Chapter 13
Somatoform Disorders

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13.1 Introduction

In reality, no illness is purely physical or psychological. Physical and psychological symptoms interact, and one cannot separate the body from the mind. It is vital to consider underlying psychological distress in children who repeatedly present with physical symptoms that are medically unexplained as children and adolescents often find it difficult to express their feelings and emotions through words. Medically unexplained symptoms refer to those bodily symptoms that do not have a recognized medical illness explanation. These symptoms may lead to distress, impairment in functioning, and healthcare-seeking behaviour, as in somatoform disorders.

13.2 Diagnostic Features

DSM-IV describes ***somatoform disorders*** as having

1. Physical symptoms suggesting a medical condition; however, no medical disease, substance misuse, or another mental disorder can be found to account for the symptoms.

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2. The symptoms cause significant distress or impairment in social, occupational, or other areas of functioning.
3. The physical symptoms are not intentionally produced.
4. No diagnosable medical condition can fully account for the symptoms.

The same diagnostic criteria are used for adults as well as children. DSM-IV subdivides somatoform disorders into *somatization disorder*, *undifferentiated somatoform disorder*, *conversion disorder*, *pain disorder*, *hypochondriasis*, *body dysmorphic disorder*, and *somatoform disorder not otherwise specified.* The most commonly seen in children and adolescents are *persistent somatoform pain disorder and dissociative/conversion disorder.*

13.3 Clinical Features (DSM-IV)

Persistent somatoform pain disorder

1. Abdominal pain, headaches, joint pains and other aches and pains constitute persistent somatoform pain disorder.
2. Pain is characterized as being persistent, severe, and distressing.
3. It is associated with psychosocial stressors.
4. It tends to be worse during the day and does not occur at night or in school holidays.
5. There may be accompanying altered bowel habit, vomiting, headache, and fatigue.

Conversion disorders

1. These disorders involve partial or complete loss of bodily sensations or movements; loss or disturbance of motor function; and pseudo-seizures being the most common presentations.
2. Less frequently, they may present in children with loss of sight, hearing, sensation, consciousness, fugue or mutism.
3. The symptoms are often brought on by abuse, traumatic event.
4. They usually remit after a few weeks or months.
5. *La belle indifference*, which refers to a lack of concern about the symptoms, is not particularly common in children.

Pseudo-seizures

1. These seizures do not have the typical features of an epileptic fit and are not accompanied by an abnormal EEG.
2. Pseudo-seizures and epilepsy can coexist, but those with both conditions form a small proportion of patients with epilepsy.
3. Pseudo-seizures can be similar to epileptic seizures leading to delays in diagnosis.

13.4 Etiology

Somatoform disorders are likely to be caused by a combination of factors. A variety of child, family, and environmental factors have been proposed as predisposing, precipitating, or maintaining factors.

Predisposing factors	Precipitating factors	Maintaining factors
Family	*Child*	Current family relationship difficulties
Genetic component	Anxiety, depression	Family model of serious illness
Physiological vulnerability	Life stresses	Current parental anxiety and somatisation
Verbal communication about emotional issues limited	Physical illness	School problems
Conditional caretaking	Peer group problems	High achievement orientation
Suspicious attitude to medical expertise	Academic problems	Conflict avoidance
Parental history of somatoform illness, anxiety, or depression	Cognitive limitations	Benefits of sick role
Problems with boundary setting for children	Low self-esteem	
Child	*Parent*	
Temperamental factors, including sensitive, conscientiousness, emotional labiality, vulnerability, + worthlessness	Life crises	
Earlier emotional abuse		
Low IQ		
Social-relating difficulties		
Physical illness		

13.5 Burden

Children with somatoform disorders tend to present repeatedly to doctors because their presenting symptoms are physical and families tend to attribute the symptoms to medical, not psychological causes. The medical help-seeking behaviour that accompanies the symptoms often leads to various unnecessary painful medical investigations and treatments before their psychological nature is identified. These investigations tend to reinforce the belief in the child and family that there is an underlying physical cause Domenech-Llaberia et al. (2004). All of this can result in a huge burden on patients in terms of time, money, and effort as well as wastage of resources. Children often miss school to attend multiple appointments, and parents may need to take time off work to care for their child and take them to appointments. Further, it may result in parents having decreased leisure time,

having to take time off work and subsequent financial implications. Families may need to reorganize themselves in their activities of daily living to accommodate caring for the sick child, which may increase overall family stress.

