2

Going to See the Paediatrician

Abstract The paediatrician has a central role as a gatekeeper both in diagnosing functional somatic symptoms and in directing the child and family onto a path toward health and well-being. In addition to determining that the child's symptoms are not caused by a disease process, the paediatrician provides the child and family with a positive diagnosis that sits under the umbrella of functional somatic symptoms. In so doing, the paediatrician validates the child's symptoms; the family feel relieved and validated; and the child and family are ready to accept referral to a mental health clinician—or to a multidisciplinary team that treats functional somatic symptoms. In this way, the paediatrician contributes to the creation of a *secure base* from which the child, family, and mental health clinician can feel safe enough to explore the various factors that contributed to the child's presentation. By contrast, when the clinical encounter with the paediatrician does not go well, the distressed family may end up consulting doctor after doctor, health professional

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after health professional. As time passes, new symptoms arise; the child's presentation gathers layer upon layer of complexity; and the child's symptoms may become chronic and more difficult to treat.

The Visit to the Doctor

When a child (including an adolescent) with functional somatic symptoms sees the doctor—the family doctor, paediatrician, or paediatric specialist in neurology, cardiology, rheumatology, or gastroenterology—she and her family are commonly told that all the tests are normal and that the physical and neurological examinations are also normal. But the paediatrician also needs to validate the child's symptoms (by giving a positive diagnosis), to explain that the symptoms are related to a temporary disturbance in body function (rather than to some serious disease), and to link up the family with appropriate help. When that all happens, the child and family are already moving along the path of recovery; early diagnosis and treatment are associated with good health outcomes (see following vignette of Amalia and summary of outcome data in Online Supplement 2.1).

> Amalia was a 12-year-old girl who was training to be a gymnast. Eight months earlier Amalia had landed badly in a fall. Because of ongoing pain in her neck and some twitching in the muscles of her right hand, she had to wear a neck collar prescribed by her orthopaedist. After three months her symptoms had fully resolved, and she slowly returned to her gymnastics training. More recently, Amalia again twisted her neck in a fall. Although repeated medical examinations were unable to find any medical problem, Amalia continued to experience headache and fatigue. Two weeks later she presented to the emergency department with leg weakness and an unsteady gait. Reassessment by the orthopaedic team—which included a blood screen, X-rays, and a head scan—led to a referral to the neurology team. The paediatric neurologist did a careful neurological examination, explained that Amalia's tests were all clear, and that the neurological examination indicated a functional neurological disorder (FND). She explained that in FND the structure of the muscles, nerves, and bones was *all good* but that the function had been disrupted. She also

explained that FND was commonly triggered by physical or emotional stress—in Amalia's case, her fall and twisting injury—and that two-thirds of children with FND also suffered from comorbid pain. She described to Amalia and her family the neurological tests that she had done and how they enabled her to assess whether Amalia's nervous system was intact. She told Amalia and the family that FND needed treatment and that, with treatment, most children recovered. She told Amalia and the family about the hospital's Mind-Body Program for treating FND, run by Psychological Medicine. Amalia and her family connected with the mind-body team, and Amalia successfully completed the standard, two-week admission to the Mind-Body Program (daily physiotherapy, psychotherapy, hospital school, and weekly family sessions). During the admission her walking difficulties resolved; she started on some melatonin to help manage her disturbed sleep; and she learnt and began to implement specific strategies to manage her pain. Amalia then returned to school and continued working with a psychologist to improve and maintain her mind-body regulation strategies (see Chapters 14 and 15). No other contributing factors were identified in Amalia's history.

