PSYCHOSOMATIC DISORDERS AND ADOLESCENT/YOUTH

Dr. Raman Kumar Jha
Assistance Professor
Department of Psychology
RPM Degree College, Saharsa, India

Abstract : A psychosomatic disorder or a psycho physiologic disorder is a condition in which psychological abuses adversely affect physiological (somatic) functioning to the point of distress. In such cases, the physical symptoms experienced by people are related to psychological factors instead of a medical cause. Psychotherapists have primarily been focused on uncovering the psychological and emotional factors in mental disorders, as somatic treatment for the same do not prove effective. Adolescents, outwardly brash, may be compensating for a general feeling of inadequacy, which may lead to development of certain psychosomatic disorders. The disorder can be diagnosed by observing recurring symptoms. Based on physiological, anatomical and morphological anomalies, the disorder can be classified; further classification helps to address the situation and find a suitable curative process for the concerned adolescent. Observation of different cases has helped therapists to understand the underlying cause of the problem, and be able to relate to the subject in order to reach a progressive conclusion.

What is a psychosomatic disorder?

As per the accepted definition by today's generation, a psychosomatic disorder or a psychophysiologic disorder is a condition in which psychological abuses adversely affect physiological (somatic) functioning to the point of distress. It is technically a condition of dysfunction or structural damage in bodily organs through inappropriate activation of the autonomic nervous system and the glands of the internal secretion.

Traditionally the medical profession has been concerned with physical illness and has concentrated research efforts on understanding and controlling the organic/generalised medical factors in diseases. In psychopathy, on the other hand, interest has been centered primarily on uncovering the psychological and emotional factors in mental disorders. Today we realise that both of these viewpoints are limited; although an illness may be primarily physical or psychological , it is always a disorder of the whole person - not just his lungs or his psyche.

Somatoform Disorder is the new term used in the diagnostic and Statistic Manual, Fourth edition (DSM - IV) to describe a group of disorders characterised by physical symptoms that cannot be fully explained by a neurological or generalised medical/organic condition.

Historical perspective

The existence of physical symptoms without an apparent physical cause is not a new phenomenon. For many years there have been reports of patients with unexpected physical symptoms.

- In 1859, Paul Bricket studied patients with multiple unexplained physical symptoms, which resulted in another term “Briquet's Syndrome”.

- Graham, in 1962 focused on the possible relationship between an individual’s attitude towards stressful situations and his coping reactions. He found that associations between attitudes, stress and psychosomatic disorders does appear relevant.
    - It would also appear relevant to consider the effects of “feedback” in terms of self-concept, changed life activities, changed family relations and so on - which are often entailed when an individual develops a psychosomatic disorder.

- The work of Flanders Dunbar (1943, 1954) and a number of other early investigators raised the hope that it could be shown that certain personality characteristics are associated with particular psychosomatic disorders.
    - For example those persons who are rigid, highly sensitive to threat and prone to chronic underlying hostility tend to suffer from hypertension.

Adolescents’ Susceptibility

Stress as it affects the body and mind can play a role in the origin and course of some illnesses. Stress can influence how an adolescent or a child perceives the symptoms of the illness, how he or she deals with the illness and the rate of recovery.

Children respond differently to stress; some may make a good adjustment and move on, some may step back, some may show aggravated responses like anger, irritation, fear or sadness; and some may express their reactions in physical complaints. If stress continues in intensity over a period of time, psychological changes occur, and the body can react in the form of illness.

All stress is not bad; maturing challenges and learning ways of dealing with abuse can result emotional growth. Some children, however have to deal with additional stresses such as the loss of significant people in their lives, separation from parents, divorce, family violence, shifting family arrangements, frequent moves, multiple hospitalisations, academic and social pressures.

Although it is common for children to report recurrent physical symptoms with no physical cause, the actual diagnosis in children rare, because the criteria for somatoform disorders were established for adults.

Symptoms and Diagnosis:-

Generally such complaints in children are short-lived but when a person complains repeatedly, and a physician can find no physical basis for the complaint, the child may have a psychosomatic disorder. The recurrent symptoms are:-

- Headaches
- Stomach aches and abdominal stress
- Back pain
- Sore muscle
- Imagined physical deformities or defects
- Symptoms that mimic neurological disorders, such as double vision, poor balance and coordination, paralysis and seizures

- With the hormonal changes of puberty, anxiety and worry, fatigue, loss of appetite, aches and pains are frequent symptoms, more prevalent in girls than in boys.

