head (mother and patient) covered ears, round mouth, long neck, short arms in 'V' shape, with thick fingers, wide feet. The adolescent and her mother are shaded.

The layout of the drawing at the top left corner: refuge in imagination; ambivalent attachment to the mother and sensitivity.

Curly hair, big head (mother and patient): narcissistic tendencies, overestimation of own possibilities.

Round eyes, round mouth, ears covered: fear or curiosity, sensitivity to criticism, infantile character.

Long neck, short arms in “V” shape: sensitive person, weak intellect. Insecure, ambivalent attachment to the mother, refuge in the imaginary world, infantile character, sensitivity to criticism.

CONCLUSIONS

The positive diagnosis was made easier by the numerous hospital admissions into different departments, with numerous and repeated investigations both in terms of paediatric and neurological examinations.

Of course, a strict framing is perhaps more difficult given the complex symptomatology of cardiac, respiratory, digestive and neurological distress, although the functional character cannot be challenged given the absence of any modifications in the clinical and laboratory examinations and the remission of complaints in the new conditions of a supportive environment. The diagnosis of Polymorphic Somatic Symptoms of functional character is the closest match, taking into account the complexity of clinical manifestations.

This case was chosen to be presented because the team who managed it was able to watch the evolution of this patient over time, with periods of maladjustment and their correction as the environment was adapted to her needs.

The case is characteristic for this pathology and commonly found in child and adolescent mental health services. It reflects the transitory nature given that intervention helps the patient overcome maladaptation. It is important that patients are constantly helped to overcome stressful moments in the future and that they are supported and prepared to adapt...
to an environment close to their possibilities that will also offer satisfaction close to their aspirations. The Centres for Child and Adolescent Mental Health do play a big role in managing these complex cases.

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REFERENCES

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