13.6 Assessment

Steps involved in assessment

1. Ascertaining the child and parents' views of the illness is important since most of them have come after meeting several doctors. Many parents may still be pursuing organic causes; therefore, it is important to address all the physical symptoms, find out what medical disorders have been excluded, explore possible physiological explanations, and be aware of the possibility for physical and psychological causes to coexist.
2. Psychiatric assessment should include developmental and psychiatric history and mental state examination.
3. Psychometric assessments may be helpful in determining the child's cognitive level, and any disparity between child's educational expectations and actual abilities, school history, and family functioning is assessed.
4. Engaging the family early in the assessment process, explain the formulation to them and engage them in therapy. The intervention module is an adaptation of the work done previously (De Shazer (1985); Gureje et al. (1997); Knapp et al. (2006); Keiling et al. (2011); Kozlowska et al. (2007); Lieb et al. (2000); Pehlivanturk and Unal (2002) and Robins et al. (2005)).

13.7 Intervention

13.7.1 Integrated Eclectic Intervention Module for Children with Somatoform Disorder and Their Parents

Outline of Module

- Number of sessions: 6
- Frequency of sessions: 2 per week
- Duration of each session: 50–60 min
- Setting: Hospital
- Type of session: Individual sessions or with parents
- Who delivers: Clinical psychologist

13.7.2 Instructions for Therapists

- Use this module as a guide. It presents the fundamental areas you should focus on during the sessions. The content worked on in each session should be integrated

and build upon in subsequent sessions. Become familiar with the module and use it based on each child/adolescent's particular symptoms, circumstances, and your own personal style. The psychiatrist is consulted for any comorbid condition.

Session 1: Preintervention assessment and Psychoeducation
Participant: Child and parent
Objective of the session

- Understand the child's problem
- Increase child's and parent's understanding of somatoform disorders
- Form a rapport with child and parent.

Duration: 60–90 min
Tasks

(i) Semi-structured interview
(ii) Preintervention study measures (child and parent)
(iii) Psychoeducation
(iv) Providing reassurance, support, reattribution
(v) Functional analysis.

Homework: ABC charting

13.7.3 Task (I) Semi-structured Interview

- The therapist should administer the semi-structured interview Performa and generate information from the child on the following areas: School, Academics, Teachers, Peer group, Family, Parents, Siblings
- The therapist starts the session by asking the child, "What is your name, age? What class do you study in?"
- The therapist inquires from the parents about their relation with child, their family setup, support, and any family stress. "Do you have a joint family or do you live with your parents, any stress the family is currently undergoing?"

13.7.4 Task (II) Preintervention Study Measures (Child)

- The therapist instructs the child and tells the child, "This is a list of 35 items assessing bodily difficulties you experienced in the last 2 weeks. You have to tell me how much you were bothered by each symptom rating from 0 which means not at all, 1 Some-what, 2 Often, 3 Quite a lot, 4 a whole lot."
- The child is given some time to complete the Childhood Somatization Inventory. Any queries are simultaneously answered.

- Following which the child is given the Coping Scale for Children and Youth. The therapist explains to the child, "During problems, how much do you make use of the following methods. You have to tick the option that you find most appropriate."
- The Children's Global Assessment of Functioning was filled by the therapist, in consultation with the parent, by rating the child's most impaired level of general functioning for the specified time period by selecting the lowest level which describes his/her functioning on a hypothetical continuum of health illness.