The Paediatrician as Gatekeeper

The Need for a Clear Diagnosis: Establishing a Secure Base

The paediatrician acts as gatekeeper. As such, the paediatrician needs to take a thorough clinical history and to conduct a good physical examination; to undertake any tests that are necessary to exclude other medical conditions; and to identify any concomitant medical factors that are part of the child's presentation. And in the following conversation with the child and family, the paediatrician needs to explain that the child's pattern of symptoms and signs has a name (a positive diagnosis)—for example, functional abdominal pain or functional neurological disorder—and that specific treatment is generally required, potentially including referral to a clinician or team that treats functional disorders. Online Supplement 2.1 provides the reader with more information about the positive diagnosis.

As gatekeeper, the paediatrician establishes *safety* for both the family and the mental health clinician. The paediatrician confirms that the child is medically safe—that the child does not have an organic condition that needs to be treated using contemporary medical or surgical interventions—and that it is safe and appropriate for the mental health clinician to proceed with a treatment intervention. In this way, the paediatrician contributes to the creation of a *secure base* from which the child, family, and mental health clinician can feel safe enough to explore the various factors that contributed to the child's presentation (see Chapter 3). We borrow this idea from Mary Ainsworth, who noted how the mother can serve as a safe base, or relationship, from which the child can 'explore the world … under circumstances in which danger is absent' (Ainsworth 1967, p. 346), and from John Byng-Hall, who used the idea of safe base in working with families (Byng-Hall 1995).

The Sequelae of Diagnostic Uncertainty

If the paediatrician has not established this safe, secure base for the family, the child and family are unable to let go of the nagging fear that some organic disease process may have been missed. Assailed by this nagging fear, the child and family will struggle to accept a referral to a clinician/team who treat functional symptoms within a psychological setting, and will find it difficult to accept a formulation and treatment plan pertaining to a functional rather than organic illness.

Likewise, if the mental health clinician senses the absence of an adequate medical assessment or if the clinician has not been provided with a clear functional diagnosis, the clinician will also feel unsafe or, at the very least, lacking a proper mandate for proceeding with treatment. Concern that the child has not been adequately assessed medically—and that an organic condition may have been missed—may lead the clinician herself to encourage the family to obtain a new, comprehensive assessment, along with whatever tests and investigations are required. As we will see below, such additional referrals can contribute to a never-ending process of doctor visits.

Addressing Diagnostic Uncertainty Head-On

Unfortunately, there are times when the gatekeeping encounter with the paediatrician does not go well, as we see in the following four vignettes. The first vignette of Lola demonstrates that providing a positive diagnosis is very different from telling the child and family what the symptoms *are not*. Stating that all the tests are normal, that the symptoms are non-organic, that the pain is not from the heart, or that the problem is not asthma or not epilepsy conveys no information about what the problem *is*, and fails to recognize the child's symptoms as real. It also leaves the family in a state of confusion, anxiety, and not-knowing. The vignette of Lola highlights that the mental health clinician may need to liaise with the paediatrician to ensure that this final step of the medical assessment process is completed.

> Lola was a 13-year-old girl who presented to hospital with intermittent shaking in her right arm that sometimes progressed to a non-epileptic seizure (more generalized shaking; NES). Lola was investigated by the neurology team. At the family assessment interview with the mind-body team, Lola's family reported that the doctor from the referring neurology team had told them that the symptoms were *not organic*, *not caused by epilepsy*, and *not harmful*. When the first author (KK) asked the family if Lola had been given a diagnosis, the family looked confused and replied that no diagnosis had been given. A phone call to the neurology doctor, with the family present in the room, confirmed a diagnosis of functional neurological disorder, or FND—of which NES is a subset. Once the diagnosis was confirmed and then communicated to the family, the mind-body team could explain the implications of the diagnosis and elaborate the treatment that needed to be implemented. In a subsequent conversation, the doctor who had seen the child and family—who was training to be a neurologist—admitted that she had struggled to provide a positive diagnosis of FND because doing so made her anxious. The first author suggested that shadowing another neurologist—one who had mastered this task—might help the training neurologist overcome her anxiety and become proficient in this clinical skill.