Diagnosis: In order to meet the criteria for the diagnosis the person must demonstrate a pattern of recurring, multiple, clinically significant physical complaints, the symptoms of which are not produced voluntarily.

Diagnostic Patterns and Types of Psychosomatic disorders in Children & Related Theories:-

Some children are in general weak. Somatic weakness increases susceptibility towards certain physical abnormalities which may get aggravated due to internal environmental imbalances, and which possibly could be triggered by various emotional and psychological upheavals.

Children who had somatoform disorders before experiencing a traumatizing event may complain more frequently and the severity of their complains may intensify.

Some children who suffer from post-traumatic stress disorder after a traumatic event report pain; this pain is rather acute than chronic and is accompanied by nightmares, intrusive thoughts and re-experiencing of the events that was the source of the stress.

Types

I. On the basis of organs affected:

a) Psychosomatic skin disorders
b) Psychosomatic neuromuscular disorders
c) Psychosomatic respiratory disorders
d) Psychosomatic cardiovascular disorders
e) Psychosomatic hemic and lymphatic disorders
f) Psychosomatic gastrointestinal disorders
g) Psychosomatic urinogenital disorders
h) Psychosomatic endocrine disorders
i) Psychosomatic disorders of organs of special functions

II. On the basis of frequency of occurrence (in no particular order):

a) Conversion Disorder (Hysteria) :- The symptoms resemble neurological conditions and physical influences such as blindness, seizures, gait imbalance, paralysis, tunnel vision and numbness. Children may complaint of weakness; they may have troubling walking talking or hearing.
Trauma and abuses increases the likelihood of conversion disorder, which is usually triggered by psychological factors.

b) Somatization Disorder :- It is a disorder that begins before age 30 years, extends over a period of years, and is characterized by a combination of pain, gastrointestinal, sexual and pseudoneurological symptoms -- often presented in a dramatic and exaggerated way.

c) Body Dysmorphic Disorder :- It is the preoccupation with an imagined or exaggerated defect in physical appearance which causes significant distress or impairment in social, occupational or other areas of functioning.

d) Hypochondriasis :- It is the preoccupation with the fear of having, or the idea that one already has a serious disease based on the person's misinterpretation of bodily symptoms or bodily functions.

e) Pain Disorder :- It is characterized by pain as the predominant focus of clinical attention. It has limited usefulness in children since there are few studies to distinguish it from Conversion Disorder.

f) Undifferentiated Somatoform Disorder :- It is characterized by unexplained physical complaints, lasting at least 6 months that are below the threshold for a diagnosis of Somatization Disorder.

Causes

- Psychosocial theory views the symptoms as social communications to express emotions or to symbolize feelings that cannot be verbalised.

- A psychodynamic interpretation views symptoms as repressed instinctual impulses. Psychosomatic pains are believed to be the bodily expressions of underlying and unresolved emotional issues.

- Biological studies seldom suggest that the child may have a faulty perception and assessment of sensory inputs.

- Genetic data also suggest that psychosomatic disorders tend to run in families with occurence of 10-20% of first degree female relatives.

How Can Parents or Guardians and Teachers Help?

- It is important to take the child seriously. Remember that a child who complains may have a real physical illness. If even after consultation with a physician, the complains persist, beware that the symptoms are not produced intentionally but may be emotionally-based. Adolescents may attempt to self medicate with alcohol or drugs.

- Encourage the person to express verbally. Reassure them of your concern and that ways can be found to alleviate their suffering. Also make them believe that you know that their pain is real. Emphasize that the pain is not a punishment and not their fault.

- Understand that the perception of pain is affected by a variety of factors including the age of the child as well as gender and his/her basic temperamental style, psychological state and individual experiences. Most youngsters have a mature understanding of pain and its significance.

- Try to point out the potential causes your child might have had traumatic experiences which you've not known about.

- Devise ways for child to develop a strong sense of control. For example ask him/her to keep a record of the frequency of pain and when it occurs in relation to activities, time of day or

other occasions. This will help to develop a better understanding of the problem through observation, and also meet certain needs such as modifications of school demands, adjustments in family relationships etc.