13.7.5 Task (II) Preintervention Study Measures (Mother)

- The mother is given the DASS and asked to fill the questionnaire, "Please read each statement and circle a number 0, 1, 2, or 3 which indicates how much the statement applied to you over the past week. There are no right or wrong answers. Do not spent too much time on any statement."
- Then, she is given the coping checklist to complete, "This is a list of commonly used methods of handling stress and reducing stress. You have to answer yes if it applies to you and no if it doesn't."
- Following which the GAF is administered.
- The therapist starting at the top level evaluates each range by asking "Is your symptom severity OR level of functioning worse than what is indicated in the range description? Keep moving down the scale until the range that best matches your symptom severity OR the level of functioning is reached, whichever is worse."

13.7.6 Task (III) Psychoeducation

- The therapist can use the following information for psychoeducating the parents.
- The parents are psychoeducated by telling them, "Your child may sometimes respond to stressful or painful experiences with somatic symptoms without having a serious medical illness. Although these symptoms are referred to as psychological, but it does not mean that the child is mentally handicapped. The child is not intentionally producing these symptoms and is not malingering."

Predisposing factors

- It is further explained to them, "Both personal and factors based on context may predispose children to developing somatic complaints. Genetic, physiological vulnerability to a particular somatic condition, a high level of suggestibility, difficult temperament and low self-esteem may predispose children to somatoform disorders. A family culture that is illness-oriented may predispose children and adolescents to develop somatic problems through a process in which the children observe that sick-role behaviours of other family members elicit excessive care and distress is communicated through somatic complaints."

Precipitating factors

- The therapist explains the role of precipitating factors, "Biological factors such as personal illness or injury or illness, injury in a family member, major stressful life events, such as bereavement or abuse, and a build-up of small stressors may also precipitate somatoform disorders."

Maintaining factors

- The therapist further educates the parents by telling them, "Somatic complaints may be maintained by the belief that they are un-controllable. Also, it permits the child to avoid anxiety-provoking issues which would have to be faced if the symptoms were resolved. Poor coping strategies and cognitive distortions involving catastrophizing about the symptoms may contribute, by increasing autonomic arousal and reducing the efficiency of the immune system. Family, school, peer-group and health-care may give the child secondary gains associated with the sick role. Poor coping strategies of parents, high levels of stress and limited support to family may compromise their resourcefulness in managing their children's difficulties."

13.7.7 Task (IV) Reassurance, Support

- The therapist reassures and gains the parents' confidence by telling them, "The child would be followed until full recovery and even later to make sure that no possible organic cause is overlooked."
- The child is told, "You will get fine soon and we completely understand your problem and it can be overcome."

13.7.8 Task (V) Functional Analysis

- The therapist explains to the parent, "You need to record information regularly about the child's symptoms, the circumstances surrounding its occurrence and treatment adherence. The Intensity of the symptoms will be rated from 0 to 10, with 0 not present being and 10 being maximum intensity, frequency counts i.e. the number of times the child reports of symptoms during the day and how long do they last."
- For child's age <10, parents will record.
- For child's age ≥10, the child records.

The following chart is used for recording:

Day/date/time	Intensity 0–10	Antecedents	Behaviour	Consequences	Duration
					.

The child and parents are asked whether they have any further questions and they are told to come for the next session.

Session 2: Symptom management
Participant: Child and parent
Objective of the session

- Engage parents in active management of symptoms
- Encourage child to take control of symptoms by teaching cognitive and behavioural skills.

Duration: 50–60 min
Tasks

(i) Review charting
(ii) Teach parents to limit secondary gains from sick behaviour
(iii) Activity scheduling
(iv) Teach child symptom control using relaxation, distraction, and cognitive restructuring.

Homework: Practice relaxation, chart self-statements

(i) Review charting
(ii) The therapist must review before beginning the next session. Revise the previous session and the homework assignment. Ask child and parent whether they have any questions from the previous session.

13.7.9 Task (I) Review Charting

- The therapist must review before beginning the next session. Revise the previous session and the homework assignment. Ask child and parent whether they have any questions from the previous session.

13.7.10 Task (II) Help Parent Limit Child's Secondary Gains from Sick Behaviour

- *The therapist educates the parent about the removal of reinforcement for symptomatic behaviour by explaining to them that*, "**Y**ou might be reinforcing illness behaviour in your child by giving excessive attention to the child whenever he displays illness behaviours. You should try and limit giving too much attention to your child, limit frequent visits from visitors, phone calls, gifts, recreational privileges whenever the child displays symptomatic behaviour. You are advised to ignore non-verbal illness behaviours and use children's complaints about symptoms as an opportunity to prompt them to use symptom-management skills."

