Organic or Psychosomatic? Facilitating Inquiry With Children and Parents*

CASE

Eric (12 years old, 6th grade) saw a new pediatrician with concern about fatigue and intermittent abdominal pain for the past 2 to 3 months. His mother observed that he appeared more tired and that the “whites of his eyes are more cloudy” than usual. He continued to be active, however, and reported that he played basketball and football without any problems. He slept 8 hours each night without a problem either initiating or maintaining sleep. When asked about the abdominal pain, Eric reported that it was usually in the left upper quadrant, more noticeable after running, and subsided after 1 to 2 minutes of rest. He denied any physical trauma, constipation, hematochezia, joint symptoms, fever, night sweats, or weight loss. His mother inquired about whether he could have hepatitis because a family friend, who was at their home cleaning the garage, had been diagnosed with hepatitis. However, she stated that neither she nor her son had any casual or intimate contact with this person and that he was in the garage for only a few hours.

Eric and his mother lived alone. For several years, he saw his father only occasionally. Eric was struggling academically in school this year; his grades changed from A’s and B’s down to C’s and D’s. He had not changed schools and denied any problems getting along with either peers or teachers. When the pediatrician asked why Eric’s grades changed, his mother reported that she thinks it is because he is missing a lot of school and not keeping up with his homework. She reported that recently he missed 1 to 2 days weekly because “he is too tired” in the morning.

Intrigued by the constellation of symptoms and concerns, the pediatrician asked Eric’s mother to wait in her office while she examined the patient. The physical examination was normal, and further questioning of the patient without a parent in the room did not elicit information to explain his school problems other than his insistence that he is often tired.

Leaving the patient to dress, the pediatrician returned to her office. She asked the mother if there was anything that she wanted to share that she was uncomfortable discussing with her son in the room. At this point, the mother appeared anxious and disturbed. She expressed apprehension about being away from her when it is time to go to school. She reported that she has undergone dental work and may have had “blood in my mouth.” Eric’s mother stated that she was so troubled after this event that she stopped any form of physical contact with her son including kissing, hugging, or snuggling as they watched television together for fear that she would pass the infection to him.

The pediatrician spent considerable time explaining the usual mode of transmission of hepatitis C and the unlikelihood that her son could have contracted the disease from her with the contact described. In addition, she pointed out that the mother’s complete withdrawal from her son may be contributing to his apprehension about being away from her when it is time to go to school. Arrangements were made to perform baseline laboratory tests and hepatitis markers, and an appointment for a repeat visit was scheduled. After a few days, the pediatrician contacted Eric’s mother with a report of the normal laboratory results. When asked, the mother said that she has given Eric an occasional hug since the office visit. Two months later, the patient returned for a well-child examination. His mother informed the pediatrician that their relationship was back to normal, that his energy level was returning to normal, and that he had missed only 1 day of school. In addition, his grades were improving, and he no longer complained of abdominal pain.

INDEX TERMS. recurrent abdominal pain, school refusal, communication skills, family pediatrics.

Dr Martin T. Stein

The acquisition of clinically critical information through interviewing has been described as the “art of medicine.” Learning effective interviewing skills, however, requires a knowledge about the process of the clinical interview, techniques with a high probability of yielding useful information, and awareness that “surface symptoms” (the main concern or chief compliant) may be the entry to the pediatrician’s office but not the underlying reason for the visit. Eric’s pediatrician demonstrated these skills in the way she framed her questions and by her recognition of a potential “hidden agenda.” It is the stuff that makes primary care pediatrics and developmental-behavioral pediatrics challenging and rewarding.

Three pediatricians who practice in different settings were invited to comment on this case. Dr Janet Crow is a primary care pediatrician and a member of the teaching faculty in general pediatrics at the University of California, San Diego, where she is an assistant clinical professor of pediatrics. She teaches residents in pediatrics and family medicine and medical students in a clinic that provides care for a large

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underserved population. This Challenging Case came from Dr Crow’s pediatric practice. Dr Myles Abbott is a Clinical Professor of Pediatrics at the University of California, San Francisco (UCSF). He has practiced primary care pediatrics for many years in the communities of Berkeley and Orinda and has directed continuing medical education programs for the American Academy of Pediatrics and the UCSF. Dr J. Lane Tanner, Clinical Professor of Pediatrics at UCSF, is Associate Director of the Division of Developmental and Behavioral Pediatrics, Children’s Hospital Oakland. Dr Tanner has been a leader in bringing to pediatrics an awareness of the importance of understanding the role of the family as we care for children and youth.

