PEDIATRIC SOMATIZATION
Professional Handbook

Dr. Theresa Newlove
Dr. Elizabeth Stanford
Dr. Andrea Chapman
Dr. Amrit Dhariwal

with contributions from
Dr. Gelareh Karimiha
Dr. Janine Slavec
and the Integrative Health Working Group at BCCH
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PART I – INTRODUCTION

At BC Children’s Hospital, we have had the privilege to work with many children suffering from somatic symptoms. We have seen that if the system is not designed effectively to help, children and families can suffer for prolonged periods. Somatization can be challenging to diagnose and treat, and at the same time, it is also one of the most clinically rewarding areas of practice. Over the years we have learned a lot from children and families affected by somatization, and we have compiled our discoveries in this professional handbook. Our goal in writing this handbook is to help reduce suffering and support children and families to accept and access the most appropriate care in a timely manner. This handbook outlines 1) our understanding of somatization, 2) how we convey this understanding to children and families, and 3) our treatment approach. Our hope is that in this handbook, clinicians will find the tools and confidence they need to help these children and families.

1. UNDERSTANDING SOMATIZATION

What is somatization? Somatization refers to the physical expression of stress and emotions (often ‘negative’ emotions). A somatic symptom is a physical (or body) symptom that occurs as a result of stress and some emotions, rather than a medical illness or injury (e.g. inflammation, infection, neoplasm, endocrine disturbance, etc.). Everyone experiences somatic symptoms during his or her life; somatization is normal and real. Examples of common somatic symptoms include stomachaches and headaches. Examples of less common somatic symptoms include gait disturbance, non-epileptic seizures, visual impairments and other body movements.

Somatization may occur in the absence of or in conjunction with a medical condition. We diagnose somatization when the physical symptom occurs without any evidence of an illness/injury or when it occurs in excess of what would be expected for a medical condition.

Somatization is not well understood by children, families, the public, or health care providers. Children may suffer with somatic symptoms for months and even years going from specialist to specialist, all the while withdrawing from normal and developmentally appropriate activities. In our work, we have tried to integrate our care – medical, psychological, and rehabilitative. We have also coached our whole team on providing consistent and clear language to normalize somatization. Our ‘foundation language’ is used to help families and health care providers understand somatization in a way that is transparent, simple and makes sense.

**Foundation Language - Somatization Explained**

- All emotions have a physical component; for example, the lightness of joy, the flush of shame, or the tears of sadness.
- “Soma” means body.
- “Somatization” is the word we use to describe the physical (or body) expression of stress and some emotions.
- Stress can be positive or negative.
- Everyone somatizes
- Somatic symptoms are real.
- Although everyone experiences somatization, for some people somatization gets in the way of everyday life and requires treatment.
- Somatization can occur on its own, or alongside another medical condition.
What is a Somatic Symptom Disorder or a Conversion Disorder? A Somatic Symptom Disorder (SSD) or Conversion Disorder (CD) is diagnosed when a somatic symptom significantly interferes with a person’s functioning. Common SSD symptoms include pain, dizziness, fatigue, cough, and nausea. Common CD symptoms include fainting, seizures/convulsions/movements, difficulty walking, numbness, and blindness. The DSM5 diagnostic criteria for these disorders are shown below.

**Somatic Symptom Disorder**

A. One or more somatic symptoms that are distressing or result in significant disruption of daily life.

B. Excessive thoughts, feelings, or behaviors related to the somatic symptoms or associated health concerns as manifested by at least one of the following:
   1. Disproportionate and persistent thoughts about the seriousness of one’s symptoms
   2. Persistently high level of anxiety about health or symptoms
   3. Excessive time and energy devoted to these symptoms or health concerns

C. Although any one somatic symptom may not be continuously present, the state of being symptomatic is persistent (typically more than six months).

**Conversion Disorder**

(Functional Neurological Symptom Disorder)

A. One or more symptoms of altered voluntary motor or sensory function.

B. Clinical findings provide evidence of incompatibility between the symptom and recognized neurological or medical conditions.

C. The symptom or deficit is not better explained by another medical or mental disorder.

D. The symptom or deficit causes clinically significant distress or impairment in social, occupational, or other important areas of functioning or warrants medical evaluation.

For the purposes of this handbook, both Somatic Symptom Disorder symptoms and Conversion Disorder symptoms are referred to as ‘somatic symptoms’. The experience and expression of these symptoms are referred to as ‘somatization’.

If some aspect of somatization is suspected but full criteria for SS or CD are not met or there is uncertainty about the diagnosis or there are ongoing medical investigations, we often use the term ‘a component of somatization’. A component of somatization means that the symptom is caused, at least in part, by somatization. Using the term ‘component of somatization’ acknowledges the interrelationship of the ‘medical’ and the ‘somatic’. It helps us remember that we aren’t always able to determine what is ‘medical’ and what is ‘somatic’.

**How are somatization and mental health related?** Somatization and mental health disorders may be inter-related. Somatization may result from or be the cause of, anxiety, depression and/or other mental health conditions. It is important to understand this interrelationship and to assess and address mental health issues. In our clinical experience, the following are different ways that we see somatization presenting along with other mental health symptoms and conditions.

**Subclinical Anxiety and Predisposing Temperamental Traits:** Somatization occurs when stressors overwhelm the child’s capacity to cope. Some children have temperamental traits that cause them to be highly sensitive to stress. For example, a perfectionistic, sensitive and internalizing
child may put pressure on themselves to perform. Often these children are sensitive to, or ‘pick up’ on everyone else’s stress, yet they have difficulty recognizing and expressing stress. This child is more likely to somatize; their body is ‘talking’ for them.

**Co-morbid Mental Health Disorder:** The child has a clear and diagnosable psychiatric disorder such as Generalized Anxiety Disorder or Major Depression in addition to the somatization. For example, a child presents with symptoms of depression, as well as non-epileptic seizures.

**Underlying and Unrecognized Mental Health Disorder:** The child initially has somatic symptoms without any identified emotional distress, however over time as somatization is treated, the anxiety/depressive symptoms become more apparent. For example, initially a child presents with a somatic symptom (e.g. abdominal pain) and as they learn to identify their own feelings, the somatic symptom diminishes and the mood symptoms become more apparent.

**Somatic Symptom Presenting as Psychiatric Symptom:** The child presents with a symptom that initially appears to be a mental health symptom, but is a somatic symptom. For example, a child presents with a “psychotic” symptom (e.g. visual hallucination) without other typical symptoms of psychosis; the hallucinations may be a symptom of a Conversion Disorder.

**Self-harm or Suicidality:** Longstanding or severe acute somatic symptoms may contribute or cause the onset or exacerbation of other mood disorders. Day to day functioning can be significantly affected, resulting in marked mood disruption, experiences of pain and/or physical distress, social isolation and hopelessness. These youth may be at high risk for self-harm or suicidal behaviours.

2. **CLINICAL VIGNETTES**

**Somatic Symptom Disorder without a medical condition**

Brenda is an elementary school girl who has always been kind and caring. She has many friends and is close with her family. Brenda enjoys being in the school band, however struggles with math and reading comprehension. During the school year, she experienced significant pain in her right arm from her elbow to her fingers. Brenda was not able to participate in academic or school band activities because of pain. Her mother is currently on sick leave from work. The results of the medical assessment did not indicate a medical cause.
Somatic Symptom Disorder with a medical condition

Raj is an athletic teenager who is involved in competitive soccer and hopes to play for a university team. Near the end of the last season, Raj sustained a concussion and subsequently missed a month of school and soccer. His concussion symptoms (headaches, photophobia, concentration difficulties and fatigue) resolved over a month, however during spring break, Raj’s headaches returned. He was not able to successfully return to school or re-join the team in time for the end-of-season play-offs.

Conversion Disorder

Sarah is a high-achieving and responsible teenager who keeps her emotions to herself. Sarah has a small and close group of friends. She recently started middle school in an academic enrichment stream. In October, Sarah began having episodes resembling seizures (falling to the ground and twitching muscles with reduced responsiveness). These occurred up to twenty times a day. The results of all the medical assessments did not indicate a medical cause. Sarah continued to attend school, but her fainting caused her to spend much of the day in the nurse’s office. Two of her friends often left class to be with her.
PART II - DIAGNOSIS

1. COMMUNICATING THE DIAGNOSIS

Who makes the diagnosis of somatization? The medical care provider – the family doctor, pediatrician, medical specialist, or nurse practitioner – makes the diagnosis of somatization. The medical care provider has assessed the physical symptom and evaluated the medical workup; therefore they are the only person who can appropriately make the diagnosis. This can be confusing because somatization is considered a psychological process and Somatic Symptom Disorders are mental health disorders typically diagnosed by a psychiatrist or psychologist. However, the diagnosis is not made on the basis of the patient having psychosocial stressors, certain temperamental or personality traits, or other psychiatric disorders. The diagnosis is based on the medical examination and workup.

What should the diagnosis be? And what language should be used? In most circumstances we have found it helpful to label somatization directly and explicitly rather than using less specific terms (e.g., functional, psychogenic, medically unexplained, amplified, non-organic, etc.). A lack of consistent language leads to confusion for the child and family, as well as the health care team. Our medical care providers will usually use the diagnosis of ‘a component of somatization’ rather than Somatic Symptom Disorder or Conversion Disorder, particularly early in the process. This diagnosis is useful for several reasons. First, it acknowledges that there may be a co-morbid medical illness or injury that hasn’t yet been identified. Second, it is appropriate when there is another co-morbid medical condition (not an uncommon occurrence). Last, it acknowledges the complexity of the ‘medical’ and ‘somatic’ (mind-body) connection in certain clinical situations (e.g. Irritable Bowel Syndrome (IBS), migraines, Postural Orthostatic Tachycardia Syndrome (POTS), concussions, etc.).

Usually the diagnosis of somatization is not a diagnosis of exclusion and it is important to convey this to the family and other health care providers. The diagnosis is made based on the symptom description, the physical exam, and the interpretation of the investigations and our extensive knowledge about medical conditions and their presentations.

Who gives the diagnosis to the patient and family? And how? The medical care provider should give the diagnosis to the patient and family. It is helpful to have all the team members who have been involved at the team meeting. The medical care provider or other team members (e.g., psychologist or psychiatrist) may explain somatization.

In delivering the diagnosis, the medical care provider should review:
1. A summary of the symptom presentation
2. The results of the physical exam
3. The results of the medical investigations

These should be reviewed in detail with time to allow patients and family members to ask questions. Also, it is important to check in with the family to see if they are expecting other tests to be performed. If
so, take time to explain why these are not needed at this time. Reviewing the diagnosis is a process and families may benefit from more than one meeting.