- *The therapist educates the parent about reinforcement of well behaviours by explaining to them that*, "When the child does not display any symptomatic behaviour for sometime (define based on the kind of symptoms) and engages in positive productive activities you have to praise the child, allow them to watch TV, give food of their choice, let them engage in other recreational activities."

Breathing exercises

- The therapist starts by telling the advantages of breathing exercises to the child.
- "Relaxation exercises have advantages and some of them are:
  - It helps us in taking more oxygen in our brain. The more oxygen reaches our brain, the more alert we feel. It helps us to bring our mind to here and now and helps us see the situations more objectively and then work on it.
  - Our mind may be full of thoughts that prevent us from seeing the true nature of problem. Therefore, through relaxation our mind becomes clear."
- The therapist sits on a chair and demonstrates the instructions before asking the child to follow them. Once the child starts practicing the breathing exercise, the therapist should ensure that the child keeps their eyes closed during the session and check whether the child is doing it correctly.
- Additionally, they should be instructed that, "The exercises can be done as many times as possible and remember to give a gap of about 1 h for eating a meal before and after the breathing exercises."

For the breathing exercise, the child is instructed to

- "Sit comfortably and assume a relaxed posture with your arms loosened and placed on your thighs, your back against a support, and your feet firmly placed on the ground, parallel to each other
- In case you wear spectacles, take them off
- Loosen your neck ties or belts
- Let your body feel loose and comfortable
- Now take a deep breath, inhale through your nose, and as you inhale feel your stomach expanding
- Hold it for a second or two
- Now exhale slowly, and as you exhale feel you stomach contracting
- Keep breathing in slowly through your nose, experience your stomach gently expand while you inhale air and gently contract while you exhale
- Now concentrate on the movement of your stomach and take 10 deep breaths while concentrating on your stomach
- Now, while breathing in the similar manner, concentrate on the movement of your chest and take 10 deep breaths
- Now, while breathing in the similar manner, bring your focus on your nose and while concentrating on your nose take 10 deep breaths
- All through-out breath in slow and deep"

13.7.11 Task (III) Teach Relaxation Exercise

- The therapist sits on a chair and demonstrates the instructions for the imagery exercise before asking the child to follow them. Once the child starts practicing the breathing exercise, the therapist should ensure that the child keeps their eyes closed during the session and check whether the child is doing it correctly.
- For imagery exercise, the therapist explains by giving an example, "Imagine a beach with clear blue water everywhere, sun just about to rise in the sky. Feel the cool touch of the air on your skin, imagine walking bare feet on the water, feel the water under your feet, smell the fragrance in the air, hear the soothing sounds of the waves."

For positive imagery, the child is instructed to

- "Sit comfortably in a quiet place
- Close your eyes
- Breathe slowly and as you inhale your stomach expands and as you exhale your stomach goes inside
- Deep breathe four times
- Create a mental image of a pleasant scene where you have been. It could be a park, mountain, sea beach
- Make the mental image as real and in as much detail as possible
- Involve all your senses such as sight, hearing, smell, touch and taste
- While imagining the scene clearly and in detail, relax yourself more deeply and feel it
- As you relax, use positive statements in your mind to reinforce the relaxation response. Use statements such as: I am deeply relaxed; my body is relaxed and my mind is calm; I am peaceful, calm and relaxed
- When you feel relaxed and calm you can gradually open your eyes"

The therapist should ask the child about their experience of the exercise. Clear any doubts regarding any difficulty or uneasiness in practicing the exercises.

13.7.12 Task (IV) Activity Scheduling

Steps involved

- Child is encouraged to return to school.
- Child is encouraged to engage in normal activities, for example, dressing, bathing, self-care, eating meals at regular times, peer interaction, recreational activities, and helping parent in household chores.

13.7.13 Task (V) Teach Distraction

- The therapist gives the rationale for distraction technique, "Distraction involves directing attention away from the present situation to something more pleasurable or engaging. This would help to bring your anxious feelings under control."