Dr Janet Crow

A busy pediatrician presented with a new patient complaining of vague symptoms and a 15- to 20-minute appointment faces a daunting task. This case illustrates a number of issues that are not uncommon in an outpatient pediatric setting. Eric and his mother appear to have come with concerns about his chronic fatigue and abdominal pain. It was not until the pediatrician explored the concerns in multiple ways and ultimately with the mother and patient separated that concerns surfaced about school performance, attendance, and fear that the patient had contracted hepatitis C from his mother.

Productivity requirements and time limitations place considerable pressure on practitioners, giving some clinicians the perception that it is not possible to communicate well or elicit the complete agenda of a patient in the time allotted. In a study that assessed the patient-physician interactions of family physicians practicing in outpatient settings, the focus was on how often patients were able to express their concerns to the physician. Although 75% of the time physicians solicited some of the patients’ concerns, among that group a complete statement of concerns was elicited only 28% of the time. In patients who completely express their concerns, the average time was only 6 seconds longer.

In addition, formal teaching about physician-patient communication in medical school and resident training is limited. For medical students, training in communication skills with pediatric and adolescent patients is even more limited. In a survey of 184 incoming residents in various specialties, the average time of formal training in patient communication was 3 to 8 hours for pediatric/adolescent medicine, compared with 16 to 24 hours for adult medicine.

Effective communication skills that determine the reason a patient seeks care may save both valuable clinician (and patient) time and limit unnecessary laboratory tests. In addition, this case serves to illustrate the benefits of conducting separate interviews with a child and his or her caregiver.

Eric’s pediatrician determined his mother’s hidden concern. This information, in association with a normal physical examination, would lead the pediatrician to ask 2 questions: (a) Is it possible that Eric contracted hepatitis C from his mother? (b) Is there a relationship between his school absence/failure and this concern? The incidence of intrafamilial transmission of hepatitis C virus (HCV) has been reported to range from 1% to 20% among nonsexual household contacts. In a meta-analysis of controlled studies, the pooled prevalence of anti-HCV antibodies among siblings and household contacts of patients with HCV-related chronic liver disease was 4% compared with 0% among contacts of anti-HCV-negative controls. Although HCV ribonucleic acid has been reported in the saliva of patients with chronic hepatitis, the implications for HCV epidemiology are not clear. It is interesting that a report from Karachi, Pakistan, found an increased risk of HCV seropositivity among household contacts of HCV-positive patients who had been bitten by the carrier or had a history of sharing a toothbrush. Thus, whereas the possibility is low, this mother’s concerns are not unfounded, and testing Eric for HCV antibodies along with counseling his mother about behaviors to avoid is prudent in this setting.

Finally, the pediatrician should think about Eric as an only child who has been close to his mother and is now confronted with an acute change in their relationship. Although Eric does not know what is wrong, he likely perceives that it is something quite dramatic, and he has begun to express a desire to stay home with his mother and not be away from her even during school. Separation anxiety disorder (SAD) in children and adolescents is described by Masi et al as “qualitatively different from early worries.” It is characterized by “an abnormal reactivity to real or imagined separation from attachment figures, which significantly interferes with daily activities and developmental tasks.” School refusal has been reported in up to 75% of children with SAD, and, conversely, a large number of children that present with school refusal suffer from SAD. A recent review of the literature regarding school refusal found that, among those without a coexisting disruptive behavior disorder, there were significantly higher rates of anxiety and mood disorder compared with controls. The authors also reported that approximately half of school refusers underachieve academically. Follow-up studies into adulthood revealed that many separation-anxious school refusers continued to have problems, including living with their parents for extended time periods and the need for more psychiatric consultations.

It is encouraging to see the quick response that Eric had to maternal attention and affection. However, the inability of his mother to discuss her illness with her son, coupled with Eric’s tendency to withdraw from school and academic underachievement, should guide the pediatrician’s work to keep the lines of communication open for future encounters.

