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PSYCHOSOMATIC DISORDERS
IN INFANTS AND CHILDREN

ESSAY

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By

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***INTRODUCTION AND
AIM OF THE ESSAY***

INTRODUCTION AND AIM OF THE ESSAY

Shafii and Shafii (1982) coined the term "psychosomatic" to describe a disorder resulting from the effect of psyche and emotion on the soma or body.

Psychosomatic disorders in children are prevalent and may have their start in infancy and persist into adulthood. (Toback, 1980).

The term "psychosomatic disorder" is typically used in a narrow sense in which the term is interchangeable with psychophysiological disorder, (Lavigne and Burns, 1981).

Psychophysiologic disorder, so called because psychologic and interpersonal factors are prominently involved, usually occur in involuntarily innervated visceral organs or organ systems that are supplied by the autonomic nervous system, particularly, by the parasympathetic branch.

Structural changes often occur during psychophysiological disorders. Such changes are sometimes reversible, but such a disorder may result in chronic and irreparable damage to the organ or organ system that is affected, (Prugh, 1983).

More recent information has indicated that predisposing physiologic factors must exist in order for a

psychophysiologic disorder to appear and that the physiologic concomitants of emotions act only to precipitate, intensify, or perpetuate the disorder (Steinhauer and RaeGrant,1983).

Engel (1976) called those disorders somatopsychic-psychosomatic disorder to emphasize the important of physiologic predisposition.

It is important to know what sort of person has a disease than to know what sort of disease a person has.

Koupernik (1965) assigns psychophysiologic disorders to three categories namely, somatic changes resulting from psychological factors; hysterical manifestations, and specific psychophysiologic illnesses.

Prugh (1983) supported the idea of pathology in parent-child relationships, early child-rearing practices, the nature of the family's equilibrium and other important early experiences of children who have certain psychophysiologic disorders. He indicated also that the parents attitudes and handling of their child may change somewhat from the beginning of the child's disorder to its later chronic stages.

Van Evra (1983) concluded that the stress is a risk factor which significantly precipitate the disorders, but

is not always associated with disease. The effect of stress depends in part on its nature, timing, duration and the life cycle of the person as well as other factors.

Finch (1975) concluded that many disorders develop as a result of the combination and interaction of genetic, physical, environmental and psychological events and characteristics. The sum of all of these factors hits a critical level, regardless of their relative contributions which vary among children.

Aim of the Essay

The child psychiatrist although trained in medicine, spends the majority of his time with emotionally and mentally disturbed children and frequently loses sight of those whose emotions disturb physiologic function. In this essay, we have attempted to present a view of psychophysiological disorders by both a pediatrician and a child psychiatrist. It is important that the child psychiatrist retains an interest in pediatric medicine and establishes a good working relationship with pediatricians in order to combine efforts when needed in the treatment of these disorders.

***PREDISPOSING
FACTORS***

Predisposing Factors

I. Developmental factors

Developmental factors may influence the responses of organs. For example, infantile colic, in which tension in the family and allergies and other factors appear to be involved, ordinarily disappears by the infant's third or fourth month. The disappearance suggests that the infant takes an integrative step in autonomic functioning at that time and develops a more effective monitoring shield or barrier against stimuli.

Most severe psychophysiologic disorders seem to occur less often in young children than in adults. Most of them seem to first appear when children are in the middle school-age period. If that is true, it may result from changing patterns of tissue response, perhaps associated with developmental changes in the mental apparatus that include an increase in the repression of emotions and in the internalization of conflict, (Prugh 1983).

Disturbances in growth patterns are specific to childhood. Innate or developmental biologic characteristics may affect a child's behavior and the emotional feedback of the parent-child relationship.

II. Loss:

Steinhauer and RaeGrant (1983) believed that many diseases begin as a response to the real or threatened, assumed or imagined loss of a significant person. This loss creates a sense of extreme insecurity and results in what

calls the "giving up give up" state, one of helplessness and hopelessness. Dependency is frequently described in many patients with classical psychosomatic diseases.