- The child is told, "You can distract yourself by listening to music, reading a book or newspaper, playing some game or talking to someone, listening to personal stereo whenever you feel uneasy or feel the symptoms coming."

13.7.14 Task (VI) Cognitive Restructuring

The therapist asks the child to

- Write down their negative thoughts.
- The therapist evaluates these thoughts in an objective way with the child.
- The child is encouraged to adopt a more balanced view based on information or evidence which has previously been ignored.
- The number of alternative explanations is generated at any one time.
- Link is made between somatic symptoms, affects, cognition, and behaviour.
- Modify their negative thoughts.

Session 3: Family-based treatment
Participant: Parent and child
Duration: 50–60 min
Objectives

- Teach parents relaxation exercises
- Improve parental coping
- Improve family communication.

Tasks

(i) Manage parental stress
(ii) Teach parental coping strategies
(iii) Teach family communication skills.

13.7.15 Task (I) Relaxation Exercises for Parents

For the breathing exercise, the parent is instructed to

- "Sit comfortably and assume a relaxed posture with your arms loosened and placed on your thighs, your back against a support, and your feet firmly placed on the ground, parallel to each other
- In case you wear spectacles, take them off
- Let your body feel loose and comfortable
- Now take a deep breath, inhale through your nose, and as you inhale feel your stomach expanding
- Hold your breath for a second or two
- Now exhale slowly, and as you exhale feel you stomach contracting

- Keep breathing in slowly through your nose, experience your stomach gently expand while you inhale air and gently contract while you exhale
- Now concentrate on the movement of your stomach and take 10 deep breaths while concentrating on your stomach
- Now, while breathing in the similar manner, concentrate on the movement of your chest and take 10 deep breaths
- Now, while breathing in the similar manner, bring your focus on your nose and while concentrating on your nose take 10 deep breaths
- All through-out breathe in slow and deep"

13.7.16 Task (II) Teaching Parent Coping Strategies

The therapist explains to the parents how to handle various kinds of stresses when managing a child with somatoform disorder:

- *Internal Stress*: Expectations of parents about their child. When expectations about parenting are not met, the first thought that comes to the parents' mind is that, "What they did wrong?" Therefore, parents are taught how to develop realistic expectations and how to recognize when negative self-talk defeats effective coping.
- *Management Strategies*: Identify their self-defeating assumptions and think of alternative messages. The parents are told to be kind to yourself and accept yourself and child as fallible.
- *External Stress*: The therapist explains that the neighbors, friends, and relatives don't understand why such a normal-acting child is having problems. Teachers frequently don't fully understand the ramifications of a child's problem. Parents are called upon by the school to help make decisions about the child's education, but often feel helpless because of their own lack of understanding. External stressors are those that are situational and often involve relationships with others.
- *Management Strategies*: Know your limits and be realistic about what you can accomplish. Say no to unreasonable demands. Learn about your child's problems and needs.

The therapist presents the following list to the parent and asks them to

- "Below is a short list of coping behaviours that has been extracted from studies of coping styles and from reports by parents and others. It is intended to help you reflect upon your coping behaviours and hopefully benefit from the positive (and negative) attributes and behaviours that have been reported by others."

Coping behaviours: thinking negatively

- Deny the problem ("It's just a matter of time before he'll grow out of it…")
- Hide ("I know, but I am so embarrassed that…")
- Become overwhelmed ("I feel helpless because…")
- Blame yourself ("I feel so guilty; if only I had…")
- Blame others ("If only his teacher had…")

- Panic ("We need to change everything right now…")
- Worry ("I can't help thinking that…")

Coping behaviours: thinking positively

- Listen carefully and ask for clarification ("Are you telling me that…")
- Take good notes ("When last we spoke, we agreed that…")
- Seek information ("What I need to know is…")
- Focus on the problem ("My specific concern is about…")
- Seek social support ("Who can I turn to when I need to talk about…")
- Become a self-advocate ("What I need you to provide for my child is…")
- Become an advocate for change ("The system needs to adjust by…")
- Reduce tension ("It feels good just to…")
- Focus on the positive ("One good thing is that…")
- Seek professional guidance ("With her help, I realized that…")
- Share your wisdom ("What I now know is…")

13.7.17 Task (III) Family Communication

Steps to building effective family communication

- *Communicate frequently*

Families should spend time together. Make time to communicate. Talk in the car turn the TV off and eat dinner together, and talk to your children at bedtime.

