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Somatic Symptom and Related Disorders: Guidance on Assessment and Management for Paediatric Health Care Providers - CPS Podcast:

Developed by Sarah Clements, second year medical student at McMaster University and Dr. Christina Grant for PedsCases.com.

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Introduction:

Hi everyone and welcome back to PedsCases. I am Sarah Clements, a second year medical student at McMaster University. Today we will be discussing the Canadian Pediatric Society statement on Somatic Symptom and Related Disorders (Canadian Paediatric Society [CPS], 2024).

This podcast was co-developed with Dr. Christina Grant, an adolescent medicine specialist at McMaster Children's Hospital working in the division of Adolescent Medicine.

Why is this topic important?
Somatic symptom and related disorders (SSRDs) encompass an overarching category of mental disorders impacting children and adolescents. Patients and families often get multiple diagnostic tests or seek out various medical opinions before receiving a diagnosis of a SSRD. Given this, there is a high utilization of health care services at all levels of care for individuals with SSRDs and delays in starting mental health treatment (CPS, 2024).

Now let's go over the learning objectives. By the end of this podcast you should be able to:

1) Define somatization and describe the five disorders categorized under SSRDs
2) Understand the epidemiology and clinical presentation of SSRDs
3) Identify when tests and further investigations would be appropriate to pursue
4) Formulate a treatment approach for patients with SSRDs
5) Develop strategies to apply during clinical encounters

Defining somatization and SSRDs:
Somatization is the experience in which "emotions, either positive or negative, and thoughts are expressed as physical signs and symptoms" (CPS, 2024). Examples of somatization in everyday life would be sweating or having abdominal cramping when you

feel nervous or episodes of fainting when you feel surprised (CPS, 2024). The point when somatization is considered a disorder is when those physical signs and symptoms lead to significant impairment or distress for a child or adolescent (CPS, 2024). This functional impairment among the pediatric population commonly presents with school absenteeism, social withdrawal from friends, and complete disengagement from regular activities such as sport participation.

Under the broad category of somatic symptom and related disorders (SSRDs) there are five specific disorders according to the DSM-5: somatic symptom disorder, functional neurological symptom disorder, illness anxiety disorder, psychological factors affecting other medical conditions, and factitious disorder (CPS, 2024). In this podcast we will focus more on the first two, as those disorders are more commonly seen in clinical practice.

Firstly, somatic symptom disorder is when somatic symptoms, such as chronic headaches, chronic pain, brain fog, or dizziness, become significantly disruptive to daily functioning or distressing to the patient (CPS, 2024). These somatic symptoms are persistent and the patient often devotes disproportionate energy, seriousness, and anxiety to their symptoms (CPS, 2024).

Secondly, functional neurological symptom disorder (FNSD) is characterized by the presence of one or more neurological symptoms without any evidence of an underlying neurological disease (CPS, 2024). These symptoms cause distress or daily impairment to the patient and commonly affect voluntary motor or sensory function. Common neurological symptoms include psychogenic non-epileptiform seizures, paralysis, and weakness (CPS, 2024).

The third disorder is illness anxiety disorder, which is the preoccupation with one's health status or excessive anxiety around getting a serious illness (CPS, 2024). This either manifests with increased health-related behaviours or maladaptive health-related avoidance (CPS, 2024).

Fourth is psychological factors affecting other medical conditions, which is when psychological or behavioural factors such as ignoring symptoms, poor adherence or anxiety adversely impact a pre-existing medical condition (CPS, 2024).

Lastly, is factitious disorder, a purposeful induction of injury or false symptoms with the intent to be deceptive about one's health (CPS, 2024).

Clinical Case:
Let's start with a clinical case. You are a resident working in the Adolescent medicine outpatient clinic today and see Lucy, a 16 year old female with an 8 month history of possible seizures that have caused her significant distress and caused her to miss multiple weeks of school. Lucy has become so worried she will have a seizure that she has stopped playing soccer, a sport she has played all her life. Her past medical history includes anxiety for which she takes sertraline. She was referred from a neurologist after

getting a normal EEG result and normal CT scan of her head. Lucy is accompanied by her mom who is worried and wants to pursue further testing and imaging for seizures. You note in Lucy's medical file she has had multiple emergency department visits and has seen multiple specialists for her seizure-like episodes.

What is going through your mind, how would you approach this conversation to explore FNSD? Keep Lucy in mind as we go through this podcast episode.