In the following vignette of Evie, we see how a positive diagnosis allowed Evie to let go of the nagging thought that an organic disease process has been missed by all the doctors who had assessed her pain. Evie suffered from with intermittent pain in her chest—called *precordial catch syndrome*—which subjectively felt like a bursting bubble (Gumbiner 2003; University of Wisconsin–Stevens Point Health Service 2005). Precordial catch pain is a functional somatic symptom thought to be caused by tension patterns in muscle and fascia tissues that sit within the chest cavity. Until the positive diagnosis was given, Evie did not feel safe—a secure base had not been achieved—and she was unable to accept the referral to, or to engage with, the mind-body team.

Evie was a 15-year-old girl who presented with intermittent pain in her chest—called *precordial catch syndrome*. Sometimes the pain became unbearable and would trigger a non-epileptic seizure, or NES. Evie had had a difficult time in the health care system. In the previous hospital, where she had been fully and extensively investigated by multiple specialists, the doctors had diagnosed NES. They also gave Evie the distinct impression, however, that her symptoms of pain and the NES were all in her head. On her subsequent presentation to our hospital (and the mind-body team), Evie remained preoccupied with her recurring chest pains and was plagued by thoughts that the paediatrician's medical assessment may have missed a disease process. For example, Evie spoke about her previous cardiology consult with sarcasm: 'She [the cardiology fellow] did not know. She said that she thinks it is not the heart. So, what if the doctors don't know? What if they have gotten it wrong?' But, after a senior paediatrician at our hospital provided the diagnosis of precordial catch syndrome, and after Evie had read the fact sheet about that syndrome, she accepted both the diagnosis and the unwelcome reality that she would need to learn to manage the pain. With the safe base thus created for Evie and her family, Evie began to engage effectively with the mind-body team. She collaborated in the history-taking process and in co-constructing a formulation (see Chapter 3), and she then got on with the task of implementing mind-body strategies that enabled her both to manage the precordial catch pain and to avert her NES. Evie and her parents also implemented family interventions that enabled them to resolve tensions in their relationships. A clear, positive diagnosis of both precordial catch syndrome and NES had enabled Evie both to accept the symptoms and to engage in the therapeutic intervention that helped her return to health and well-being.

Premature Referrals

The third and fourth vignettes demonstrate that, when the paediatrician as gatekeeper refers the child too early—prior to the completion of a comprehensive medical assessment—and therefore fails to create a safe, secure base for the child, family, and mental health clinician, serious organic conditions can be missed, potentially leading to serious harm.

> When the first author was a junior consultant—and had not yet leant to stand her ground when determining whether referrals had been properly worked up medically—she was pressured by the referring neurologist to fit in a family assessment for Martha, a 13-year-old adolescent. Martha was presenting with an unusual array of neurological symptoms, which the neurologist assumed to be functional. The mind-body team's family assessment did not yield any particular story or pattern, even after much gentle, but lengthy, probing. Two days later a head scan, ordered prior to the referral but conducted after the family interview, revealed that Martha's symptoms were caused by a brain tumour.

> Ian was a 15-year-old boy referred by a general paediatrician for the treatment of NES. On screening the referral, the mind-body team noticed that the medical workup was incomplete; the paediatrician had not done an electroencephalograph (EEG), the gold-standard test for distinguishing epileptic from non-epileptic seizures. Despite our request for an EEG, the paediatrician refused because she had seen the seizures events and was sure of her diagnosis of NES. During the family assessment interview with Ian and his family, the first author noted the stereotypic nature of the events over a period of ten years—a characteristic of epileptic seizures. After completing the interview she referred Ian for an EEG herself and briefed the neurology team that her provisional diagnosis was that of epileptic seizures. An EEG confirmed epilepsy, and an MRI showed a seizure focus—a scar in the brain. After surgical removal of the scar, the seizures ceased.