**Why is it important to have a thorough review of the all the medical assessments when giving the diagnosis?** Understandably, many children and families are focused on the physical symptom and finding a medical cause for the symptom. Some children and families tend to be more focused on physical symptoms and medical causes, particularly if they feel that the symptoms are not being taken seriously. Many children perceive that the health care providers and others believe that “the symptom is not real”, or “it’s all in their head”. Additionally, some children and families have difficulty identifying negative emotions and stress and therefore do not intuitively understand somatization. They may acknowledge that the only stressor is caused by the symptom itself, but be unaware of other stressors in the child’s life. Thus, if a family’s medical questions and concerns are not directly addressed in the diagnostic discussions they may seek additional medical assessments and investigations.

**When should the family be advised to stop further assessment and investigations?** This is a hard question to answer and there is no clear response. It depends on each situation and each medical care provider’s conviction about their diagnosis. Although we do not want to facilitate unnecessary medicalization of the symptom, extensive testing, iatrogenic harm with unwarranted medical treatments, or a delay in seeking treatment for the somatic component, we often suggest that our medical colleagues investigate thoroughly. We often suggest families “walk two paths” – i.e., engage in treatment for somatization while medical investigations are still underway (*more details on p. 13*).

**When should the concept of somatization be introduced?** If you suspect that there is a component of somatization, we encourage you to introduce the concept that stress, emotions, and physical symptoms are often linked early in the process, even prior to the completion of all the medical investigations. This link between stress and emotions and the body is called the mind-body connection.

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**Example: Introducing the Mind-Body Connection**

- We are going to order some tests and investigations to determine if there is a medical condition causing this symptom.
- At the same time, we know that stress and emotions make physical symptoms worse and can, sometimes, even play a role in the onset and maintenance of physical symptoms.
- We also know that having physical symptoms like this, getting medical tests done, and waiting for the results is often stressful for children and their parents.
- Because the connection between stress, emotions and physical symptoms are so powerful, we want to find out about the different kinds of stress or emotions that [child] is experiencing.
What if the child or family is not “ready” for a diagnosis of somatization? As mentioned, we have found that using the term ‘somatization’ or Somatic Symptom Disorder is generally the most helpful for families and the team of care providers. Only in rare cases, do we choose to completely omit any reference to somatization, Somatic Symptom disorder, or Conversion Disorder. In those cases, we will have a team meeting to review the results of the medical assessment (i.e. review the ‘normal’ or ‘typical’ findings) and then discuss ‘stress, emotions and coping’.

**Example: Conveying the Diagnosis**

**Start of conversation:**
- You first experienced [physical symptom] last year and over the past few months it has become more frequent and intense. You have also started to have a few other symptoms, including [details].
- You saw your family doctor, and two pediatric specialists – a cardiologist and a neurologist and most recently you were admitted to the hospital.
- The doctors have all examined you and ordered lots of tests and investigations including [details]. It was very important to do these tests.
- In medicine, we listen carefully to the description of the symptom, we do physical exams (like listening to your heart) and we ask for special tests (like blood work and x-rays).
- Our diagnosis is based on the results of these three things and all the knowledge that we have about medical illnesses that present with similar symptoms.

**If the child has a somatic symptom with no medical condition:**
- Let’s review the tests and investigations you have had:
  - Description of symptoms
  - Summary of physical examination
  - List of tests and results
    - e.g. your MRI did not show any abnormalities
  - Summary of major conclusions
    - e.g. your heart is functioning perfectly
- Based on your symptoms and our assessment we do have a diagnosis.
- You have a serious and complex condition that is not a result of a medical illness or injury.
- You have what we call somatization/Somatic Symptom Disorder/Conversion Disorder.
- We are going to explain what a somatic symptom and somatization are – these aren’t words that many people know about.

**If the child has a somatic symptom with a medical condition:**
- In addition to your [medical condition], you have what we call somatization.
- Many medical conditions have a component of somatization.
- This is not a word that many people know about, so we are going to explain what this means.
2. EXPLAINING THE DIAGNOSIS OF SOMATIZATION

In our team meetings with the family, the medical care provider reviews the medical assessment(s) and gives the diagnosis of a ‘component of somatization’, Somatic Symptom Disorder, or Conversion Disorder. Often the psychologist or psychiatrist (if available) then explains the diagnosis. Our goal in this meeting is to help the family accept, or move towards accepting, that somatization is a component of the symptom presentation and can support their agreement to engage in appropriate treatments.

We have found it important to cover the following key points during the explanation of somatization:
A. Validate the child and family’s experience
B. Explain somatization using ‘foundation language’
C. Describe the mind-body connection
D. Agree to ‘walk two paths’; the medical and the somatization path
E. Recognizing family acceptance and readiness
F. Review the basics of treatment

The following scripts outline how we explain somatization to the child and their family.

A. Validating the Child and Family’s Experience:

At the outset, it is important to spend time trying to genuinely understand the experiences children and families have shared with you. This may not be a brief conversation. In many cases, their medical journeys have been confusing, frustrating, or upsetting. In doing so, clinicians can offer respect to the symptoms that are presenting and empathize with families’ perspectives. Moreover, clinicians can thereby also model support and acceptance of negative emotions. Allowing space to build this relationship with the family provides a trusting foundation on which somatization and the mind-body connection can be explained and understood.

Example Beginning to Conversation: Validation of the experience

- We want to acknowledge the suffering that the symptoms have caused and the impact they have had on [child] and your family.
- Having these kinds of experiences can be very difficult. People can feel helpless and uncertain about the future. Sometimes, experiencing these symptoms, going to doctors and hospitals, and worrying that something bigger has been missed can lead to confusion, frustration, or fear.
- It makes sense that you are so concerned about what could be causing these symptoms.
- You have been working hard to do all you can to help [child].
B. **Explaining Somatization**: Somatization is not well understood by children, families, the public or even health care professionals. Children and families are often confused, think that they are being dismissed too quickly and worry that a medical condition is being missed. They also often perceive that others (family members, teachers, doctors, nurses, etc.) think the child is “faking” the symptom.

By using the foundation language, we have an explanation intended to reduce some of these concerns. It is clear and transparent, normalizes somatization, and emphasizes that the symptom is real and not intentionally produced. We have found that using this explanation instead of using metaphors (e.g. computers and connecting wires, car alarms, etc.) reduces confusion. We have also found that in contrast to ‘using the family’s language’ or giving metaphors, this direct language helps families really understand the concept of somatization and allows them to move forward with treatments.

*As mentioned above, there are rare cases when we chose not to use the term ‘somatization’. In these cases, we still review the points above, but leave out the first two points, and in later points talk about the “physical expression of stress and emotions” instead of ‘sometimes’/somatization’.*

C. **Explaining the ‘mind-body connection’**: Many, although not all, children who present with somatization, have difficulty recognizing, understanding or talking about their stress and specific ‘negative’ emotions. It is important to educate the child and family about the mind-body connection and also to begin to make the links between the child’s specific stressors, emotions, and physical symptoms.
D. **Agreeing to ‘walk two paths’:** Many families struggle with the somatization diagnosis. Families who have children presenting with sudden and/or severe symptomology (non-epileptic seizures, gait disorder, blindness, fainting) typically experience a significant amount of anxiety and fear that something is being missed. Similarly, families whose children who have suffered chronic symptoms (pain, headache, fatigue) have been to multiple medical providers, undergone multiple investigations over time, and may also continue to seek a ‘medical’ diagnosis. For these families, we respect their concerns and uncertainty about the diagnosis and also suggest that we can agree to begin to treat the component of somatization, or at least help with symptom management.

The term ‘walking two paths’ refers to the simultaneous and non-mutually exclusive processes of:

i. continuing to engage in medical assessments, investigations and treatment as appropriate over time (in fact, ongoing medical monitoring and check-ins are highly recommended), and

ii. beginning to engage in psychological and rehabilitation treatments and strategies.

This ‘walking two paths’ approach allows for treatment to begin for children whose families who have issues with accepting a somatization formulation and/or who have ongoing medical concerns about their child’s physical symptoms. It helps families be more confident about engaging in treatment for somatization even if they still are seeking a medical diagnosis. The goals of the ‘walking two paths’ approach are to 1) collaborate with the family to provide some immediate symptom relief and/or increase in functioning for the child 2) reduce the possibility of a family disengaging with the health care team and possibly trying seek further medical investigations independently.

**Example Conversation: Agreeing to move forward with treatment - ‘walking two paths’**

*At this point in time, what we would like to suggest is that we agree to ‘walk two paths’ for [child] - the medical path and the somatization path. On one path, we will continue to monitor [child’s] physical symptom, watch for any changes to the symptom, and figure out if there are any more assessments that need to be done. At the same time, we will walk together on another path: We can work towards reducing the impact [child’s] symptoms are having in their life. We will support [child] with symptom management and help [child] to get back to her normal life as much as possible during this time. This other ‘path’ also includes exploring experiences of stress and emotion. Going forward, by helping [child] understand how stress and strong or mixed emotions can affect their body, [child] will also have the opportunity to learn ways to manage their symptoms.*

E. **Recognizing family acceptance and readiness:** Over the course of the assessment process, the health care team may come to position of certainty about the somatization diagnosis, however, it is understandable that a child and family may not be as certain or ‘ready’ and may advocate for additional medical investigations. We address this openly and non-judgmentally with children and families over the course of the assessment and diagnosis process.
F. Describing the Basic Treatment Approach: There are many components of treatment drawing on different specialties within health care and on a variety of aspects of the child’s life and family. The ‘BC Children’s Pediatric Somatization Treatment Model’ outlines the components we have found most helpful. We use this framework amongst health care providers and with children and families. Part III of this handbook describes the treatment model. In the initial conversation when the diagnosis and explanation is given, we may give an overview of the treatment model or we may outline the basic principles of treatment, leaving a more detailed conversation about the treatments for the next appointment.

Example Beginning of Conversation: Recognizing family acceptance and readiness

- Hearing that all test results are normal can be both a relief and at the same time a source of frustration for families.
- Many parents on one hand feel relieved that a serious medical condition has been ruled-out, but on the other hand do not feel relieved at all because [child] is continuing to experience the [physical symptoms].

