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Functional Somatic Symptoms in Children and Adolescents: The Stress-System Approach to Assessment and Treatment

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Online Supplement 3.1

The Family Assessment Interview

In this supplement to Chapter 3, we briefly discuss the importance of conceptualizing functional somatic symptoms in context. We also describe two different formats for conducting the family assessment interview, whose key function is to elicit the story of the child's symptoms in the context of the child's life story.

The Association Between Context and Functional Somatic Symptoms

In the experience of the first (KK) and third (HH) authors, functional somatic symptoms in children (including adolescents) are in most cases clearly related to contextual factors. The association between functional somatic symptoms and antecedent stressors and adverse life events is also evident in research (see Chapter 4 for a discussion of the association of functional somatic symptoms and syndromes with adverse childhood events). It needs to be acknowledged, however, that such a clear connection between context and symptom onset is not always evident from the clinical assessment process in adults. Unfortunately, when working with adults the clinician's options for gathering the story are far more narrow since the

story is gathered from one individual only. It is very likely that, in adults, sensitization of the stress system occurred much earlier in development – by events that the patient may dismiss as important or about which the patient may have no knowledge and no memory. Sometimes the priming of the stress system may have taken place in utero, or even in the life of the previous generation (Yehuda et al. 2005, 2016). By contrast, in working with children, information is usually mainly gathered from the family – which enables the clinician to gather a broader range of information, in a time-efficient way, across three generations. A good example of this process is the vignette of Evie in Chapter 12. Evie herself had denied any family conflict during her account of the family story and when filling out the Early Life Stress Questionnaire (ELSQ). But information from other members of her family – and in particular, from her father and stepmother – corrected this omission and highlighted that a breakdown of the relationship between Evie and her father was a core antecedent to her functional presentation. In this context, repair of the relationship between Evie and her father was a key component of the treatment intervention.

Different Formats for Conducting the Family Assessment Interview

The family assessment can be done in many different ways. Here we give a brief description of how this process is run in two different clinical settings. The first description prioritizes a concise assessment and a quick shift from the assessment phase into treatment. The second description prioritizes a more comprehensive assessment, but this comes at the cost of pushing back the time that the treatment interventions are actually implemented.

In the Mind-Body Program run by the first author and her team at The Children’s Hospital at Westmead, the assessment interview is usually attended by a mini-team – the members of the psychological medicine team who will be working with the family. This mini-team generally includes a clinical psychologist, a child and adolescent psychiatrist (KK), and a paediatric registrar doing his or her psychological medicine rotation. In this way the engagement and the meaning-making (formulation) process, as well as the articulation of the therapeutic contract, all occur in a group setting

that involves the child, family, and mini-team. If the child is admitted into the Mind-Body Program, the treatment intervention starts the day after the assessment interview. The physiotherapy assessment then occurs and are part of the treatment process, and a cognitive assessment, if indicated, may also be undertaken during the treatment process. For more detail about the assessment interview, see Kozłowska and colleagues (2013).

At the hospital of the third author, Oslo University Hospital, the family initially meets a multidisciplinary team that includes a neurologist, psychiatrist, psychologist, physiotherapist, and teacher trained in cognitive testing and evaluation of scholastic skills. On the first day of the actual admission, the neurologist initially meets the child and the parents in a separate consultation and takes the medical history in light of the referral and previous medical assessments. Later the same day, the neurologist repeats and shares this information with the full team while the family is listening and is given the opportunity to make any corrections and to put forward additional information. The first day of admission ends with a separate session in which the family, psychiatrist, and psychologist work together to draw the family genogram. During the following days, the assessment process – as described in this chapter – is completed by the psychiatrist. Alongside and in parallel, each member of the team prepares his or her own evaluation of the child (through the lens of each particular profession), and these evaluations are then shared with the family and other members of the team at the end of the admission's first week. Together, this information creates the basis for co-constructing a biopsychosocial formulation with the family. This shared understanding is therapeutic in itself and also guides the choice of treatment interventions.

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