The Loss of Trust and the Spiral into Chronicity

As we have already seen, when the clinical encounter with the paediatrician goes well, it is the first, forward-looking step toward a favourable outcome. The child and family are able to take the fork in the road

that leads to health and well-being. We also need to track what happens, however, when the encounter does not go well and the child and family take the fork in the road that spirals into chronicity.

If the paediatrician provides no positive diagnosis and, with no adequate explanation, refers the child and family to a mental health clinician, the family may leave the doctor's office baffled and distressed or even angry. Their eyes tell them that their child's *body* is ill: the child is shaking, or having seizures, or struggling to walk, or experiencing disabling pain, or too exhausted to do anything. It is difficult for them to believe that the findings of the medical examination are normal, that nothing is wrong. If the paediatrician has suggested that the symptoms may be caused by emotional or psychological distress, or that an emotional trauma may have caused the debilitating symptoms, the family may emphasize that the child has grown up in a loving home and that emotional trauma is not part of the family story. In other cases, the family may note that their child's somatic symptoms started after a common infection or illness, or after a physical injury, sprain, fall, or bump on the head, and that no psychological stress has occurred (see, for example, the vignette of Amalia, above). In any event, whereas most families see the logic of bringing in a physiotherapist, the suggested need to bring in a mental health clinician might be experienced as a rejection and taken as proof that the doctor thinks the symptoms are not real. The child—and her parents—may feel that the doctor does not understand. They are likely to feel hopeless, angry, and dismissed (see following vignette of Samantha).

> Samantha, a 10-year-old girl, lived with her father, paternal grandparents, and one younger sibling. As a child she had been exposed to domestic violence between her parents and to considerable family upheaval. At school, Samantha was an engaged, compliant student who had good relationships with her teachers and peers. At the beginning of year 5 in school, following a nasty viral infection, Samantha developed recurring headaches that slowly became chronic, with the consequence that the pain in her head was constant. Two months later, Samantha began to experience dizziness, shaking, and jerking. Over a six-month period, Samantha had frequent presentations to her local doctor and her local emergency department. She was repeatedly examined, including via an EEG (to exclude epilepsy) and a head scan. She and the family were

repeatedly told that everything was normal, that the doctors could find nothing wrong. Because the problem was conceptualized as *psychological*, Samantha was referred to the community mental health team for treatment. Since the mental health team believed that functional neurological symptoms pointed to a history of sexual abuse, they kept asking Samantha and her family questions whose aim was to uncover sexual abuse. This naturally upset Samantha and her family, who discontinued their contact with the mental health team after a few sessions.

Six months later the shaking and jerking culminated in non-epileptic seizures, or NES. A diagnosis of *pseudoseizures* (an old term for NES) was given. Samantha interpreted the diagnosis to mean that she was *making the seizures up*. On another occasion, the diagnosis of *psychogenic NES* was given. This time Samantha interpreted the diagnosis to mean that she was *psycho* (i.e., crazy). Because the seizure events were occurring many times a day, Samantha became wheelchair-bound. Her family insisted that she use the wheelchair to keep from falling and hitting her head. After one frightening seizure—in the ninth month of her illness—Samantha was taken by ambulance to the local hospital for treatment. Because the family refused to take Samantha home, insisting that something had to be done, the hospital transferred Samantha to the first author's tertiary care hospital for 24-hour EEG monitoring. At the hospital Samantha was assessed by the neurology team—who gave Samantha and the family a clear diagnosis of NES and chronic complex pain. The neurology team also told the family that these illnesses were common and that the mind-body team in Psychological Medicine ran a specialized program for NES. With reluctance, the family agreed to meet the mind-body team because they were now desperate for Samantha to receive treatment (see Chapter 3 for this family's clinical encounter with the mind-body team).

When the family is unable to understand or accept the diagnosis provided by the paediatrician, the child and family may simply move on to another doctor. And each new doctor, not knowing what else to do, orders the same (or even further) tests—which simply fuels the family's anxiety and serves to perpetuate the child's symptoms.