In considering the role of dependency the regressive potential of any disease must be taken into account. It is often difficult to decide whether the dependency conflict is primarily a precursor to or a consequence of the disease process, in fact it is usually both.

III. Alexithymia

This word means that no words for feeling.

In 1963, Marty and DeMusan, described a group of patients suffering from psychosomatic diseases for whom verbalizing or imagining feelings were very difficult. They found that the patients with chronic pancreatitis and ulcerative colitis presented prominent alexithymia features. Alexithymia was considered the result of defects in early personalities formation that are neurophysiological, neuroanatomical and developmentally based.

IV. Psychosomatogenic Family

Gottlieb (1982) stated that the five transactional characteristics are identified, in psychosomatic families namely; enmeshment which refers to certain kinds of intrusive behaviors characterizing transactions between family members, direct two way discussion often is blocked; overprotection and undue degree of concern for each other welfare is a related phenomenon which usually not allowing individual growth; rigidity (normal developmental crises are met with

stereotypic responses and little flexibility); failure of conflict resolution (therefore, problems are left unresolved and recur repeatedly), and conflict avoidance (an ill child can interact with parents in a specific pattern to avoid conflict).

V. Predisposing physiological Factors:

Predispositions include the consideration of genetic, psychoendocrine, autonomic, physiological, biochemical, immune and latent virus factors.

VI. Perpetuating Psychological Factors

The precise nature of psychological responses and contributions in an individual case will be determined by multiple factors including the child's age, morbid personality, family system and the nature of disease itself. The development of a chronic disease may increase the vulnerability of psychosocial difficulties, (Steinhauer and Rae Grant, 1983).

VII. Perpetuating Physiological Factors:

Sometimes drugs that are medically indicated have both direct and indirect psychological effects. The steroids can cause hirsutism, acne and a moon face that can be particularly hard on the child's self-image and self esteem and this lead to increasing isolation and social withdrawal from peers, (Steinhauer and Rae Grant, 1983).

CLASSIFICATION

. Classification

Shafii and Shafii (1982) Modified

A. Eating disorders:

- Anorexia nervosa
- Bulimia
- Obesity

B. Gastrointestinal disorders:

- Nausea
- Vomiting
- Cyclic vomiting
- Rumination
- Pylorospasm
- Infantile colic
- Recurrent abdominal pain
- Peptic ulcer (gastric or duodenal).
- Regional enteritis
- Ulcerative colitis
- Functional encopresis
- Constipation
- Cardiospasm
- Disorder of salivation

C. Respiratory disorders:

- Bronchial asthma
- Hyperventilation
- Breath holding spells
- Vocal nodules
- Allergic Rhinitis

D. Central nervous system disorders:

- Migraine
- Motion sickness
- Headache
- Epilepsy
- Tension headache
- Sacroiliac pain
- Fever of psychophysiologic origin
- Neurodermatitis
- Hyperactivity

E. Cardiovascular disorders:

- Tachycardia
- Arrhythmia

- Angina pectoris
- Syncopal attacks (Fainting spells).
- Iatrogenic influences
- Blushing and pallor
- Hypertension
- Raynaud's disease

F. Genitourinary Disorders:

- Dysmenorrhea
- Amenorrhoea
- Infertility
- Frequent micturation
- Functional enuresis.

G. Autoimmune disorders:

- Rheumatoid arthritis

H. Endocrine disorders:

- Diabetes mellitus
- Hyperthyroidism
- Growth failure
- Pseudocyesis
- Hyperinsulinism

I. Movement disorders:

- Transient tic disorder
- Chronic tic disorder
- Tourette's disorder
- Nodding spasm

J. Skin disorders:

- Acne
- Psoriasis
- Urticaria
- Dermatitis
- Alopecia
- Angioneurotic edema

K. Hematology disorders:

- Haemophilia
- Autoerythrocyte sensitization
- Iron deficiency anemia

L. Sleep disorders

- Nightmares and Night terrors
- Restless sleep