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Pediatricians often see children with chronic non-specific symptoms. A complete medical history and physical examination is the first step; as we are taught in medical school, this will lead to the correct diagnosis 90% of the time. In this patient, the first objective was to determine whether the symptoms were organic or nonorganic in origin. The pediatrician did an excellent job in digging below the surface to obtain essential parts of the history that eventually led to the diagnosis. Wouldn’t it be nice if all our patients had such a straightforward problem and happy outcome!

Pediatricians are sensitive to family dynamics and understand the impact of the child’s environment, including home and school, on children’s health. Today, this global approach is referred to as “family-focused behavioral pediatrics,” but that title may be too limiting. This approach explores all environmental factors that affect children’s health. The family is the most central player, but school, friends, and even world events are known to affect children’s health and well-being.

In this case, the medical history is unremarkable, the symptoms are chronic and lack major constitutional “red flags” (eg, fever and weight loss), and the physical examination is normal. The pediatrician apparently sensed that there was something more to be learned and spoke with both Eric and his mother separately. This elicited the mother’s hepatitis C diagnosis and her related concerns and behavior. Too often, because of managed care constraints, pediatricians may feel rushed and may not take the extra few moments that might disclose important information. As this case shows, a little extra time spent exploring family dynamics can save the patient from a lengthy, expensive, and unnecessary diagnostic evaluation.

The pediatrician used several other noteworthy techniques. She was direct with Eric’s mother and said she suspected the mother’s behavior was contributing to Eric’s symptoms. She educated and reassured the mother about her illness, performed baseline laboratory tests, and scheduled a follow-up appointment.

Familiarity over time provides pediatricians with insight into a family’s dynamics. When continuity of care is absent, the pediatrician is without a foundation for comparison. Eric’s pediatrician recognized that she needed to learn more about the family situation because it was her first encounter with them. Even when the pediatrician knows the family well, it is important to remember that life events and family dynamics change, and these changes can affect a child’s health. Asking open-ended questions to acquire updated information about the family is an important part of ongoing pediatric health care.

Dr J. Lane Tanner

In reviewing this case, my first reaction is one of admiration for the pediatrician’s careful and stepwise approach in eliciting the “story” of the problem. Several clues in the initial history suggest the possibility of a somatoform disorder, including the vague symptoms of the symptoms, the preservation of normal sleep and physical activity, the negative review of systems, and the somewhat abrupt change in school attendance and academic performance in a boy who had previously had good grades. In addition, the mother reports a worry she has had about contact with a family friend who has hepatitis—a worry that seems out of proportion to the degree of exposure.

The urge to run from a potential psychosomatic problem is not unknown in pediatrics and can take several forms. Clinicians may prematurely reassure. They may refer the patient to some higher biomedical authority such as the laboratory to “prove” the child’s “wellness,” or they may become overly focused on possible biomedical etiologies, thus helping to confirm the family’s fear of an organic disorder. This clinician rejected those options and, “intrigued by the constellation of symptoms and concerns,” moved to facilitate a deeper inquiry by providing the boy and his mother the opportunity to share with her her personal concerns. 1

The pediatrician’s curiosity and persistence is rewarded by the mother’s private revelation of her own diagnosis of hepatitis C and her anxiety over the fact that she may have transmitted the disease to her son or that she could do so in the future. The pediatrician is now in a position to effectively reassure the mother and encourage a return to her usual relations with her son. With this approach, a problem of 2 to 3 months’ standing was promptly resolved.

On its face, this sequence sounds straightforward. Yet, we can easily imagine the clinician’s internal dialogue. No doubt she was mentally reviewing a “pull-down menu” of possible disorders such as chronic fatigue syndrome, leukemia, lymphoma, anemia, or various gastrointestinal infectious or immunologic disorders, not to mention the possible place of psychopathologies including anxiety and depression. For pediatric clinicians, there is routinely a set of pressures, intrinsic to our role and our clinical context, for seeing the problem as residing in the
child. After all, the child and the child’s problems are what are usually presented to us. The family context is frequently not volunteered and typically out of our view unless we specifically inquire about it. The success of this case hinged on that inquiry, which located the likely source of the symptoms as originating in the territory between mother and child.2