This process of never-ending doctor visits—fuelled by inadequate clinical encounters—has unfortunate consequences. The anxiety experienced by both the family and child is likely to increase. Anxiety in parents may also lead to catastrophizing about the child's symptoms and increased

vigilance; they begin to *look out* for the symptoms, to pay the symptoms more and more attention, and to respond to the symptoms with caregiving behaviours. This constellation of parental behaviours has the effect of increasing symptom intensity and frequency. Moreover, as the child's parents become more anxious, so does the child. In the absence of a clear diagnosis, some children may worry that they never will recover or that they have a life-threatening illness. Anxiety is a powerful top-down activator of the stress system—further amplifying symptom intensity, increasing symptom frequency, and often contributing to the generation of new, additional functional somatic symptoms. The children's book *Malte and Malte's Stomach* has beautiful illustrations about the child and family's journey through the medical system (Toscano 2016).

As time goes on, the somatic symptoms will begin to impair the child's functioning. The child will miss school and stop exercising. Connections with friends, as well as all the benefits that these relationships provide, will deteriorate. With social isolation and a progressively sedentary lifestyle that leads to deconditioning, a range of body systems will become more dysregulated and shift even further toward a non-healthy brain-body state. With each shift, the child will become sicker and sicker, and may develop new symptoms—a vicious cycle of ever-progressing illness. At this point, much will need to be done to help the child regain her physical well-being and conditioning. Eventually, even if emotional symptoms had not been part of the child's original presentation, the child may become very distressed, and her mood may be affected. In addition, her sleep may now be disturbed, with the consequence that she experiences no relief from the symptoms day or night.

Family interactions will also have changed. The child is now disconnected from her life outside the family and overly connected—in a way that is not appropriate to developmental stage—with one or both parents and with any siblings in the family who have adopted a caregiving role. The situation pushes the child into a sick role and also changes the parents' behavioural expectations for their child. These patterns of relating together, where the child signals her symptoms and distress, and the parents respond to the signalling, will have stabilized into a pattern that is difficult to break and that creates a barrier to getting well. Additional

work will be needed to help the family change their patterns of relating, and to adopt ones that promote the recovery process.

Working in a children's hospital, we have seen many children and families who have walked this complicated pathway, the spiral to chronicity, because they were unable to find (or in some cases, accept) help within the existing medical system.

Going from Doctor to Doctor: How a Child Can Collect Multiple Diagnoses

If the child's functional somatic symptoms disrupt function in multiple body systems and if the child and family end up seeing a number of doctors—each with a specialty oriented toward a particular body system—the child may accumulate many specialty-specific *positive* functional diagnoses from different specialists, which can seriously confuse the family (see vignette of Paula, below). If the doctor is unable to explain that these diagnoses are interrelated and that they all sit under the umbrella of functional somatic symptoms, then the family will remain confused.

> Eleven-year-old Paula, in year 5 at school, fell while playing soccer and was diagnosed with a hairline fracture in the lateral epicondyle of the right femur that caused severe pain in the knee. The fracture healed, though Paula continued to experience intermittent pain. She found it difficult to sleep, and as time went on, even a bump to the leg near the knee would cause pain that lingered for weeks, often requiring the use of crutches. That same year, Paula's maternal grandfather—with whom she was very close—was diagnosed with cancer; his visible physical decline was an ongoing stress.
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> Two years later, an orthopaedic surgeon diagnosed Paula's problem as chronic regional pain syndrome (CRPS Type 1). On an outpatient assessment, our hospital's Pain Team rejected the diagnosis of CRPS and used the terms *chronic pain* or *complex pain* to describe the problem. With weekly physiotherapy and hydrotherapy, both the pain and Paula's walking got better. During that year, however, Paula's *paternal* grandfather—whom Paula did not know well—died from cancer. And, given that her

maternal grandfather's health continued to deteriorate, the death was a distressing reminder that he was dying, too.