Epidemiology:
It is unknown what the exact prevalence of SSRDs are across Canada due to the non-specific nature of somatic and neurological symptoms that patients present with (CPS, 2024). It is additionally difficult to distinguish between the universal typical somatization experience, from experiences that meet the threshold to be considered a disorder (CPS, 2024).

SSRDs are associated with high rates of health system utilization, school absenteeism, and disability (CPS, 2024). The cost to the healthcare system for patients with SSRDs in Canada the year before and after diagnosis is similar to the healthcare costs for children who are the most medically complex (CPS, 2024).

Common Clinical Presentations:
When considering the clinical presentation of patients with SSRDs, symptoms are often non-specific. This means that individuals with SSRDs are seen by a wide variety of clinicians from general pediatrics to subspecialty pediatrics such as neurology, rheumatology, adolescent medicine, and gastroenterology (CPS, 2024). These symptoms can include fatigue, dizziness, joint pain, abdominal pain, nausea and dysphagia, hypermobility, orthostatic intolerance, anorexia and pelvic pain (CPS, 2024). Patients may also present with questions about common symptoms or presentations such as postural orthostatic tachycardia syndrome (POTS), ehlers-danlos syndrome, post-covid-19 condition, or chronic lyme disease (CPS, 2024).

Investigations:
When considering which diagnostic investigations and testing to order as a clinician, it is important to be judicious with investigations while also listening to the patient's worries about missing another medical diagnosis (CPS, 2024). A holistic biopsychosocial approach encourages clinicians to consider both physical and mental health conditions that could be contributing to a patient's symptoms (CPS, 2024).

In being judicious with investigations, the decision on which tests to pursue should be based on the potential benefit the outcome of the test provides, risks associated with the test, cost to the family or health care system, and the possibility of incidental findings (CPS, 2024). Significant clinical judgement and pattern recognition is required when deciding the extent to which you investigate further (CPS, 2024). Table 2 in the CPS statement outlines some common testing considerations for SSRDs based on presenting symptoms that you may find helpful to review (CPS, 2024).

Returning back to Lucy, she had a previous normal EEG test result and CT scan and is asking to have further imaging such as an MRI. In this case given her previous negative tests, the likelihood of a clinically significant finding with an MRI is low and instead could reveal incidental findings that increase patient stress and prompt additional investigations unlikely to change management.

Treatment:
When looking at treatment for a patient diagnosed with a SSRD, there are 5 management considerations. We will review these 5 considerations, and then discuss how you can apply this framework of treatment in a clinical encounter.

Firstly, psychoeducation is crucial for both the patient and family to understand the mind-body connection and somatization. This looks like describing the connection between the patient's physical symptoms with the mind, such as the role of neurotransmitters in both the brain and the gut that could cause abdominal symptoms (CPS, 2024).

Secondly, patients are referred for psychotherapy, most commonly cognitive behavioural therapy (CPS, 2024). At the same time, caregivers are provided coaching with how to support and validate their child with SSRD as they cope with somatic symptoms.

Thirdly, patients are encouraged to engage in rehabilitation and return to social and academic activities they may have previously not attended due to their symptoms (CPS, 2024). This often is the main challenge in the treatment process for both parents and children. Rehabilitation focuses on re-engaging in activities and improving mobility with allied health professionals such as occupational therapy, physiotherapy and speech language pathology (CPS, 2024).

Fourth, with returning back to school and activities, individualized accommodations can support patients with this transition. This could involve clinicians meeting with the school or writing a letter about possible accommodations that can assist with a paced return back (CPS, 2024). If a patient's somatic or neurological symptom is distressing to other students, such as with Lucy having psychogenic non-epileptiform seizures, having a discussion with the school describing what her typical episode looks like, how to support her if she has an episode, and when to call emergency services can help ease the transition back to school (CPS, 2024).

Lastly, patients may have other psychiatric disorders in addition to a SSRD, such as anxiety or an eating disorder that should be treated concurrently (CPS, 2024).

Strategies for Clinical Encounters and Recommendations for Clinicians:
Now that we have discussed treatment approaches for SSRDs, let's discuss some strategies for clinical encounters. Before diving into a discussion about SSRDs, it is

important to gather more information about where the patient is on their diagnostic journey, how well their symptoms have previously been addressed, their familiarity with the concept of the mind-body connection, and their readiness to talk about mental health. This is particularly useful to know for patients who have never heard of the mind-body connection or are in the earlier stages of pursuing diagnostic testing (CPS, 2024).