Example Conversation: Describing the basics principles of treatment

- We have every expectation that [child] will get better.
- There are very good treatments for somatization and we will help you understand and access these treatments.
- There are a number of different components that we use in treatment, including
  - learning how to manage and cope with the symptom,
  - learning about stress, emotions and the mind-body connection
- A major goal of treatment will be to help [child] get back to their regular activities in a manageable way.
iii. HELPING FAMILIES EXPLAIN THE DIAGNOSIS TO OTHERS

A child has been rushed to the Emergency Department an acute onset of visual disturbance following a few weeks of dizziness and difficulty walking. The child is admitted to the hospital and is being cared for by the neurology team. An MRI, EEG and eye exams have all come back as ‘normal’ and the treatment team has been speaking with the child and parents about stressors. The parents have been updating extended family members and friends about the child’s care. The neurologist and team members explain that their child does not have a serious neurological condition – instead they have diagnosed the child with a Conversion Disorder and that the physical symptoms are a result of psychological stress. The treatment is physiotherapy and psychotherapy.

The above example occurs in the hospital setting on a regular basis. Sometimes the family themselves receive feedback from their friends and extended family telling them they should be asking more questions, getting more tests and that they should not leave the hospital until they have a better explanation. The somatization diagnostic discussion can ‘stall’ when a family or child is uncomfortable or having trouble thinking of how they can explain that there were no medical findings to explain the child’s severe symptoms. We have found it most helpful to be proactive with children and families by having the ‘what do we tell other people’ discussion.
We remind children and families how complex somatization is, and how difficult it can be to explain to others. For the child, we help them use their own words to explain their condition and treatment. We ask the child if they are comfortable sharing more information with people they are closer to and less information with people that they don’t know as well. We ask children to think of questions they might ask someone who has had the same kind of symptoms to allow them think of answers if they are asked similar questions. We follow the same process with parents. Parents typically appreciate this conversation and it also provides an opportunity for them to clarify their understanding of the diagnosis and the treatment plan.

Examples of Child/Youth Explanations:

Example (1): I went to the hospital because I had trouble seeing and walking and my parents were really worried. The doctors did a lot of tests and found out that I don’t have a really serious (bad) medical condition or injury. I am doing some physiotherapy to help with walking and I’m learning about why my body is having these symptoms and other things I can do to get better.

Example (2): I went to the hospital because the symptoms from my concussion that happened months ago seemed to be getting worse instead of better. The doctors ran some more tests and it seems like I am recovering from the concussion, but some of my symptoms are not related to my injury. They explained that stress and emotions can be expressed physically and that these symptoms are likely related to the things that are going on in my life. They taught me some pain management strategies and I am learning how the stress I have is affecting my body and some better ways to deal with the things that are bothering me.

Examples of Parent Explanations:

Example (1): We were really worried when our child was having trouble walking and talking. The physicians at the hospital had a lot of questions and ran a number of tests. The good news is that they did not find any serious medical condition or injury. They explained that our child was experiencing somatic symptoms – sometimes called conversion disorder. So although our child is having these symptoms they are not because of a brain tumour or encephalitis. Instead, it seems like our child is experiencing stress and sadness and since it is hard for them to talk about it, their body is doing the talking for them. Our child is receiving physiotherapy to help them improve their walking and balance and psychotherapy to help them find better ways to deal with their stress. We are all still monitoring our child closely.

Example (2): We were concerned that our child’s concussion was not healing and that the symptoms seemed to be getting worse instead of better. When we took the child to emergency, they ran some more tests and went over the course of child’s symptoms. They also asked about any stresses in our child’s life. They explained that it is likely that our child has recovered from the concussion, but that the headaches are somatic symptoms. So our child is experiencing real and painful headaches but not because of the concussion, instead they seem to be related to stress and emotion. We started to talk to child some more and realized that they are really stressed about school and sports. They are able to treat these headaches and have taught our child some pain management strategies. They encouraged us to talk to the school and child’s coach. Our child is also doing therapy to help him cope with stress in a different way and to be able to talk about emotions instead of bottling them up.
iv. **RESPONDING TO CONCERNS ABOUT THE DIAGNOSIS**

We have found that, if the above communication strategies are followed, children and families usually understand and accept that there is component of somatization and are willing to engage in psychological and rehabilitative therapies. However, there are times when the children and families may disagree or express concern about an aspect of the treatment plan. The following are some concerns that families may raise and examples of our responses.

**The family disagrees with diagnosis and does not accept that there is stress in child’s life:**

> We agree that we cannot be 100% certain that there is not an underlying medical cause for these physical symptoms. We are certain that [child] does not have any serious medical condition that is causing these symptoms. We appreciate your time and motivation in finding a way to understand/explain what is causing the symptoms. We can go over the possibilities and ideas you have researched to understand the possible medical causes of the symptoms and how they relate to types of medical investigations and results that we have completed to date.

> I think that we can also agree that if [child’s] symptoms were gone tomorrow, there probably would be stress in his life because of having had the symptoms. Let’s work on the stress he is experiencing as result of the symptoms by discussing options for symptom management and also supporting [child] with some stress management techniques.

**The family wants a second opinion:**

> Thank you for letting us know that you are seeking a second opinion from another provider. It would be very helpful, and in [child’s] best interests, if we could connect with that provider to share our results with them and hear their formulation of [child’s] symptoms. With this shared communication way we can all be on the same page to understand her needs. Let’s have a discussion about what therapies you are seeking so that we have the best combination of treatment approaches.

**The family do not want their child to return to school until they are symptom free:**

> If we wait for [child] to be 100% symptom free before returning to school, it will be even harder on him in the long run than returning on a part-time basis now. Even though it isn’t easy, we find that when children get back in their ‘normal’ routine, with some of the accommodations we have suggested for [child], this actually helps their overall recovery. Isolating from friends and worrying about getting behind in schoolwork can make symptoms worse.

**The family believe that the health care providers think the child is “faking” the symptom:**

> We want to reassure you that although we have found no medical cause for [child’s] symptoms, we are equally certain that they are experiencing the symptom(s). We know these symptoms are real; and, we can see that your child is suffering and that their life has been significantly impacted. This is part of the reason that somatization is such a complex condition. There may not be a simple explanation for these symptoms; instead there may be a number of factors that have contributed to the onset of these symptoms. I think we can agree that we can walk down two paths to support the treatment and recovery of these symptoms.
PART III - TREATMENT

THE BC CHILDREN’S PEDIATRIC SOMATIZATION TREATMENT MODEL

OVERVIEW

The BCCH Pediatric Somatization Treatment Model (BCCH PSTM), shown on p. 19, outlines different components of treatment that we have found most useful in helping children who somatize. Flexibility is the hallmark of the model. At any given time one or more of the components may be the focus of treatment and the inclusion of treatment components will vary with the needs of the child and family. The model components are not mutually exclusive, and there is no linear directionality among them. The path of treatment depends on the child and family’s unique strengths and needs and readiness to engage in treatment components. The child, their family, and other individuals or factors in their environment are all important in treatment planning. The key to successful treatment is active collaboration with the child and family and consistent communication between providers.

The MODEL
BC Children’s Pediatric Somatization Treatment Model

Physical Symptom Presentation

Assess and Treat Medical Conditions

Develop Understanding of the Mind-Body Connection

Assess and Treat Mental Health Conditions

Teach and Provide Symptom Management

Support Limited Environmental Adjustments

Encourage Balance and Pacing

Normalize Developmental Expectations

Facilitate Emotional Skill Development

Psychology

Psychiatry

Physiotherapy

Pediatrics

Family Medicine

Complementary and Alternative Medicine

Other Medical Specialists

All components above are integrated into individual and/or family therapy approaches as part of the treatment for Somatic Symptom and Related Disorders. See back page for explanatory text on treatment components.
The BC Children’s Pediatric Somatization Treatment Model components explained.

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<th>Assess and Treat Medical Conditions</th>
<th>Develop Understanding of the Mind-Body Connection</th>
<th>Assess and Treat Mental Health Conditions</th>
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<tr>
<td>Somatization on may occur its own OR along with another medical condition.</td>
<td>Somatization, the physical expression of stress and emotion, is not well-understood. Somatic symptoms can occur on their own or in conjunction with a medical condition (e.g. ‘component of somatization’).</td>
<td>Somatization may occur on its own or as part of a constellation of mental health symptoms (anxiety, depression, or personality traits).</td>
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<td>• Assess and investigate medical condition</td>
<td>• Label and define somatization</td>
<td>• Assess for mental health conditions</td>
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<td>• Have a team meeting to communicate diagnoses and treatment plan</td>
<td>• Explain how it is possible for physical symptoms to be connected to stress and emotions</td>
<td>• Identify any self-harm risk factors</td>
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<td>• Treat medical condition</td>
<td>• Help the family develop an understanding of the child’s diagnosis and stress-symptom predisposition</td>
<td>• Treat mental health conditions</td>
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<td>• Arrange for medical follow-up</td>
<td>• Be sensitive to the family’s acceptance of the somatization and readiness for treatment</td>
<td>• Note some mental health conditions may not emerge until after somatic symptoms are treated</td>
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<td>• Monitor symptoms</td>
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<th>Teach and Provide Symptom Management</th>
<th>Facilitate Emotional Skill Development</th>
<th>Redefine Parent-Child Roles</th>
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<tr>
<td>Physical and somatic symptoms that occur with somatization may benefit from specific treatment strategies. Consider a range of modalities for treating specific symptoms.</td>
<td>Difficulties with emotional awareness, expression and regulation can be related to somatization, and somatization can affect the development of these emotional skills too. In individual or family-based psychotherapy:</td>
<td>Somatization can influence roles within the parent-child system, and parent-child roles can have a bearing on somatization. Assess and support:</td>
</tr>
<tr>
<td>• Medication</td>
<td>• Help children investigate the connection between their physical symptoms and their emotions</td>
<td>• Normative development of the child’s independence and decision making</td>
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<tr>
<td>• Behavioural coping strategies</td>
<td>• Coach children and parents to tune into their emotional experiences, verbally express them, and empathetically respond to others.</td>
<td>• Parents’ taking time for themselves</td>
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<tr>
<td>• Physiotherapy</td>
<td>• Coach families in tolerating, accepting, and managing difficult emotions and stress.</td>
<td>• Normative involvement in family activities and routines</td>
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<td>• Complementary therapies</td>
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<td>• The need for family-based psychotherapy</td>
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<th>Support Limited Environmental Adjustments</th>
<th>Promote Resilience, Recovery, and Relapse Prevention</th>
<th>Encourage Balance and Pacing</th>
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<tbody>
<tr>
<td>Somatic symptoms, like many physical symptoms, are stress sensitive. The need for adjustments and supports in the following areas should typically lessen over time.</td>
<td>During the recovery process, resiliency is developed by participating in the range of treatment components. Recovery is usually non-linear. Continuing to follow the child after recovery can prevent relapse.</td>
<td>Somatic symptoms may take over a child’s life. Encourage activity and involvement in normal daily activities without overdoing it.</td>
</tr>
<tr>
<td>• School, sports, extra-curricular activities</td>
<td>• Identify and report resiliency/coping skills</td>
<td>• Avoid an “all-or-nothing” approach</td>
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<tr>
<td>• Peer group and social relationships</td>
<td>• Educate about the course of recovery</td>
<td>• Take small steps and keep going even if there are set backs</td>
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<tr>
<td>• Family expectations</td>
<td>• Plan wellness check-ups</td>
<td>• Pace physical symptom treatments/therapies</td>
</tr>
<tr>
<td>• Schedules, transitions, activities, etc.</td>
<td></td>
<td>• Avoid over-focusing on physical gains</td>
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</table>
In the initial stages, a thorough medical workup is necessary to ensure accurate diagnosis. Somatization may occur on its own (e.g. gait disturbance), as a component of another medical injury or illness (e.g. migraines) or co-morbid with another medical condition (e.g. epileptic and non-epileptic seizures). It is also important to reassure children and families that the child’s symptom is being taken seriously and evaluated appropriately. It can also be helpful to acknowledge that recent medical stress or illness can often be a precursor to somatization and to review that that illness or injury has been treated adequately. Once somatization has been identified it is very helpful to have a team meeting with all providers. During the team meeting the medical care provider should give the diagnosis. The discussion during the team meeting should include:

1. A summary of physical symptom(s)
2. The clinical findings from the physical exam and investigations
3. The diagnosis
4. An explanation of somatization
5. A plan for treatment – the BC Children’s Pediatric Somatization Treatment Model can be used as a tool to start treatment planning
6. An opportunity to address the family’s questions/concerns

The team meeting helps the family understand that the child’s symptoms are being taken seriously. It also reduces miscommunication and mixed messages.

It is important to have at least one medical care provider continue to be involved in the child’s ongoing care. Ongoing care may range from infrequent monitoring, with re-assessment when new symptoms emerge, to weekly check-ins. Families are more likely to accept and participate in psychological/psychiatric treatment if a medical provider is involved with ongoing care.¹

GOALS:
- Ensure an accurate diagnosis
- Build the therapeutic alliance with the child and family
- Set the stage for treating the somatization
- Treat the physical symptom and medical condition appropriately, at the same time as avoiding over ‘medicalization’ and iatrogenic harm

STRATEGIES:
- Assess and investigate the physical symptom
- Arrange a meeting with the child, family and health care team
- Treat the physical symptom that is associated with a known medical condition (e.g. pain medication, physiotherapy, anti-seizure medication, etc.)

¹ Please see PART II: Diagnosis of this handbook for more details and examples.
• Support understanding of treatment that is related to the somatic symptom which may or may not have some common approaches as treatment for symptoms related to medical conditions (e.g. pain medication, physiotherapy). Identify the additional treatment components outlined in the BC Children’s Pediatric Somatization Treatment Model that will be used to treat the somatic component or symptom*
• Ensure ongoing medical care provider involvement for routine follow-up visits
• Arrange for further medical assessments if indicated for new symptoms or changes in symptoms
• Actively engage in discussion with families

* Example: (1) Epileptic seizures are treated with anti-seizure medication. Once it has been determined that there are also non-epileptic seizures, medication is NOT increased, instead the child/family are taught how to recognize these seizures and respond with a safety plan and behavioural coping strategies. (2) Somatic symptoms such as gait disturbance often benefit from treatment such as physiotherapy along with other treatment components that make up individual treatment plans.

ii. DEVELOP UNDERSTANDING of THE ‘MIND-BODY CONNECTION’

In addition to a taking a medical history, a psychosocial assessment with a focus on the presence of stressors (e.g. school, family, extra-curricular activities, transitions, drug use, relationships, acute or chronic trauma) is necessary. Often families question why they are being asked about stresses in a child’s life when they have come to seek medical attention – this is one of the first opportunities to introduce the role that stress can play in the onset or exacerbation of physical symptoms.

It may be difficult to identify a child’s stresses. For example, a family may not perceive a child involved in competitive sports or multiple extra-curricular activities or unusually high achieving students as being ‘stressed’. We often hear from families that their child pushes themselves hard, is ‘naturally competitive’ or that they really want to participate in their extra-curricular activities. In these situations, it can be difficult for both the child and/or parent to appreciate how these ‘positive’ stresses might impact the child.

Children presenting with somatic symptoms are often seen as sensitive, perceptive and internalize their emotional responses such that they experience the ‘stress of others’ again, without recognizing the emotional impact. Additionally, stress in younger children may not easily be identified as ‘stressful’ (example: loss of a pet, a best friend moving away, illness of another family member) and/or they are perceived as ‘coping’ because there is no obvious emotional expression of stress.

In most circumstances, we have found it helpful to label somatization rather than using less specific terms. Labeling and describing somatization is helpful for understanding the symptoms and moving forward with appropriate treatments.2

GOALS:

2 Please see PART II: Diagnosis of this handbook for examples of the diagnostic discussion.
• Understand the child’s unique stress-symptom predisposition and history with a focus on developmental and environmental stressors
• Increase the child and family’s acceptance of somatization to the symptom presentation
• Increase awareness that all emotions have a physical component and that somatization is normal
• Make the connection between the child’s individual physical symptoms and stress and/or emotions if a link is initially apparent

STRATEGIES:
• Label and define somatization
• Help the family identify the unique stresses that have been affecting the child (e.g. school, family, extra-curricular activities, transitions, drug use, relationships, acute or chronic trauma)
• Teach children and parents that the ways individual people experience stress usually relates to either a physiological vulnerability or a learned physical vulnerability
• Teach ‘body-talk’; how the body processes emotions in helpful and non-helpful ways
• Encourage parents to share any ways that they express stress physically (e.g., blushing when embarrassed, muscle tightness when stressed)
• Be sensitive to the family’s acceptance of somatization and readiness for treatment
• Consider a referral to a relevant support or psycho-educational group. Examples from BC Children’s Hospital include: the Mind Body Connection Group, Pain 102, Mindfulness for Adolescents, etc.)

iii. ASSESS AND TREAT MENTAL HEALTH CONDITIONS

Somatization and mental health disorders may be interrelated. Somatization may result from, or be the cause of, anxiety, depression and/or other mental health conditions (for more information, see pages 4-5). In order to develop a individually-tailored treatment plan, it is important for a mental health clinician to clarify which of the following ways that somatization may present along with other mental health symptoms and conditions.

Subclinical Anxiety and Predisposing Temperamental Traits
Co-morbid Mental Health Disorder
Underlying and Unrecognized Mental Health Disorder
Somatic Symptom Presenting as Psychiatric Symptom
Self-harm or Suicidality

GOALS:
• Understand how somatization presents as part of the mental health spectrum
• Identify and treat any mental health conditions
• Identify and respond to any self-harm risk factors

STRATEGIES:

See the Kelty Mental Health Website Somatization Information sheet for more details: http://keltymentalhealth.ca/sites/default/files/kelty-somatization-brochure_final.pdf
• Complete an extensive developmental, psychosocial, and mental health history
• Assess the impact of somatic symptoms on the child’s mental health
• Educate the child and family about the relationship between the mental health condition and somatization
• Treat mental health conditions if appropriate, using psychotherapy and/or pharmacotherapy

iv. **TEACH AND PROVIDE SYMPTOM MANAGEMENT**

‘Symptom management’ is the most important therapeutic tool in the initial stages of treatment. It can be approached with medication, behavioural coping strategies, physical and complementary therapies to alleviate and/or reduce the intensity of the physical symptoms. Behavioural strategies are often the first step of symptom management and build the foundation for understanding the mind-body connection. They also help the child develop a sense of control and mastery. When the clinician helps develop symptom management strategies, they demonstrate to the child and family that they have a strong respect for the child’s symptoms. The symptom management approach helps build alliance and rapport with families who are ambivalent about diagnosis (e.g. we don’t have a diagnosis yet/we don’t have to agree on the diagnosis, but we can agree to a common goal of treating the symptoms). Although many children/youth benefit from symptom management, a number will require more intensive therapy approaches to address the underlying factors contributing to their somatic symptoms.

**GOALS:**
• Symptom reduction and relief
• Build rapport with child and family
• Develop tools to help prevent or lessen the impact of symptoms in daily life
• Promote a sense of control and mastery

**STRATEGIES:**

**Medication**
• Medication can be an important component of symptom management and may target symptoms such as pain or insomnia

**Behavioural Coping Strategies**
• Teach the child how to self-monitor their symptoms (if possible), and/or how to “catch” symptoms early
• Assess which behavioural coping strategies will be most helpful. Teach the child and family (if appropriate) how to implement strategies.
• Develop a symptom management plan that includes:
  1. Child-specific behavioural coping strategies
     - Diaphragmatic Breathing (e.g. ‘Belly Breathing’)
     - Progressive Muscle Relaxation
     - Visualization techniques
     - Distraction activities (e.g., listening to music)
     - Mindfulness techniques
     - Other physical or cognitive strategies that prevent or minimize the symptom
Physiotherapy Strategies

- Families are often willing to engage in physical therapy as it can validate the experience of the symptom and need for physical treatment.
- A referral to physiotherapy should convey all information regarding medical investigations and diagnostic formulation to ensure there is no duplication or request for additional medical workups for the presenting symptoms.
- Involvement of physiotherapy can provide necessary rehabilitation for disturbances of gait, coordination, and sensory impairment and may be essential to prevent long-term outcomes of physical inactivity (e.g. ligatures).
- The treatment approach to physiotherapy should typically be paced and activity oriented and coordinated with treatment approaches of other team members.
- Engagement in physiotherapy activities often provide an opportunity for the family to observe the child’s physical ability under different conditions.
- Physiotherapy can support the paced reintegration to typical school, social and family activities.

Complementary Strategies

- Families may have previous experience with complementary strategies (e.g., massage, acupuncture, aromatherapy, etc.) and these should not be discouraged unless there is a contraindication to the presenting symptoms.