A year later (year 8), Paula was bullied at school. Again, her sleep became disturbed. And after one particular instance of bullying—being pushed while trying to close a door—she developed left arm weakness and pain. Later that same year, over a period of months, Paula developed bilateral weakness in the legs, a persistent headache, and musculoskeletal pain that migrated all over her body; the pattern of pain kept changing over time. As Paula became less and less mobile, and spent more time in her bed, she developed symptoms of dizziness—especially on standing up from bed—and fatigue, as well as intermittent nausea, abdominal pain, and loss of regular bowel motions. Sometimes her body lost control: her heart thumped, she sweated, and she felt breathless and faint. The symptoms were worse when the stress at school was worse, and they remitted when the stress eased. During this time, Paula's parents took her to see many different specialists for her various symptoms. In the respective specialist reports, the neurologist presented a diagnosis of FND; the psychiatrist, conversion disorder and generalized anxiety disorder; the gastroenterologist, functional gut disorder; and the rheumatologist, amplified musculoskeletal pain syndrome (Sherry 2000) and probable postural orthostatic tachycardia syndrome (POTS) secondary to physical deconditioning (Wells et al. 2018).

At the first author's hospital, the Pain Team continued to see the problem (as per its initial assessment) as chronic or complex pain accompanied by intermittent functional neurological symptoms, but the Pain Team also recognized that Paula was becoming progressively more debilitated; effectively bed-bound, she was unable to mobilize around the house for more than five minutes at a time. The family, now very worried about Paula's fatigue, had begun to wonder if Paula might also be suffering from chronic fatigue syndrome.

Because of Paula's progressive debilitation, the Pain Team referred her for admission to the hospital's Mind-Body Program. In the weeks prior to initial assessment by the mind-body team, Paula developed another new symptom—intermittent loss of vision in the left eye—and an ophthalmologist told the family that the problem was non-organic. During the assessment itself, it became apparent that the profusion of diagnoses made the family confused and gave them the impression that Paula—now 15 years of age and in year 9—was suffering from a combination of disorders from which recovery was unlikely.

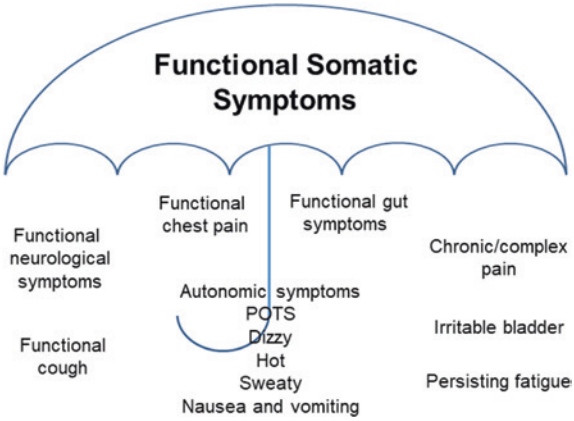

Fig. 2.1 The wide-ranging functional diagnoses that fall under the umbrella term *functional somatic symptoms* (© Kasia Kozlowska 2019)

To overcome the confusion that multiple medical diagnoses can create, some researchers and clinicians have suggested the use of a unifying diagnosis, such as *bodily distress syndrome* (or *disorder*) (for references see Online Supplement 1.1). The key problem is that this unifying terminology is not currently integrated across the two key diagnostic systems, the *International Classification of Diseases* and *Diagnostic and Statistical Manual of Mental Disorders* (for more detail about terminology, see Online Supplement 1.1). In this book we have chosen the term *functional somatic symptoms* as the unifying term for the broad range of functional somatic symptoms that we see in our child and adolescent patients (see Fig. 2.1). For a description of our use of the term, see Chapter 1.