From the vantage point of a developmental-behavioral pediatrician, I would suggest 2 particular aspects of this case that may help explain the striking reactivity of the boy to his mother’s change in mood and behavior. The first of these involves the family dynamics that are common to single-parent/only-child families. Without a second parent or siblings, the child’s focus is on the parent in all aspects of family life. Stress resulting from change experienced by the parent tends to be more directly transmitted to the child, without the shared attention and without the distractions that are typical in larger families. Without a spouse or additional children to consider, the single parent likewise may become more intensely involved with her only child. Under these circumstances, the child, especially as he approaches adolescence, is more likely to assume a companion role and in other ways become more vigilant and feel more responsible for a stressed parent.3

On the developmental front, I am also mindful of the sensitive and somewhat vulnerable preteen period of transition—a kind of existential passage during which awareness of the potential for harm is not yet balanced with the cognitive structures and experience for self-reassurance. Clinicians are well aware of the higher prevalence of psychosomatic symptoms of all kinds in older school-aged children and preteens.

We are left with a question in this case. What, if anything, will the mother communicate to Eric about her diagnosis of hepatitis C, and when should she do so? While this certainly depends on the specifics of the mother’s health and prognosis, it is easy to imagine this mother returning to the pediatrician for consultation and support in deciding how to handle this dilemma. I would expect that this fine example of “family pediatrics” will be the basis for the mother’s future reliance on and confidence in her pediatrician.4

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That pediatricians have at least 2 patients at most encounters, a child/youth and a parent(s), is a core principle of our work. The simplicity of that statement hides the complexity of providing care that qualifies as “family pediatrics.” We are effective at providing parents with education about health conditions and anticipatory guidance with a focus on prevention. We generally do this work with the recognition that the child is our patient, and we try to understand all aspects of the child’s medical, psychosocial, and developmental history. However, how many pediatricians inquire about a parent’s childhood experience, educational history, or current employment? How often are we aware of marital conflict that may affect our patient’s well-being? How often do we hear about a divorce before its completion? When are we aware of the family constellation—single parent, blended family, grandparent involvement in child care, or a gay/lesbian parent family? How often do we take into account the effect that the family constellation may have on symptom formation?

Eric’s physical symptoms, declining academic achievement, and school refusal were associated with a change in his mother’s parenting style, which was due to her fear of transmitting an infectious disease. I support Dr Tanner’s commendation to the pediatrician who had the wisdom to want to know more about the family. A simple maneuver—to interview the mother separately—and the ability to start the interview with an open-ended question (asking whether there was anything that she wanted to share that she was uncomfortable discussing with her son in the room) allowed Eric’s mother to reveal her secret. Once it was in the open, she was prepared to receive the information about her illness and the effect it had on her parenting behaviors.

This case is similar to that of a 7-year-old child I cared for several years ago. I was unable to discover an etiology for his recurrent abdominal pain after several office visits. I did interview the child separately from his mother, but, frankly, I cannot recall if I interviewed the mother separately. After approximately 5 follow-up office visits and the persistence of the abdominal pain, I sent the child to a child psychiatrist. On the 5th visit with the psychiatrist, during a play-therapy session, the patient revealed that he feared his mother’s death. She was a healthy woman who had undergone bilateral mastectomies and breast implants because a significant family history of breast cancer and her own history of fibrodysplasia, which made screening techniques for breast cancer less reliable. After a 3-day hospitalization, this child’s mother came home with a visible vertical sternal scar. Without an explanation for the hospitalization, the patient interpreted the scar to mean that his mother’s death was imminent. When he was told that the scar was from a medical procedure and that his mother was well and would not die, the recurrent abdominal pain resolved. (Note: a 20-year follow-up revealed no further abdominal or...
other psychosomatic symptoms in a college graduate without significant emotional illness.)

In the introduction to the recent report on family pediatrics from the American Academy of Pediatrics,¹ the case is made for making the effort to anticipate the role of the family in the provision of child health care:

The practice of pediatrics is unique among medical specialists in many ways... Regardless of whether parents or other family members are physically present, their influence is pervasive. Families are the most central and enduring influence in children’s lives. Parents are also central in pediatric care. The health and well-being of children are inextricably linked to their parents’ physical, emotional and social health, social circumstances, and child-rearing practices.¹ (p1541)

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The online version of this article, along with updated information and services, is located on the World Wide Web at:
/content/114/Supplement_6/1496.full.html