SUPPORT LIMITED ENVIRONMENTAL ADJUSTMENTS

Somatic symptoms are stress-sensitive. A thorough and developmentally sensitive psychosocial assessment of stress in the child’s life can inform any adjustments and accommodations to support the child. Adjustments and accommodations in the child’s environment will support the child’s participation in school, social events and extra-curricular activities. It is important that ‘stressful’ situations are not altogether avoided. Every child needs to build skills in managing normal/typical levels of stress and resiliency for atypical or more intense experience of stress. A finely balanced approach to reduce stressors yet encourage participation in developmentally necessary and appropriate activities is vital. The child’s level of participation and need for accommodations/adjustments will change over time, ideally with supports lessening over time. A discussion of pacing and subsequent weaning of adjustments or accommodations is essential in the collaborative treatment planning process with the child and family.

After the onset of symptom, sudden or gradual, the child will experience ‘outcomes’ in their environment (e.g. missing school, non-participation in sports, changes in social or family routines). This is referred to as un-intended secondary gain. Since somatization is usually a response to stress, a pattern can emerge such that children may often be asymptomatic for certain situations compared to others. At this point in time it is essential to remind family and educators that these symptoms are unintentional, as there is a risk that they may believe that the child is ‘faking’ the symptoms to achieve a certain outcome. Intentional production of symptoms can happen over time as a child has learned how expectations change when
symptoms are present; however in our experience usually there is an unconscious component. We always work on the assumption that that the symptoms are unintentional but stress-responsive.

GOALS:
- Reduce the stress burden
- Facilitate participation in school, social and extracurricular activities
- Maximize functioning and reduce the need for unconscious secondary gain

STRATEGIES:
- Elicit child and family stressors
- Limit participation in overly stressful activities or situations
- Add supports to reduce stress (e.g. tutoring for school; modified participation in activities)
- Support the family to learn to respond to physical symptoms differently including an increased focus on the child’s emotional experiences
- Create realistic activity schedules with attention to transitions
- Advocate for a School Based Plan including:
  - a plan for symptom management with school based behavioural coping strategies clearly outlined
  - specific social integration supports
  - academic accommodations
  - information for the school to help facilitate a special needs designation, if appropriate

vi. ENCOURAGE BALANCE and PACING

Somatic symptoms may take over a child's life and have a significant impact on other family members. We often encounter children who have stopped attending school, dropped their extracurricular activities, and/or have stopped spending time with friends. Children may have stopped these activities because of the stress associated with participation and the subsequent development of the somatic symptom and/or the somatic (or medical) symptom prevented the child from participating in these activities. Either way, it is very important for the child to return to participating in their normal daily activities again, without ‘overdoing it’, which can result symptom intensification or the onset of new symptoms.

It is important to understand that symptom reduction and physical recovery may place the child or youth ‘at risk’ for having to face the stresses that may have contributed to the somatization before they are fully ready to do so. It is essential to understand, accommodate and treat the underlying stressors simultaneously so that recovery is ‘safe’; and, the child or youth have developed emotional resilience or coping strategies as they start participating in activities again. While reducing physical symptoms is an important treatment goal, focusing too much or too quickly on symptom reduction or physical gains can

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4 Please see APPENDIX 3 of this handbook for a template of a school letter to facilitate understanding of and accommodations for somatization in the school setting.
actually trigger a setback or decline in functioning. Providers can support the coordination of care (e.g. physiotherapy, occupational therapy, complementary therapies) to ensure a paced return to activity.

**GOALS:**
- A gradual return to normal activities (social, school, extracurricular) without ‘overdoing it’
- Incorporate tools learned to manage normal stressors without avoidance or ‘overdoing it’
- Help child and family tolerate ongoing symptoms while the child is concurrently returning to activities

**STRATEGIES:**
- Avoid over focusing on physical recovery unless emotional stresses are being effectively addressed/treated (see below)
- Educate the child and family about the importance of pacing
- Teach the child to avoid an ‘all or nothing approach’
- ‘Prescribe’ the child to take small steps but keep going (e.g. physical therapies)
- Choose one or two target activities at a time and plan a gradual return to these
- Teach the child to use their behavioural coping strategies and tools (see above) in specific activities
- Make sure that appropriate environmental accommodations and adjustments are in place (see above)
- Pace physical symptom treatment (e.g. physiotherapy)

**NORMALIZE DEVELOPMENTAL EXPECTATIONS**

Somatic symptoms can greatly delay or alter the achievement of a child’s developmental milestones, especially their emerging autonomy from parents, relatedness with peers, identity formation, and experience of rich emotions.

For example, with somatization an overemphasis on the child’s ‘sick role’ and/or the parent’s ‘caregiver role’ can emerge. Longstanding, high levels of parental involvement in the diagnosis and treatment of somatic symptoms may hinder a child’s ability to engage in age-appropriate activities in school, social events, and extra-curricular activities. In some cases, physical symptoms rather than emotional expressions can become the modal communication between children and parents, thereby getting in the way of symptom reduction.

In other cases, an overemphasis on perfectionism and achievement in the family can emerge, and child may start to communicate the stress by shutting down (e.g., feeling tired, feeling pain, etc.). A child can become focused on what others think of them rather than on their own experience of what it is like to struggle with a problem, discover something, find out what they are passionate about, and feel competent and capable.
It will be important for skilled clinician to assess and address atypical developmental trajectories that may unintentionally be preventing or slowing down the recovery process.

**GOALS:**

- Re-calibrate roles for family members and their understanding and expectations for healthy family interactions
- The child adopts a developmentally typical role in the family that is not defined by somatic symptoms
- The parent adopts a typical caregiver role that is not defined by their child’s somatic symptoms
- The child engages in developmentally-appropriate tasks – e.g., testing boundaries with parents, becoming more intimate with friends and romantic partners, searching for identity through appearance, experimentation, peer groups, etc., and experiencing many emotional ups and downs

**STRATEGIES:**

- Promote understanding of typical developmental goals and milestones
- Prepare parents to expect to see more age-typical emotions and behaviours in their child or teen as their somatic symptoms recede
- Promote the child’s independence and decision making
- Observe and modify parental accommodations that initially were helpful behaviours in relation to the somatic symptoms, but are no longer necessary
- Support parents’ understanding that being a ‘caring and loving parent’ is not fully defined by high levels of attention to the child’s somatic symptoms
- Assess and understand if traits of perfectionism are present and how they may be contributing to the physical expression of emotions and stress
- Encourage the child to focus enjoyment of the process rather than on producing a perfect outcome
- Support parents’ to understand how their lives have changed as a result of caring for their child (e.g. not attending work, changes in relationships with the other parent, not socializing, etc.) and what the impact will be to ‘change-back’ these aspects of their lives
- Understand and promote understanding of the differences between parent behaviours of validation versus reassurance, and child behaviours of coping versus avoidance
- Consider providing or referring the family for family therapy to support the re-alignment of family relationships that support the child’s recovery

**FACILITATE EMOTIONAL SKILL DEVELOPMENT**

Difficulties with attending to, identifying, labelling, accepting, expressing, and regulating emotions can be related to somatization, and inversely, somatization can affect the acquirement of these emotional skills. To better comprehend a child's emotional skills, it is important to understand each family's immediate and inter-generational family history, culture and beliefs around the expression of emotion, physical illness, and how stress is experienced and defined. It is also important to assess how family dynamics such as styles of communication, quality of relationships, and management of stress have changed as a...
result of somatization. To best help the child to reduce symptoms we would next focus on supporting family members to understand their stress-symptom predispositions, to become aware of their emotional experiences, to verbally express emotions and respond to emotions of others, and to manage or regulate emotional ups and downs. Within this work, there may or may not be the need to address a family history of trauma.

GOALS:

- Recognition of the larger family history that may contribute to somatization
- Understand sources of current stressors in the immediate and extended family
- The child becomes more adept at attending to, identifying, labelling, accepting, expressing, and regulating emotions
- The parent demonstrates awareness of their own emotions and those of the child, models appropriate emotional expression, is empathically responsive to emotions expressed by the child, and supports the child and family in regulating the emotional ups and downs of life

STRATEGIES:

- Help the child and family investigate the connection between their physical symptoms and their emotions.
- Provide individual or family-based psychotherapy to support the development of emotional skills and re-alignment of family relationships that support the child’s recovery.
- Re-assess the stress-trauma history of the larger family system that is typically not recognized nor articulated, at the onset of the somatization
- Identify patterns of emotional expression, or lack thereof to understand the ‘emotional culture’ of a family
- Support the child’s and parents’ understanding of how patterns of emotional expression may have developed in their family system and how continuing these patterns may not facilitate symptom reduction
- Provide individual therapeutic support or recommend therapeutic support for family members with an ‘untreated’ history of trauma or stress-symptom predisposition that has impacted their life.
- Coach the child and parent in tuning into their own emotional experiences and verbally expressing them in a developmentally-normative way. Help the family develop an emotional vocabulary, especially for negative emotions.
- Coach the parent to tune into their child’s sharing of emotions through strategies like reflective listening.
- Coach families in tolerating, accepting, and managing difficult emotions and stress.

ix. PROMOTE RECOVERY, RESILIENCY AND RELAPSE PREVENTION

Recovery from somatization can take a variable course. We typically find that once there is a reduction of symptoms, this pattern continues with some ‘flare ups’, ‘relapses’, or ‘setbacks’ along the way; however,
symptoms tend to be less intense or frequent. Recovery from one symptom can sometimes lead to an emergence of a different symptom – in this case we understand that there is more work to be done with the child and family, often across a range of treatment modalities. Children and their families develop resiliency and coping skills through participation in the treatment components. When ‘flare-ups’ occur this can be an important opportunity to help the child and family explore potential stressors and/or emotional experiences. Whether or not this can be done depends on where the family is in terms of understanding the association between stress, emotions and physical symptoms. When children and families understand ‘why’ a flare up has occurred (e.g. identifying a stressor AND use their coping skills to either minimize the impact of a symptom or reduce the intensity of the symptom) this often represents a significant milestone on the path towards long lasting recovery. Full recovery is usually best supported by extending follow-up visits beyond initial symptom reduction.