- *Communicate clearly and directly*

Families should communicate their thoughts and feelings in a clear and direct manner. This is especially important when attempting to resolve problems that arise between family members (e.g., spouse, parent–child).

- *Be an active listener*

Listen to what family members and the child are saying. Being an active listener involves trying your best to understand the point of view of the other person. It is important to pay close attention to their verbal and non-verbal messages. As an active listener, you must acknowledge and respect the other person's point of view. For example, when listening, you should nod your head or say, "I understand," which conveys to the other person that you care about what he or she is saying. Another aspect of active listening is seeking clarification if you do not understand the other family member. This can be done by simply asking, "What did you mean when you said…?" or "Did I understand you correctly?"

- *Openness and honesty*

Individual family members must be open and honest with one another. This openness and honesty will set the stage for trusting relationships.

- *Think about the person with whom you are communicating*

Not all family members communicate in the same manner or at the same level. This is especially true of young children. When communicating with young children, it is important for adults to listen carefully to what the children are saying without making unwarranted assumptions. It is also important to take into consideration the ages and maturity levels of children. Parents cannot communicate with children in the same way that they communicate with their spouse because the child may not be old enough to understand.

- *Pay attention to non-verbal messages*

Pay close attention to the non-verbal behaviours of other family members. It is important to find out how the person is really feeling.

- *Be positive*

It is very important for family members to verbally compliment and encourage one another.

- *Speaking skills*

Clearly articulating what you want to communicate. Often communication, particularly disagreements, between two people can escalate to conflict.

- *Roadblocks to communication*

Sometimes when communicating, roadblocks appear that get in the way of really hearing what your family member is saying or that hinder your ability to communicate what you are thinking and feeling.

- *Deployment communication*

Communication between two people usually involves not just the words that are used but also the listener's interpretation of the speaker's words, the body language of the speaker and listener, and the tone of voice. These factors change depending on the medium being used (i.e., face to face, phone, e-mail, video chat, letters). Families who have a member deployed or away from the other(s) for periods of time require an additional skill set to enhance these relationships.

- *Listening skills*

It describes how to use "I statements" to accurately convey what you are saying and start the conversation off well, how to respond, and how to have more productive and positive conversations.

Session 4: Stress management and problem-solving
Participant: Child
Objective of the session

- Help the child understand and handle stress-inducing situations
- To help child improve decision-making by eliciting and evaluating all possible solutions and choosing the best alternative to resolve their problem.

Duration: 50–60 min
Task

(i) Managing stressful situations
(ii) Finding solutions to problems.

13.7.18 Task (I) Managing Stress

Stress management steps for children under 10
Acknowledging their feelings

- It is important that children understand what they are feeling, that we teach the word "stress" by letting them know what they may feel that they may feel.
- Let the child know that it is all right to feel angry, alone, scared, or lonely.
- Teach children names or words for their feelings and appropriate ways to express them.
- The therapist shows more interest in the child's experience and feeling than in the behaviour that results.

Promote a positive environment

- Praise children for the acceptable things that they do also explain to the parents to do so.
- The experience of stress and tension can serve to defeat an individual's concept and confidence. Help the child sees and understands the positive things about themselves and that they are worthwhile persons.
- Listen without judging the child or the situation; that is, if the child chooses to tell you about the situation that produced the stress.
- Help the child feel comfortable in expressing feelings. Assist the child in clarifying his or her feelings. Correct any misconceptions that the children may have about themselves or their feelings.

Set a good example

- Children learn lessons from the family and other adults around them, whether these lessons are positive or negative.
- Children are imitators and may cope with stress in the same way they see adults handle their stress. In some cases, it is appropriate to explain why something is being done. This explanation can often ease the child's reaction.

