Somatoform Disorders in Children and Adolescents

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Summary

Somatization is common among children and adolescents. A consecutive series of 112 children and adolescents who fulfilled the ICD-10 clinical diagnostic criteria for somatoform disorders attended at a psychiatric consultation center were included in this study to delineate the pattern of presenting features and to find out associated abnormal psychosocial situations and disabilities. Out of 112 cases 52 were boys, 60 girls, of them 59 were children and 53 adolescents. Polysymptomatic presentation was commoner (92%) than monosymptomatic presentation (8%). Pain was the most prevalent symptom. Children showed significantly higher rates of abdominal complaints and adolescents showed higher rates of headaches. All cases reported an average of 14.21 somatic symptoms. Boys and girls reported an average of 13.75 and 14.61 somatic symptoms respectively and this difference between two groups was not significant. Whereas children reported an average of 12.66 somatic symptoms and adolescents reported an average of 15.94 somatic symptoms. The difference was significant. Differences were also found in the diagnostic categories of somatoform disorders. Girls reported higher rates of somatization disorder and persistent somatoform pain disorder than that of boys. Children reported higher rates of undifferentiated somatoform disorder and somatoform autonomic dysfunction. In contrast, adolescents reported higher rates of somatization disorder. Abnormal psychosocial situations were found to be associated with predisposition, onset, and course of the disorders in majority of the cases and most common was parental overprotection. Remarkable social impairments particularly, in the domains of academic and peer relationship were found among the cases. Findings suggest that somatoform disorders in children and adolescents are frequent in clinical practice. Better understanding of these disorders can promote early diagnoses and timely treatments and improve the quality of life by preventing negative consequences.

Introduction

Children and adolescents commonly expressed somatic symptoms, which are persistent and frequent without identified pathology[1]. This symptoms are called 'functional' somatic symptoms or 'somatization' symptoms. Lipowski's definition of somatization is generically useful: "the tendency to experience and communicate somatic distress and symptoms unaccounted for by pathological findings, to attribute them to physical illness, and to seek

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medical help for them[2]. These persistent somatic symptoms have a complex aetiology involving the misinterpretation of normal bodily sensations on the autonomic symptoms of anxiety. Social and psychological factors seem to predispose to functional symptoms and to reinforce and maintain them such as over concern of caregivers, the experience of previous illness, knowledge of illness of peers and relatives, inadequate explanation or inconsistent or ambiguous information[3]. These somatization symptoms are now grouped together as somatoform disorders (i.e. somatic form of presentation). According to ICD-10, main feature of somatoform disorders is repeated presentation of physical symptoms, together with persistent requests for medical investigations, in spite of repeated negative findings and reassurances by doctors that the symptoms have no physical basis. If any physical disorders are present, they do not explain the nature and extent of the symptoms or the distress and preoccupation of the patient. In these disorders there is often a degree of attention-seeking behaviour, particularly in patients who are resentful of their failure to persuade doctors of the essentially physical nature of their illness and of the need for further investigations[4].

Children and adolescents in both community and clinical samples frequently endorse medically unexplained physical symptoms. In a general population survey, Offord et al found recurrent distressing somatic symptoms to be present in 11% of girls and 4% of boys aged 12 to 16 years[5]. Garber et al evaluated somatic symptoms in 540 school-aged children and reported that children endorsed a variety of somatic complaints which may be symptoms of somatoform disorders[6]. In a clinic sample of 162 children and adolescents consecutively reported to a child neurology and psychiatry center for emotional and/or behavioural disorders, somatic complaints were reported in 69.2% of the patients[7]. There are also cultural differences in the expression of symptoms and the ways that doctors interpret symptoms and diagnoses. Further, diagnoses of somatoform disorders are not only based on exclusion of physical causes rather based only on positive grounds that such symptoms are of psychological origin. However, using of particular diagnostic criteria is most important factor for the variation of prevalence rates.

In Bangladesh, it has been observed that a considerable number of children and adolescents come to the hospitals with somatoform disorders but any analysis on these disorders has yet not been reported. The present exploratory study on somatoform disorders among children and adolescents has been carried out to delineate the pattern of presenting somatic symptoms, specific types of somatoform disorders with sex and age group wise variations, associated psychosocial situations and the impact of the disorders.

Materials and methods

The study was carried out at a private Child and Adolescent Consultation Centre in Dhaka city during January to December, 2001. All the consecutive new cases referred to the center within 16 years of age who fulfilled the ICD-10 clinical diagnostic