GOALS:
- Educate children and their parents about what recovery paths look like, stressing optimal functioning in the presence of symptoms
- Enhance existing resiliency and coping skills
- Facilitate relapse prevention

STRATEGIES:
- Describe what is to be expected during the course of recovery. Make sure that children and parents expect that there may be a recurrence of symptoms after symptoms have receded, but usually recurrences are less intense or frequent because the child and family have new skills and knowledge to draw upon
- Educate families about the possibility of new symptoms during the course of recovery and support development of a plan for dealing with new symptoms
- Assess any new symptoms as needed, understanding that if the initial symptom has not been part of a medical condition, it is unlikely that the new symptom is either
- As a child and family works through the various components of treatment, highlight the types of coping skills that they have enhanced or learned. Reinforce how these skills can be applied in their day-to-day living and/or in relation to symptom recurrence. Often emotional expressiveness and the ability to identify stressors are critical skills in relation to recovery and long standing resiliency
- For all cases (regardless of how long treatment has been required or provided), provide follow-up ‘wellness check-ups’ appointments overtime. ‘Wellness check-ups’ should be held with medical, psychiatric and psychological treatment providers and should aim to support the child and parents in preventing relapse by highlighting resiliency, emotional and physical wellbeing
- Encourage the family to connect with you even after discharge from ‘Wellness check-ups’ should any questions or concerns arise. This level of support fully engages and promotes the treatment collaboration. Often a telephone conversation can support the family taking perspective and reinforce their understanding and coping and reduce the possibility of seeking medical treatment
The PHASES OF THE JOURNEY

While flexibility is the hallmark of the treatment model, the phases of the patient journey follow a general pattern. The phases have been described by Dr. Tyler Pirlot and Dr. Andrea Chapman (2015):

<table>
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<tr>
<th>PHASE</th>
<th>PHASE I: CONFUSION</th>
<th>PHASE II: CONNECTIONS</th>
<th>PHASE III: ENGAGEMENT IN TREATMENT</th>
<th>PHASE IV: FUNCTIONING AND RECOVERY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage</td>
<td>The patient and family are confused about the symptoms</td>
<td>The patient and family learn about the mind-body connection</td>
<td>The patient and family engage in multidisciplinary and multi-faceted treatments for somatization.</td>
<td>The patient engages in normal developmental tasks (academic, social).</td>
</tr>
<tr>
<td>Goals</td>
<td>Appropriate and timely assessment and containment of confusion and suffering</td>
<td>Acceptance of the concept of somatization and willingness to engage in treatments</td>
<td>Focus on psychotherapy and rehabilitation and minimization of treatments that may cause iatrogenic harm. Psychotherapy includes emotional awareness and emotional regulation strategies; moving from “body” language to emotional language.</td>
<td>Return to normal developmental tasks and functioning regardless of the physical symptom.</td>
</tr>
</tbody>
</table>
Questions about causes of somatization and the nature of somatic symptoms

Are somatic symptoms real? Yes. ‘Soma’ means body. Somatic symptoms are symptoms experienced in the body - physical sensations, movements or experiences. Some examples include pain, nausea, dizziness, and fainting. All emotions have a physical expression. Somatic symptoms are the physical expression of stress and emotions. Just like tears of sadness are real and a heart racing from excitement is real, so are somatic symptoms. Somatic symptoms can be symptoms that we often associate with stress, such as stomachaches or headaches. Or they can be ones that we don’t typically associate with stress, such as blindness, seizures or numbness.

Are my child’s symptoms ‘all in their head’? No . . . and yes. The mind and body are intricately connected – we call this the mind-body connection. The brain and the body are amazing. They are partners that are always ‘talking’ to each other and ‘cooperating’. They connect through very complicated back-and forth signals or ‘messages’ that involve the nervous system, hormones, and brain chemicals. Most of the time, when things are running smoothly, the system of signals between your brain and body is automatic. The brain-body message system allows you to do what you need to do in your daily life. It also works as a warning system by producing symptoms that you should pay attention to. Your brain and body communicate when you experience emotions. You often experience emotions not only as feelings in your mind, but also as sensations in your body. For example, when you are embarrassed or nervous, you may “blush”. Or when you are stressed, your brain sends signals to increase your heart rate, to breathe more quickly, to tense your muscles, and to empty your intestines. This “fight-flight-or-freeze” response helps you to survive dangerous situations.

Are children with somatization ‘faking’ their symptoms? No, somatization is an ‘unconscious’ (involuntary) process. Somatic symptoms are the expression of an underlying emotion. Just like ‘butterflies’ in your stomach aren’t fake, these symptoms are not made up. However, there are times when the symptoms help a child get out of an uncomfortable situation or a distressing emotion. For example, if a child is being bullied at school and has a somatic symptom like a stomachache, staying home from school may unconsciously or consciously reinforce and intensify the physical symptom.

Do children have conscious (voluntary) control over their symptoms? No . . . and yes. Initially children don’t have control about when and where they have symptoms or the ability to control the symptoms. However, there are a number of things that help children to gain some control over the symptoms. Understanding that the symptom is a somatic symptom and not a symptom of a medical illness may help. Beginning to learn what some of their internal stressors are and expressing them in other ways helps build control. Taking a “rehabilitative” approach – encouraging school attendance, socializing, and extracurricular activities – also helps to take the focus away from the symptom.
What is the difference between ‘complex pain’ and somatization? Pain often has a ‘component of somatization’ – stress or distress make any type of pain worse. For example, if you have migraines, stress is one of the factors that worsen them. Other things, like lack of sleep or too much sun, also play a role. Complex pain refers to a pain syndrome that has a component of somatization. Most chronic illnesses, even things like asthma or diabetes, have a component of somatization.

How are epileptic seizures different from non-epileptic seizures? The movements and behaviours that occur during epileptic and non-epileptic seizures can be similar, but the cause is different. Epileptic seizures are caused by a disruption in electrical communication between neurons in the brain. Non-epileptic seizures are caused by subconscious emotions, thoughts or stress. Sometimes we call them ‘stress-seizures’. Both epileptic seizures and non-epileptic seizures are involuntary (not intentionally produced). About 1 in 6 people with non-epileptic seizures have epileptic seizures or had them in the past. We now know that non-epileptic seizures are common.

What kinds of stressors are common causes of somatic symptoms? Any kind of stress or psychological distress (anxiety and worry, sadness and grief, anger and frustration) can cause somatic symptoms. Every child has a different experience of stress – the same thing that causes stress in one child may not cause it in another. But, every child has stress in his or her life. Examples of stress include feeling that they are not doing well enough at school or in other activities, being bullied, worrying about friends and parents are common causes of somatic symptoms. Not only do kids have different causes of their stress, but children also show their stress in different way. Some kids yell, cry, or talk when they are stressed while others keep their stress to themselves.

My doctor said that somatization is often caused by stress. I don’t think my child is stressed. How can they really have somatization then? Everyone has stress and everyone somatizes. Kids who have strong or frequent somatic symptoms are often (but not always) kids who are sensitive, have high expectations for themselves, keep their emotions to themselves (‘internalize’) and are stoic. They often keep their stress to themselves and may not recognize their own stressors. Parents may not be aware of the internal stress that their child has.

If my child is stressed, why are the symptoms presenting physically and not emotionally? Often the ways individual people experience stress usually relates to either a physiological vulnerability or a learned physical vulnerability. For example, a person who regularly experiences headaches might get a headache during a very long and stressful conversation with another person. By learning about and developing the connection between the mind and body, we can start to recognize, express, and deal with the underlying emotional components of problems.

Do all children with somatization have a history of trauma or abuse? No. Trauma and abuse are one source of stress and can be the cause of somatic symptoms in some children. However, most of the children that we treat have not been abused nor had a very traumatic event in their lives. Instead, we see children where a relatively ‘minor’ stressor might occur (e.g. poor performance in exams, a minor sport injury, illness of a friend or family member, changes in peer relations,
changes in family situation) that seems to be the trigger for somatization. Often that single situation represents a longer accumulation of stresses that have not been recognized or dealt with. Sometimes we also see children in situations in which their abilities do not meet the demands of the situation – e.g., children who have been strong students in elementary school who are now struggling in high school, youth who perform well at a certain level of extracurricular activity but struggle when the demands of the extra-curricular activity increase or become more complex, etc.

What is the typical course of recovery? The course of recovery is different for each child. In general, the earlier the somatic symptoms are treated with appropriate treatments, the faster the recovery. We often see ‘functional’ recovery before we see an actual change in the somatic symptoms. That means that the child is attending school, spending time with friends, engaging in some extra-curricular activities; their functioning has improved. A fuller recovery (involving reduction of somatic symptoms and expansion of emotional functioning) can occur within days or can last for years.

Questions about the Diagnosis & Treatment

If my child’s symptoms are no longer occurring – will they return? It is not unusual for children’s symptoms to re-occur (or for new somatic symptoms to present) in times of stress. The first time this happens is a critical time in treatment. Getting through the first re-occurrence is a real test of the child and family stress coping skills and an opportunity to reinforce the child/families’ ability to identify stresses in their life and solidify previously successful coping skills.

Why is my child/youth not having more medical diagnostic tests? This is a very normal question that sometimes needs to be answered again and again. Often after the initial key medical tests are completed the focus turns to helping this child cope with and minimize the stress relating to the medical symptoms and increasing functioning in the context on ongoing symptoms. Key communication over time with a trusted medical care provider is needed.

If the symptoms continue after a diagnosis has been made, does this mean the diagnosis is wrong? No. This is very typical. Symptoms will continue in the context of stress. Often the process of addressing and alleviating stress can take time.

My child’s symptoms have changed over time. Does this mean that the somatization diagnosis is wrong? No. The body has many ways to express stress physically and many children who have somatization express stress physically in different ways over time.

Can medications be helpful? Sometimes, depending on whether or not there is also an existing medical condition and/or a co-occurring mental health issue (e.g., anxiety or depression).

What do we do if our child does not want to see a counselor or therapist? For many children with somatization, talking about stress is very uncomfortable. Work with your medical care team to find a professional who has training in working with somatization. At first, it is often helpful to
focus on ‘practical’ supports that decrease stress and promote symptom management and as a therapeutic relationship is developed work can start to help the child start talking about stress and emotions. Never push ‘talk therapy’ to the point that the child feels so stressed that this compounds the stress that is underlying the somatization.

After diagnosis and initiating new supports (e.g. therapy) my child’s symptoms got worse. Is this typical? Why would this happen? This can happen when children are first beginning to talk about stress and emotions. It’s scary and new. It is important to help parents and children know that this may happen at the outset of therapy.

My child has non-epileptic seizures and keeps getting sent home from school when they have an episode – is this a good idea? Since these seizures are not a medical emergency, it is not necessary to send the child home from school. Generally, we try to minimize the amount of time children miss school. What is important is the developing of a coping/safety plan for the child both during and after an episode that includes the appropriate supports and allows for the child to remain at school.