Stress management for children above 10 years
The child is taught how to
Prepare for the stressor

- You can develop a plan to deal with it.
- Just think about what you have to do.
- Just think about what you can do about it.
- Worrying won't help anything.
- You have lots of different strategies you can call upon.

Confronting and handling the stressor

- You can meet the challenge.
- One setup at a time; you can handle the situation.
- Just relax, breathe deeply, and use one of the strategies.
- Don't think about the problem, just do what you have to do.
- That's right; it's the reminder to use your symptom management skills.

Coping with feelings at critical moments

- When pain comes, just pause; keep focusing on what you have to do.
- Don't try to eliminate the pain totally; just keep it under control.
- Just remember, there are different strategies; they'll help you stay in control.
- When the pain mounts, you can switch to a different strategy; you're in control.

Reinforcing self-statements

- Good, you did it.
- You handled it pretty well.
- You knew you could do it!

13.7.19 Task (II) Problem-Solving

The steps involved are as follows:
Stressors experienced

- Discuss about the stressors which the child is experiencing in their day-to-day life. Ask them, "What kinds of stress do you experience in your lives?"
- "What are the stressful situations that you experience over which you have absolutely no control?"
- "What are the stressful situations that you experience over which you do have some control?"

Finding solutions to problems

- Tell the child, "We would learn about these steps by using an example."
- Give child a situation.
- Encourage responses from the child and write them down.

General orientation

- Explain to the child that they need to accept that problem situations are a normal part of life and that one can cope with such situations.
- To deal with their problems, they need to prepare a list of all the problems that need fixing them and start working on solving them.

Problem definition, formulation, and goal setting

- Definition of the problem in concrete terms.
- Decide the time frame for solving the problem and accomplishing goal.
- Specify a desirable outcome by deciding what you would like to have happen instead of what did happen.
- What is the situation right now that is upsetting me?
- How would I like the situation to be?
- How would things be if I weren't upset?
- What are the obstacles?

Generation of alternatives

- Brainstorming all possible solutions without judging whether solutions are good or bad
- Come up with as many solutions as possible to deal with the problem situation
- Seek help of others if need to be

Decision-making

- Evaluating each alternative in terms of its likelihood of solving a problem.
- Going back through the list of alternatives generated and predict the consequences of each alternative behaviour.
- Each alternative may have several possible consequences all of which need to be considered.
- Both immediate and long-term consequences should be examined in determining the costs and benefits of a given solution.
- The following questions can be asked:
  - "Will this solution help me reach my goal and solve my problem?"
  - "If I choose this solution, how good or bad am i going to feel?"
  - "How much time and effort does this situation involve?"
  - "Does this solution have more benefits than costs if I choose it?"

Choosing a solution and putting solution into action

- It consists of two tasks
- Decision regarding which alternative has the most probable benefits and least probable cost in light of original problem and the stated goal
  - If you are given what you want to happen, which one of these alternatives would be the best for you?
  - Which one would be most likely to help you get what you want and avoid what you don't want?

- Need to identify the specific manner in which the chosen solution is to be carried out. For example, for a problem encountered in a social situation, one can ask:
  - What will be said?
  - What will the non-verbal behaviour be like?
  - What will the setting be?
  - When will it be done?
  - What might the reaction of others be and how will I deal with these reactions?
- Using this method, the best possible option is chosen. The strategies and behaviours should then be rehearsed by means of imagery, behavioural rehearsal/role-play, and graduated practice

Evaluation

- Evaluation is done after one has carried out the chosen solution
  - "Did i do what i set out to do?"
  - "Did i accomplish what i said i wanted to accomplish?"
  - "Am i satisfied with the results?"
- If you are satisfied with the results, then the solution was implemented effectively.
- If solution doesn't seem to be working, then ask yourself.
- "Did i define my problem correctly?"
- "Were my goals unrealistic?"
- "Was there a better solution?"
- "Did I carry out the solutions properly?"

Rewarding self for successfully solving the problem

- Once the implemented solution proves to be effective in solving the given problem, reinforce/praise yourself.