The Problem That Multiple Specialty-Specific Diagnoses Pose for Professionals

Specialty-specific diagnoses also pose problems for professionals, potentially compromising their ability to communicate with each other and to provide mutually complementary care. Specialists from one specialty (e.g., neurology) may not be up to date with the specialty-specific

diagnoses used by their colleagues from other fields (e.g., gastroenterology). Specialist also tend to work in a blinkered sort of way—addressing problems pertaining, for example, only to the gut, nervous system, heart, or ear, nose, and throat. Consequently, when a specialist makes a functional diagnosis related to his or her particular medical specialty, the specialist may not even recognize the diagnosis as being functional, may fail to make links to, or even inquire about, potential symptoms in other organ systems, or may fail to communicate the interrelated nature of all functional diagnoses to the child and the family.

The vignette of Louisa (below) demonstrates how the phenomenon of specialization within modern medicine—and the loss of holistic care—can also create confusion between specialists, and how difficult it can be, even for teams who work in the field of functional somatic symptoms, to reach conceptual clarity. The vignette is also a good example of a system intervention that takes place within the health care system—to build a common way of thinking about the child's problems between all the professionals involved in a child's care.

> When referred to our Mind-Body Program, Louisa, an 11-year-old girl in year 6 at school, was experiencing symptoms of anxiety, depression, fatigue, disturbed sleep, and buzzing in the left ear that was described in the referral letter as tonic tensor tympani syndrome. Louisa had a long history of separation anxiety and intermittent functional abdominal pain, which had been worse when Louisa was bullied in year 4. When Louisa's first ear, nose, and throat specialist and his team were unable to treat her ear problem effectively using various recommended therapies for tinnitus (for references see Online Supplement 1.3), she proceeded to be seen by a long series of other ear, nose, and throat specialists and pain specialists, each of whom had issued a specialty-specific diagnosis. A second ear specialist had diagnosed tinnitus, another hyperacusis, and a pain specialist had used the diagnosis of chronic ear pain. Nevertheless, despite the long list of medical consultations, Louisa's health and function had not improved.
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> Our review of Louisa's medical history suggested that her sensitivity to sound and her pain in the ear were consistent with a functional disorder. In this context, we read the neuroscience literature about tinnitus and discovered that in cases where tinnitus—which is uncommonly reported

by children presenting to our program—is *not* associated with any damage in the auditory apparatus, it *is* associated with increased activity in the brain stress systems (see Chapter 11), a finding that parallels those in other functional disorders (see Chapter 11).

With this information in hand, and through a series of telephone calls over a two-week period to each of the health professionals previously involved in Louisa's care, we all came to the same conclusion (though only after considerable probing by the mind-body team): despite the different terminology and what appeared to be ongoing disagreements about what exactly was happening to Louisa, all the specialists agreed that Louisa's various symptoms and difficulties were best conceptualized under the umbrella of functional somatic symptoms with comorbid anxiety.

In the above vignettes of Paula and Louisa, we see that the medical professionals had focused narrowly on what they saw as specialists, and that all had generated specialty-specific diagnoses and treatment recommendations. What they had all failed to recognize was that the symptoms that they were focusing on were interconnected not only with other functional somatic symptoms but with other stress-related disorders, such as anxiety, depression, and post-traumatic stress disorder.

Putting It All Together

One way of understanding the myriad terms that doctors have used to talk about functional somatic symptoms—both now and in previous eras (for a terminological history reaching back to Ancient Greece, see Online Supplement 1.1)—is through the parable of the blind men who tried, each through a single touch, to determine the true nature of an elephant. Depending upon the specific part that each had access to, the elephant was considered to resemble, for example, a snake (trunk) or fan (ear) or rope (tail) or wall (body) or tree (leg). In much the same way, each set of terms that has been used, over time, to refer to functional somatic symptoms reflects some portion of the truth (Fig. 2.2).