What should I do when my child is experiencing a somatic symptom? Symptom type and severity are different across all children and families. It’s important for families to work with their medical providers and mental health support staff to have a specific symptom management plan. However, in general, the following principles should apply:

a. Remain calm. Recognize that this is a somatization experience, that the symptoms are normal and not dangerous. Families that become very scared or anxious when symptoms occur often inadvertently worry their child. Keeping your cool will ultimately lead to de-escalation in symptom severity/intensity.

b. Validate the symptom and stressful experience. For example you can say “I can see that you’re feeling worried right now by your arm shaking.” These kinds of comments help the child make the connection between emotional events and their physical symptoms.

c. Provide support as needed and help the child implement the symptom management plan (e.g., using distraction).

d. Don’t over support. Sometimes well-meaning families may inadvertently provide a great deal of attention around a symptom (e.g., videotaping a child in an NES event; recruiting siblings/extended family to help support during a somatization event), but this may increase both parent and child stress levels and can lead to further symptom escalation. It can often be enough to assure the child that you recognize they are stressed, that you will remain close by and ready to help if needed, and to remind them of a coping strategy (e.g., “I can see you’re stressed. I’m right here making dinner. You have your book to read. I’ll be right over there ready to help you if you need anything”).

How can we tell the difference between a new somatization symptom and a physical symptom? We recommend that families treat new symptoms as they typically would; see your health care provider to a reassessment unless it is clear that the symptom is a somatic one.
Questions Asked by Treating Professionals and Educators

Is it common to have to review the diagnosis with the family many times? Yes. Somatic Symptom and Related Disorders are complex conditions. The physical symptoms themselves can be frightening and confusing. Additionally, families have been told that there is a psychological component to their symptoms, which may be unsettling and/or surprising. Reviewing the diagnosis with a family more than one time and at different times during the course of treatment is common and can be very helpful to support the therapeutic relationship and understanding of the condition.

My patient with conversion/somatization doesn’t endorse any or few negative emotions. Is this common? Yes. Although there is not singular profile for children and youth who suffer from somatization, we find that these children have a difficult time with emotional expression. In particular, recognizing and expressing negative emotions (e.g. anger, frustration, disappointment, etc.) is particularly challenging and, at some level can be ‘threatening’. These children are often very perceptive, sensitive and sometimes perfectionistic and the combination of these characteristics with challenges in expression of negative emotions can result in a higher risk of somatization.
APPENDIX I

EXPANSION OF CONCEPTS FROM THE
BC CHILDREN’S PEDIATRIC SOMATIZATION TREATMENT MODEL

These concepts are introduced in the BC Children’s Pediatric Somatization Treatment Model and expanded on below.

Facilitate Emotional Skill Development

1. **Identify how families attend to and express emotions:** The experience of emotion is an internal mental activity that can happen with or without us being aware of it. Some emotions are easier to pay attention to and others are more difficult.

   - What people find easy or difficult is different for different people.
   - Difficult experiences are usually those that are unpleasant or even confusing.
   - If we find certain feelings difficult, we can sometimes become so good at ignoring them that *we don’t even notice we felt them.*
   - This can be a helpful strategy in the short-term because it allows us to cope with that difficult moment.
   - But this strategy can be problematic if it prevents us from solving a problem that is chronically upsetting us.

   The good news is that we can learn to develop an awareness of what is happening inside. By finding the links between our emotions and body sensations, we can start to uncover what our bodies are telling us. We can start to feel more capable, effective, and resilient in the long-term.

   Families can be similar in their emotional awareness. For example,
   - In some families, sadness or tenderness was more difficult to experience because they lead people to feel vulnerable.
   - In some families, anger was more difficult to experience because it lead people to feel in conflict with others.
   - In some families, happiness and pride was difficult to experience because they lead people to feel guilty for their success.

   In all of these examples, holding back certain emotions helped people feel more connected to others, yet at the same time, lead them to become disconnected from themselves.

2. **Support parents to “be with” their child’s emotions:** Parents play a big role in helping their child attend to, identify, label, accept, and express their emotions. One way to “be with” a child’s emotions is to first seek to understand what the child is feeling, and then offer it back to them (e.g., “you seem disappointed”). This is called “reflective listening.” When kids are experiencing intense emotions, reflective listening can at first be difficult. Parents can worry that by showing they understand, they must also agree with the child or must come up with ways of protecting the child from the difficult emotion. However, reflective listening simply involves being able to see something through the child eyes, to sense what the child senses, and to feel what the child feels. When parents “reflect” their understanding back to the child, the child feels validated and accepted. They feel comfortable sharing the frightening parts of their lives with parents. Most importantly, they become responsible for deciding what to do with that emotion. If an emotion is expressed and goes unrecognized, a
child may think that their expression is not acceptable. When this happens chronically, children may start to ignore emotions that come up for them.

APPENDIX II

Pediatric Somatization

Dictation Template for Treatment Recommendations

The following dictation template outlines general recommendations that we have found helpful in treating children/youth with somatization. This template outlines general strategies and should always be personalized for individual patients. Anything in italics is for the reader’s information and is not to be dictated. In the impression/formulation section, we almost always mention ‘somatization’. Sometimes we diagnose Somatic Symptom Disorder or Conversion Disorder; other times we describe the clinical presentation as having a ‘component of somatization’.

RECOMMENDATIONS

1. Information about somatization that was reviewed with the family:

We had the opportunity to review our diagnosis and impression with [patient/family], including the team’s understanding of somatization and how it affects [patient]. We conveyed the following to the family.

• All emotions have a physical component, for example, the lift of elation, the flush of shame, or the tears of sadness.
• “Soma” means body.
• “Somatization” is the word we use to describe the physical (or body) expression of stress.
• Stress can be positive or negative.
• Everyone somatizes.
• Somatic symptoms are real.
• Although everyone experiences somatization, for some people somatization gets in the way of everyday life and requires treatment.

There are two types of DSM5 somatization disorders; Somatic Symptom Disorder and Conversion Disorder. In Somatic Symptom Disorder, common symptoms include pain, dizziness, and fatigue. In Conversion Disorder, symptoms involve sensory or motor systems, such as fainting, convulsions, difficulty walking and numbness. However, often the medical team diagnosis a ‘component of somatization’ rather than a specific somatic disorder.

Our experience has been that there are underlying stressors for the child (e.g. school, social, family). Stressors that trigger somatic symptoms may be current and/or from the past. The somatic symptom does not always occur immediately after a stressor has been experienced. Often children have difficulty recognizing stress in their lives and making the connection between stress, emotions and physical symptoms. We call this connection the ‘the mind body connection’.
In reviewing the above information with the family, we understand that [choose one]:

- the family are accepting of this formulation and treatment plan
- or the family appears to understand the concept of somatization and understands the need for stress management and supports, however are interested in pursuing further medical investigations
- or the family does not appear to agree with our formulation and treatment plan.

Resources about somatization for children and families are located at http://keltymentalhealth.ca/Somatization-Disorders. These include a brochure, a video of two children and their parents describing their journey from confusion to recovery, and a Family Handbook.

2. General treatment recommendations for somatization

Treatment for somatization is individually based and depends on the presenting symptoms, co-morbid medical and psychiatric conditions as well as individual and family factors. Additionally, the patient and family's understanding of the condition and readiness to engage in treatment will determine the focus of the approach. Our experience has been that kids and parents are more likely to accept appropriate treatments for somatization if they know that a family doctor or pediatrician will continue to be involved and that their child will be assessed if a change occurs or a new symptom emerges. Most children benefit from a team approach that includes a primary care doctor, a counselor (e.g. registered psychologist or mental health clinician), a school case manager and other specialists as required (e.g. physiotherapists, medical specialists). We find most successful outcomes occur in situations where all the care providers communicate with each other prior to initiating any new assessments or treatment protocols. Differences in treatment strategies can be a very confusing for a family.

Components of treatment for somatization include [writer to include as appropriate]:

1. Assessing and treating any medical conditions: Somatization may occur along with another medical condition. Treat medical conditions appropriately.
2. Develop the Mind-Body Connection: Somatization, the physical expression of stress and emotion, is not well-understood. Label and define somatization, explain the mind-body connection, help the child and family understand the child’s diagnosis and stress-symptom predisposition.
3. Assessing and treating any mental health conditions: Somatization may occur with another mental health condition or symptoms (anxiety, depression or personality traits). Treat mental health conditions appropriately and identify self-harm risk factors.
4. Teach and provide symptom management: Somatic symptoms and physical symptoms that occur with somatization may benefit from specific treatment strategies. Consider a range of modalities for treating specific symptoms (e.g. medication, behavioural coping strategies, physiotherapy, complementary therapies).
5. Facilitate Emotional Skill Development: Difficulties with emotional awareness, expression and regulation can be related to somatization. Individual and family-based psychotherapy is an important component of treatment. Help children investigate the connection between their
symptoms and emotions, coach children and parents to tune into their emotional experiences, verbally express them, and empathically respond to others, and coach families in tolerating, accepting and managing difficult emotions and stress.

6. Redefine parent-child roles: Somatization can influence roles within the parent-child system, and parent-child roles can have a bearing on somatization. Assess and support normative independence and decision-making, parents taking time for themselves and normal involvement in family activities and routines.

7. Support limited environmental adjustments: Somatic symptoms, like many physical symptoms, are stress sensitive. The need for adjustments and supports in the following areas should typically lessen or shift over time.

8. Encouraging balance and pacing: Somatic symptoms may take over a child's life. Avoid an 'all or none' approach to participation in normal activities. Encourage activity and involvement with a paced approach that supports participation in normal life even in the presence of physical symptoms.

9. Promote resilience, recovery and relapse prevention: Identify and label resiliency and coping skills, educate about the non-linear course of recovery and plan wellness check-ups.

At any given time, the focus of treatment will vary based on a range of factors. The focus of treatment will change over time. For more detailed information about the treatment of pediatric somatization please see the Pediatric Somatization Professional Handbook.

3. Individual treatment recommendations for [patient]

At this time, we would recommend [key specific recommendations]
Dear School Team,

I am writing this letter to assist in the school plan for [patient]. I am involved through my role as [e.g. Psychologist with the Medical Psychology team] at BC Children’s Hospital. [Patient]’s medical care is currently provided by [healthcare professionals].

[Patient] has been diagnosed with [somatization, a Somatic Symptom Disorder, a Conversion Disorder, or as having a component of somatization]. *(Note to writer: if patient has been diagnosed with a medication condition, provide a brief summary here.)*

What is somatization?

- All emotions have a physical component; for example, the lightness of joy, the flush of shame or the tears of sadness.
- “Soma” means body.
- “Somatization” is the word we use to describe the physical (or body) expression of stress.
- Stress can be positive or negative.
- Everyone somatizes.
- Somatic symptoms are real.
- Although everyone experiences somatization, for some people somatization gets in the way of everyday life and requires treatment.