When approaching a clinical encounter about SSRDs, you should first validate both the patient and their family (CPS, 2024). For the patient, their symptoms may have caused distress or significant functional impairment in their daily life, whether that is social or academic. In addition to this, both the patient and family may have previously met with other clinicians and received mixed messages or felt dismissed. Acknowledging the patient and family's journey to this point and exploring their expectations for the clinical encounter helps foster trust and builds rapport (CPS, 2024). This is also a great opportunity to address any misconceptions patients may have heard or believe.

Secondly, "walk a parallel journey" with the patient (CPS, 2024). This means that a physical health and mental health condition could separately or both contribute to a differential diagnosis (CPS, 2024). With this in mind, it is important to communicate that pursuing treatment for a SSRD does not immediately rule out alternative physical causes. Further investigations and testing for physical health diagnoses can be done in parallel with treatment for the SSRD (CPS, 2024).

Third, you want to explain your rationale for investigations and set limits for unnecessary testing (CPS, 2024). Patients and families may worry something is being missed and this fear can contribute to seeking out multiple medical opinions and unnecessary tests. With more medical opinions there is a chance patients can receive mixed messages from clinicians. Inadvertently this perpetuates a cycle of mistrust, distress, and delay in seeking mental health support (CPS, 2024). By providing a rationale on why a test is not being ordered in addition to validating the patient's feelings, patients can better understand decisions and engage in shared decision making. For example, you can explain that testing is based on pattern recognition or evolution of symptoms, risks and benefits of tests, and current best practices (CPS, 2024).

Fourth, with the high utilization of health services among patients with SSRDs, having one clinician take the lead for healthcare coordination maintains a unified message for the care of the patient (CPS, 2024). Caregivers may feel isolated when navigating the health care system and trying to understand various interpretations and medical opinions. With one clinician centralizing a patient's care, this maintains the clarity of interpretation of tests and provides a unified plan for the patient (CPS, 2024).

Lastly, some clinicians may shy away from having conversations about SSRDs and using terminology such as "somatization" or "mental health disorder" (CPS, 2024). However, not naming and sharing the diagnostic impression of SSRD with a family can contribute to more confusion and uncertainty around the patient's diagnosis (CPS, 2024). Naming SSRD as a possible diagnosis not only provides patients more clarity but also can prevent delays in a patient receiving psychoeducation or rehabilitation for their SSRD.

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Let's return to Lucy. What are your next steps?

Firstly, it is important to explore with Lucy and her mom what testing she has previously done and how Lucy's psychogenic non-epileptiform seizure episodes have impacted her daily functioning. When introducing FNSD as a possible diagnosis, it is helpful to name and explain the concept of somatization and situate FNSD in the broader category of SSRDs.

When discussing further diagnostic investigations in lieu of a possible diagnosis of FNSD, if prior tests have been re-assuring and negative, explaining why additional testing may not be necessary can bring clarity and foster trust with Lucy and her mom. If testing is necessary, this can occur in conjunction with treatment for FNSD. For Lucy, first line management would involve psychoeducation, focusing on exploring the mind-body connection. Continued treatment would focus on rehabilitation, specifically gradual re-engagement in school and her soccer team. For a comprehensive approach, managing her anxiety at the same time should be considered. Lucy should have ongoing close follow-up to support her and her family, ensuring that all members of her care team are updated on her diagnosis to ensure unified messaging.

Before we end the podcast, let's finish with some key takeaways.

1) Somatization is the normal expression of emotions or thoughts as physical symptoms and considered a disorder when the symptoms lead to functional impairment or distress
2) SSRDs are associated with higher health care utilization with individuals often getting multiple clinician opinions and extensive investigations before receiving a diagnosis
3) SSRDs are not just diagnoses of exclusion and investigations should be guided by clinical reasoning
4) Treatment is holistic and rehabilitation-focused with the goal of restoring function and supporting re-engagement in school and activities
5) Communication strategies are crucial in clinical encounters, such as validating a patient's experience, being transparent with investigations, and providing clarity with diagnosis

That brings us to the end of today's podcast on Somatic Symptom and Related Disorders. This episode was based on the 2024 Canadian Paediatric Society statement titled Somatic symptom and related disorders: guidance on assessment and management for pediatric health providers. I am Sarah Clements and this is PedsCases. Thanks for listening.

Reference

Canadian Paediatric Society, Mental Health and Developmental Disabilities Committee. (2024, November 20). *Somatic symptom and related disorders: Guidance on assessment and management for paediatric health care providers*. https://cps.ca/en/documents/position/somatic-symptom-and-related-disorders

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