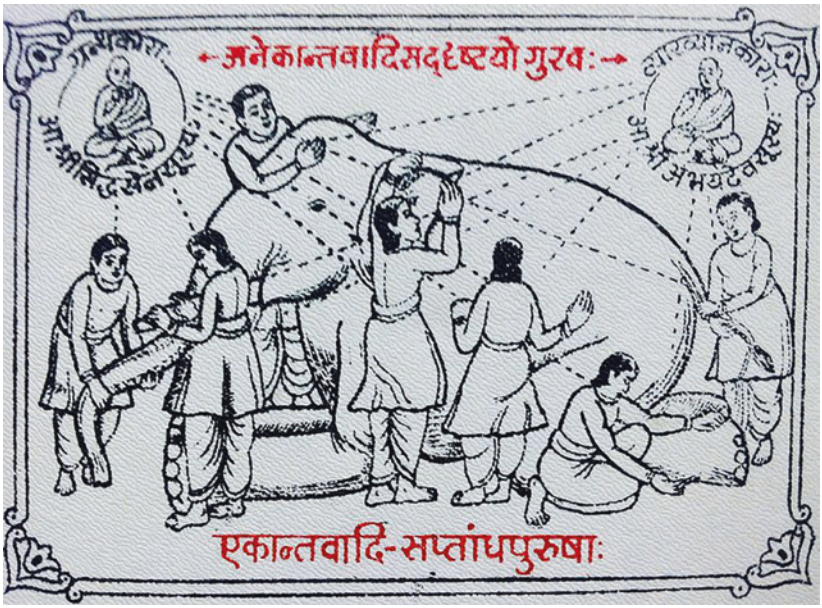

Fig. 2.2 The parable of the seven blind men and the elephant. This parable comes from the Indian tradition, where it was used to highlight the multi-sided, multifaceted nature of truth. This particular image is taken from Siddhasena's *Sanmatitarkaprakaraṇa* (1986), an Indian text from the fifth century. [Siddhasena Divākara, Jayasundaravijaya, and Abhayadeva. (1986). *Sanmatitarkaprakaraṇa* (Prathamāvṛtti ed.). Dhoḷakā, Gujarāta: Divyadarśana Ṭrasṭa.] (*Source* Romana Klee via Wikimedia Commons CC-BY-SA)

The Role of the Support Group

The use of speciality-specific diagnoses has led to the growth of support groups for specialty-specific conditions. Some of the children and families who present for assessment and treatment of functional somatic symptoms will have searched the internet for information and will have accessed support from such groups. Our clinical experience is that some support groups are primarily health focused and serve to support the child and family with the process of getting well. Other support groups are symptom focused, however, and by focusing on symptoms—rather than the process of getting well—these groups may lead the child and family further down the spiral into chronic illness.

An additional problem is that many support groups are made up predominantly of patients whose symptoms have become chronic and who have, in effect, had to adjust to and accept the experience of being chronically unwell. Those who have gotten well have returned to their ordinary lives and have no need of ongoing support. Consequently, if a child and family make contact with such a support group when the child first presents, the child will get the erroneous message that the condition is always chronic. This erroneous message, in and of itself, will affect the child and family's expectations, and will make it less likely that the child will return to health and well-being (see Chapter 12 for a discussion of expectations).

In sum, families face ongoing challenges in managing and assessing the information that they and their child might obtain via the internet or via support groups. Just how they address these challenges will continue to affect the child and family's willingness and capacity to engage effectively with mental health professionals.

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In this chapter we have discussed the important role of the paediatrician (or other doctor)—as gatekeeper—in both diagnosing functional somatic symptoms (a positive diagnosis) and in referring the child and family for appropriate treatment. As gatekeeper, the paediatrician establishes *safety* for both the family and the mental health clinician. The paediatrician confirms that the child is medically safe and that it is safe and appropriate for the mental health clinician to proceed with a treatment intervention. In this way, the paediatrician contributes to the creation of a *secure base* from which the child, family, and mental health clinician can explore the various factors that contributed to the child's presentation (see Chapter 3).

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