See [http://keltymentalhealth.ca/Somatization-Disorders](http://keltymentalhealth.ca/Somatization-Disorders) for more details on pediatric somatization. There are two types of DSM5 somatization disorders; Somatic Symptom Disorder and Conversion Disorder. In Somatic Symptom Disorder, common symptoms include pain, dizziness, and fatigue. In Conversion Disorder, symptoms involve sensory or motor systems, such as fainting, convulsions, difficulty walking and numbness. Sometimes, medical condition can be accompanied by a strong component of somatization.

[Patient]’s symptoms include [list]. There has been a significant impact on [Patient]’s functioning.

It is essential that [Patient] attend school [part-time, full-time, through distance education]. Although [Patient]’s somatic symptoms are powerful at times, it is possible and important for symptoms to be managed at school. I recommend that the school develop a symptom management plan that includes:

- List of typical triggers
- List of warning signs for symptom escalation
- Strategies to prevent symptom escalation (e.g., relaxation breathing)
• Strategies to manage symptoms when present (e.g., rest/recovery locations at school)
• Strategies for re-entry back to class as soon as possible
• List of support team members at school

School counselors play an important role in successful participation in school and the recovery process. If possible, it would be very helpful for [Patient] to work with a school counselor to further develop the following skills:
  • Being an ‘early detector’ of stress triggers and physical symptoms
  • Proactively pacing activities throughout the day/week.
  • Practicing stress and symptom coping skills (e.g., relaxation breathing, taking a break to lie down, going for a short walk)
  • Developing emotional awareness and expression (e.g., being aware of stressors and emotional responses, and talking about them)

Support relating to social integration is often as important as support for academics. It is useful to figure out what school activities [Patient] enjoys/might enjoy (e.g., drama club, peer tutoring, sports) and to help prioritize these as part of [Patient]’s week at school. Initially, [Patient] may require adult facilitation to support social engagement both in and outside of school.

Other specific symptom management strategies that may be helpful to ensure successful school participation include:
  • Use of medication
  • Plan for how to move between classes (e.g., locker location, reduce books to carry, use of walking aids only if needed)
  • Use of seating support
  • Consideration of lighting and use of sunglasses/caps
  • Scheduled meetings with a counselor or an educator for proactive check-ins even when somatic symptoms are not present

(Note to writer: these recommendations will vary depending on the patient. Delete as appropriate.)

Based on [Patient]’s profile and learning needs, the following is strongly recommended. Please note that these recommendations are respectfully offered.
  • Designation: Consider a Ministry of Education Special Needs designation category.
  • Learning Plan: Develop a learning plan or IEP to help document [Patient]’s learning goals.
  • Psychoeducational Assessment: I recommend that [Patient] receive an updated learning/psycho-educational assessment to help better understand [Patient]’s learning profile.
  • The school team will be in the best position to determine the timing and professionals who should be involved with this assessment. Additional learning adaptations may be apparent after such an assessment is complete.
  • Additional specific academic accommodations may include:
    o Being excused from oral presentations.
    o Extra time for assignments and examinations.
- Reduced workload in subjects of specific challenge.
- Access to class notes in order to follow along.
- Modified expectations in PE class (e.g., access to the course on-line, individual activities rather than group classes). Note: This should be assessed regularly, with the goal to be to help the student move actively towards increased participation over time.

We would be pleased to offer a phone consultation to the school-based team with the family’s consent.

[Provider contact information]

Sincerely,
APPENDIX IV

BC Children’s Pediatric Somatization Treatment Model: Patient & Family Worksheet

The TREATMENT MODEL for PEDIATRIC SOMATIZATION
CLINICAL WORKSHEET

Patient Name: ___________________________  Date: __________________________

Completed By: ________________________________________________________________________________

Current Treatment Team Members (can include MD’s parents, child, school, community professionals, etc.):
______________________________________________________________________________________________

Overview
The BC Children’s Pediatric Somatization Treatment Model outlines different components of treatment that we have found most useful in helping children who somatize. Flexibility is the hallmark of the BC Children’s Pediatric Somatization Treatment Model. At any given time one or more of the components may be the focus of treatment and the inclusion of treatment components will vary with the needs of the child and family. The path of treatment depends on the child and family’s unique strengths and needs and readiness to engage in treatment components. The child, their family and other individuals or factors in their environment are all important in treatment planning. The key to successful treatment is active collaboration with the child and family and consistent communication between providers.

How To Complete The Patient Worksheet
The child, parent(s), and a primary care team member should complete the worksheet together. Check off when one treatment element has been discussed/addressed/completed/a treatment plan is in place. Indicate what treatment team member(s) is taking key responsibility for that area, and any other relevant notes. Review and revise the worksheet regularly and as needed.

Assess and Treat Medical Conditions
Somatization on its own or may occur along with another medical condition.

Key Treatment Team Member(s): ________________________________________________________________

☐ Assess & investigate medical condition
☐ Have a Team Meeting to communicate diagnoses and treatment plan
☐ Treat medical condition
☐ Arrange for medical follow up
☐ Monitor symptoms

Plan/Notes: _____________________________________________________________
_______________________________________________________________
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/box3/Assess & investigate medical condition
/box3/Have a Team Meeting to communicate diagnoses and treatment plan
/box3/Treat medical condition
/box3/Arrange for medical follow up
/box3/Monitor symptoms
**Develop an Understanding of the Mind-Body Connection**

Somatization, the physical expression of stress and emotion, is not well-understood. Somatic symptoms can occur on their own or in conjunction with a medical condition (e.g. ‘component of somatization’)

Key Treatment Team Member(s):

- Label and define somatization
- Explain how it is possible for physical symptoms to be connected to stress and emotions
- Help the family develop an understanding of the child’s diagnosis and stress-symptom predisposition
- Be sensitive to the family’s acceptance of the somatization and readiness for treatment

Plan/Notes:

Assess and Treat Mental Health Conditions

Somatization may occur on its own or as part of a constellation of mental health symptoms (anxiety, depression, or personality traits).

Key Treatment Team Member(s):

- Assess for mental health conditions
- Identify any self-harm risk factors
- Treat mental health conditions
- Note some mental health conditions may not emerge until after somatic symptoms are treated

Plan/Notes:
**Teach and Provide Symptom Management**

*Physical and somatic symptoms that occur with somatization may benefit from specific treatment strategies. Consider a range of modalities for treating specific symptoms.*

Key Treatment Team Member(s): _________________________________________________________________

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☐ Consider: medication
☐ Consider: behavioural coping strategies
☐ Consider: physiotherapy
☐ Consider: complementary therapies

**Support Limited Environmental Adjustments**

*Somatic symptoms, like many physical symptoms, are stress sensitive. The need for adjustments and supports in the following areas should typically lessen or shift over time.*

Key Treatment Team Member(s): _________________________________________________________________

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☐ Consider: school, sports, extracurricular activities
☐ Consider: peer group and social relations
☐ Consider: family
☐ Consider: schedules, transitions, activities, etc.
**Encourage Balance and Pacing**

*Somatic symptoms may take over a child's life. Encourage activity and involvement in normal daily activities without overdoing it.*

Key Treatment Team Member(s): __________________________________________________________________________

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**Normalize Developmental Expectations**

*Somatic symptoms can greatly delay or alter the achievement of a child’s developmental milestones, especially their emerging autonomy from parents, relatedness with peers, identity formation, and experience of rich emotions.*

*Note: Complete this section with the parents alone without including the patient, if appropriate.*

Key Treatment Team Member(s): __________________________________________________________________________

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- Avoid and ‘all or nothing’ approach
- Take small steps and keep going even if there are ‘set-backs’
- Pace physical symptom treatments/therapies
- Avoid over-focusing on physical gains
- Normative development of the child’s independence and decision making
- Parents’ taking time for themselves
- Normative involvement in family activities and routines
- The need for family-based psychotherapy
Facilitate Emotional Skill Development

Difficulties with emotional awareness, expression and regulation can be related to somatization, and somatization can affect the development of these emotional skills too. In individual or family-based psychotherapy:

Key Treatment Team Member(s): _________________________________________________________________

☐ Help children investigate the connection between their physical symptoms and their emotions
☐ Coach children and parents to tune into their emotional experiences, verbally express them, and empathically respond to others.
☐ Coach families in tolerating, accepting, and managing difficult emotions and stress.

Plan/Notes:____________________________________________
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Promote Resilience, Recovery, and Relapse Prevention

During the recovery process, resiliency is developed by participating in the range of treatment components. Recovery is usually non-linear. Continuing to follow the child after recovery can prevent relapse.

Key Treatment Team Member(s): _________________________________________________________________

☐ Identify and report resiliency/coping skills
☐ Education about the course of recovery
☐ Plan wellness checks

Plan/Notes:____________________________________________
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REFERENCES


ADDITIONAL READING


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ABOUT THE AUTHORS

Theresa Newlove, PhD, RPsych, is the Head of Psychology for BC Children’s Hospital, BC Women’s Hospital and Health Centre, and Sunny Hill Health Centre for Children. She is a Clinical Investigator for the Child and Family Research Institute and Adjunct Professor of Psychology at the University of British Columbia. Dr. Newlove specializes in Medical Psychology, with a clinical and research focus in Somatic Symptom and Related Disorders. She actively collaborates with medical sub-specialty teams to design integrated health service delivery models of care.

Elizabeth Stanford, PhD, RPsych is a clinical psychologist who works on the Medical Psychology team at BC Children’s Hospital, a team that specializes in supporting children who have medical illnesses and symptoms. Dr. Stanford is a Clinical Instructor in the Department of Psychiatry at the University of British Columbia and a Clinical Associate in the Department of Psychology at Simon Fraser University.

Andrea Chapman, MD, FRCPC is a Clinical Associate Professor of Psychiatry in the Division of Child and Adolescent Psychiatry at the University of British Columbia. Dr. Chapman is a clinician who specializes in Consultation-Liaison Child Psychiatry, working with children and youth who have medical illness and symptoms. She is also the Program Director for the UBC Child and Adolescent Psychiatry Subspecialty Residency Program.

Amrit Dhariwal, PhD, RPsych is a Clinical Assistant Professor in the Division of Child and Adolescent Psychiatry at UBC. Dr. Dhariwal is a practicing psychologist within outpatient mental health at BC Children’s Hospital and she is also BC Children’s Hospital Research Institute Investigator. Her clinical and research interests include parent-child relationships and somatization.