- Be careful not to inadvertently reinforce the behaviour by becoming visibly alarmed and overly solicitous.
- Be a good role model . Examine your own ways of dealing with stress to see if you also tend to express emotional conflicts through physical complaints and take steps to change this pattern of response.

Treatment

- Conduct a complete workup of the symptoms including a physical exam. Examine in the absence of parents and note if there are any changes in the child's behaviour.

- Obtain a psychological history, including information about possible abuses in order to differentiate symptoms from other disorders.

- Do not underestimate the severity and disorders must be distinguished from Factitious Disorders (a pattern of behaviour centered on the exaggeration or outright falsification of one's own health problems or health problems of others without any personal motive) and Malingering Disorder (to have clear eternal motivation that drive their falsification of health problems. Generally adopted by victims of Antisocial Personality Disorder).

- Inform the family of importance of psychological factors which may contribute to the symptoms and the plans to manage them.

- Discuss the advisability to an in-depth psychiatric or psychological evaluation to assist in understanding of the symptomatic picture and causes.

Intervention Procedure

- Communication with the primary care physician to be clear and to avoid duplication of services and tests and the transmission of contradictory information to the family.
- Development and reinforcement of coping behaviours that reduce the positive gain associated with the sick-role through individual, family group and cognitive behaviour therapies.
- Identification and appropriate treatment of coexisting diagnosis, i.e; anxiety, depression, medication, when indicated is effective.

Case I

A 17 year old girl Ania, born in the U.S to eastern Arabic parents wanted to attend an out-of-town college; against the cultural custom that needed her to remain at home while attending college. The disagreement wasn't properly discussed with parents openly and it was assumed that Ania would attend a local college. She developed seizures and was admitted to a hospital for observation. After psychiatric consultation and a number of sessions with both Ania and her parents, they come to view the seizures as related to a long established pattern in which Ania was unable to deal properly. Her conflict in asserting her feelings resulted in pseudo-seizures. When the family was helped to consider the symptom as a manifestation of cultural stress they learned new ways to communicate their feelings and the symptoms remitted.

Case II

Scott, aged 13, complained for more than a year of severe stomach aches, which often resulted in vomiting. His paediatrician conducted a series of diagnostic tests and found no physical basis for his complaints. A school avoidance pattern was ruled out, since scott willingly attended school, was a good student, well liked by his classmates and an outstanding soccer player. However he spent many after school hours at soccer practice, practiced compulsively at home, travelled with his team, took trombone lessons and often stayed up until midnight completing his homework. Scott's parents began to think that his complaints were imagined. In a consultation with a mental health professional they were helped to understand that when stress builds up without relief the body may react. They were advised to make lifestyle changes such as limiting Scott's soccer practice and trombone lessons to reduce the pressure. The symptoms subsided within a few months.

These cases were published in Child Study Center, undertaken by Melvin D. Oatis. Both Ania and Scott were diagnosed as having Somatoform Disorder. However each of the cases presents a different technique of treatment. To give in to the demands of a stress-building situation may prove hazardous to the individual. Hence, proper communication (as in Ania's case) as well as certain intervention procedures (as in Scott's case) together help to alleviate the symptoms when and as the stress is relieved. Another randomised controlled intervention trial by Ann dulurg and her team from the Center of Health Care Sciences, Sweden, showed improved self assessment of stress and psychosomatic symptoms among school-age girls.

Case III

The researchers recruited 158 adolescent girls, age 13 to 18 years, with psychosomatic problems and/or recurrent experiences of stress. The subjects were randomly assigned to

either a dance intervention group ar a control group. The dance group met twice a week for 75 minutes over a period of 8 months. The focus of the program was on the joy movement and not on performance. Body awareness and relaxation were always part of class. Compliance with the intervention was 70% and 86% of the girls attended the study follow up. 91% of them rated the dance intervention as a positive experience. Those girls who participated in the dance program showed a significant improvement in self rated health compared to the control group.

Duberg hypothesizes that the dance group experienced an increase in energy and self-esteem. According to these results despite problems such as stress and psychosomatic symptoms dance resulted in high adherence and a positive experience for the participants.