Session 5: Coping skills and assertiveness training
Participant: Child
Duration: 50–60 min
Objectives

- Teach child coping skills
- Teach assertiveness skills.

Tasks

(i) Coping practice exercise
(ii) Assertiveness exercise.

13.7.20 Task (I) Coping Skills

Steps involved:

- Write down experiences because of which you become stressed or upset
- Coping skills practice for getting over each above upset

For each upsetting experience, write down your answers to these questions:

- Name which types of upset your experience might be called. Is it a loss; rejection; betrayal, or humiliation?
- What does this upset make me feel like inside?
- How does this upset make me feel about myself? Usually, this answer shows what you really want and need that is the opposite of the upsetting experience you've had. So write down what positive thing you've found out about yourself by going through this upset and coping exercise.

13.7.21 Task (II) Assertiveness Skills

The steps are as follows:
Creating an assertiveness hierarchy

- You need to write down 10 situations in which you would like to be more assertive. This can be at home, at work, with friends, or out in public.

Work out the order of difficulty

- To do this, first give each situation a rating of how hard or difficult you think the task would be. Another way of thinking about it is to ask yourself how anxious would it make you. You give each situation a rating from 0 to 100. A rating of zero would mean the task wasn't difficult at all. A rating of 100 would mean it was the most difficult thing you could imagine doing. Using the ratings, you can then work out which task would be the easiest and which would be the hardest. You can then give each task a rank going from the easiest to the hardest. The therapist asks this to child:

  1. What is the situation in which you want to become more assertive?
  2. What unhelpful beliefs are maintaining the unassertive behaviour?
  3. What are more assertive beliefs?
  4. What unassertive behaviours are you using?
  5. What are more assertive behaviours you could use?

Identify and change any unhelpful thinking

- There is usually some unhelpful thinking underneath non-assertive behaviour.
- Use a thought diary and come up with more assertive thoughts. Once they have come up with this new thought, they were able to do that task and move on to the next task.

Identify and change any unhelpful behaviour

- Change unhelpful behaviours with more helpful behaviours

Rehearse and practice

Session 6: Relapse management
Participant: Parent and child
Duration: 60–90 min
Objectives

- Assess progress
- Reinforce gains
- Prepare for continued coping
- Relapse management.

Tasks

(i) Completing post-intervention measures
(ii) Review relaxation and behavioural, cognitive, and distraction techniques.
(iii) Prepare for minor setbacks and a plan of action to manage them.

13.7.22 Task (I) Completing post-intervention measures

- The child is given the post-intervention measures consisting of Coping Scale for Children and Youth, Children Somatization Inventory, and Children Global Assessment of Functioning using the same set of instructions.
- The parent is given the post-intervention measures consisting of DASS, coping checklist, and Global Assessment of Functioning.

13.7.23 Task (II) and (III) Review and relapse management

- All the doubts are clarified whether the child and the parent have any.
- It is explained to the parents that the symptoms might reappear, which might be just a phase. They can manage them with the above-explained strategies or can come back to us.
- All the skills taught are reviewed.

13.8 Barriers to Treatment

The belief system of the people that it is God's wish and nothing can be done about it or that it is black magic is a major barrier to families seeking treatment for their

children. Poverty and lack of knowledge makes these patients vulnerable to taking treatment from people not specialized to handle such issues. There is a dearth of trained professionals to meet the mental health needs of children and adolescents, and barriers to care include poor identification and lack of specialized personnel. Hence, attention needs to be focused on the training and supervision of professionals.

13.9 Conclusion and Future Directions

Unexplained physical symptoms are common in children and adolescents. These symptoms when severe, impairing, associated with psychological factors and result in frequent medical help seeking they form the basis of somatoform disorders. In some cultures, families may explain the physical symptoms in religious ways. Psychiatric comorbidity also commonly occurs. Medical examination and investigation, acknowledging parental and child attitudes and management strategies to reduce impairment, are essential to successful management. The best evidence of treatment comes from involving the family. Involving families during assessment and treatment is important and will aid recovery. Psychoeducation may be an effective means of preventing and managing these disorders across different countries and cultures.

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