criteria of any type of somatoform disorders were included in the study after taking informed consent from the patients and their families. For the purpose of diagnoses, somatic symptom was defined as a symptom or sensation that is perceived to originate from the body or one of its organs in contrast to psychological symptoms, which reflect inner psychic experience. The poorly expressed, undifferentiated, inconsistent and unreliable symptoms were not considered for the diagnostic purpose. Where necessary, relevant clinical examinations and laboratory investigations were performed to rule out any possibilities of having organic causes to explain the symptoms. The cases were diagnosed on the basis of ICD-10 clinical diagnoses of multiaxial classification of child and adolescent psychiatric disorder[4]. Somatoform disorder and its types were recorded according to Axis One of this classification which comprises clinical psychiatric syndromes. These clinical diagnoses were phenomenologically based following diagnostic guidelines of somatoform disorders. Associated abnormal psychosocial situations of the patients during the period of assessment were recorded according to Axis Five of this classification. This axis provides a means of categorizing those aspects of child's psychosocial situation that are significantly abnormal in the context of the child's level of development, past experiences and prevailing sociocultural circumstances. The assessment was carried out on the basis of the guidelines for the categories. Global assessments of the patients' psychosocial disabilities at the time of clinical evaluation were recorded according to Axis Six of the classification. This axis concerns disabilities in functioning that have arisen as a consequence of psychiatric disorder. Disabilities were rated on the basis of the patients' lowest level of functioning in psychological, social and educational domains during the last 3 months. In each case, thorough clinical assessment was undertaken at the time of first assessment or subsequent series of assessment whenever required using semistructured case assessment sheet designed for the study which consisted of sociodemographic parameters, history and clinical findings including information on somatoform disorders. The diagnoses were based on extensive information on symptoms, associated abnormal psychosocial situations, and resultant psychosocial disabilities from the cases, their parents and other accompanying reliable informants.

The collected data were processed and analysed. The sample was divided according to sex and age group (child and adolescent). Age above 12 years considered was adolescent adopted from a clinic study of similar nature[7]. Comparison was made between the groups. Statistical analyses involved two tailed t-test and χ^2-test with Yeates' correction.

Results

A sample of 112 child and adolescent cases of somatoform disorders were included in the study out of a total 546 child and adolescent patients attended in the centre during the study period as recorded in the patients' register. Therefore, somatoform disorders was found among 20.5% of the total of clinic population.

Among the cases, 52 were boys and 60 girls, 59 were children and 53 were adolescents; and 84 and 28 were from urban and rural areas respectively. Their age ranged between 5 and 16 years with a mean of 11.82±2.85 years. Highest number of cases (53) were in the age group of 13-16 years was followed by 43 cases in the age group of 9-12 years. By educational status, 10 had preprimary, 39 were of primary, and 63 were of secondary level of education. Seventy-five cases were predominantly of middle-income group and the rest 37 cases belonged to higher class.

The source of referral of the cases revealed that paediatricians referred 52 cases. Referral from interns was the second largest group with 22 cases followed by neurologists with 10 cases and 13 cases referred from other specialties. General practitioners referred 7 cases and 8 cases were brought directly by their parents. Main reason of referral was for probable psychiatric diagnosis and management (83 cases) the rest 23 cases were referred for management of already diagnosed cases, though the diagnoses were namely 'functional.'

Frequency of doctors' consultation for the problems before the referral explored that 70 cases had been consulted many times (6 times or more), 38 cases consulted quiet a few times (3 to 5 times) and only 4 cases had been consulted once or twice. Almost all the cases had undergone a wide range of investigations before the referral to find out any organic causes of the problems.

Quantitative analyses of somatic symptoms revealed that a total of 1592 symptoms were recorded. By sex, boys reported a total of 715 symptoms, with a mean of 13.75±3.52 for each case and the girls reported a total of 877 symptoms, with a mean of 14.61±5.15 for each case. Though girls reported excess of somatic symptoms, the deference was insignificant ($p>0.1$). On the other hand, by age group children reported a total of 747 symptoms, with a mean of 12.66±3.79 for each case and the adolescents reported a total of 845 symptoms, with a mean of 15.94±4.32 for each case. This difference was significant ($p<0.01$).

In total 89 types of somatic symptoms among the cases were recorded. The frequency of somatic symptoms explored that 103(92%) cases had multiple somatic symptoms (polysymptomatic presentation) while only 9(8%) cases (all of whom were children) had single somatic symptoms (monsymptomatic presentation). Most frequent 9 somatic symptoms were (1) discomfort, burning sensation or pain in the abdomen (80.4%), (2) headache (73.2%), (3) pain, feeling of pressure or tightness in the chest (71.4%), (4) body weakness, tiredness, fatigue (67.9%), (5) difficulty in taking breath, hurried respiration (65.2%), (6) burning of the hands, feet or all over the body (63.4%), (7) pounding or racing of the heart, palpitation (62.5%), (8) trembling or shaking of the limbs or body (60.7%), (9) pain in the joints or legs and hands (58.9%).

Frequency of somatic symptoms indicated that abdominal pain or discomfort was the most frequent symptoms found in both the boys and girls. Three symptoms were reported significantly higher in the boys than that of the girls at 5% level: (1) pounding or racing of the heart, palpitation, (2) dryness

of mouth and throat, (3)frequent and loose bowel movements. On the other hand, 9 symptoms were reported significantly higher in the girls than that of the boys at 1-5% or higher level: (1) headache, (2) pain, feeling of pressure or tightness in the chest, (3) pain or tension in the neck, (4) sensation of feelings or moving pains all over the body, (5) heaviness or pressure inside the head, (6) pain in the back or waist, (7) pain, burning or thorny sensation in the eyes, (8) any other pains or aches, (9) menstrual difficulties (irregular menstruation, excessive menstruation, excessive pain with menstruation), the only symptom specific for girls. The frequency of somatic symptoms according to age group should showed that abdominal pain or discomfort and headache were the most frequent symptoms in the children and adolescents respectively. Two symptoms were reported significantly more frequent in the children at 1% level-(1) cold feelings of the hands and feet or body, (2) frequent bowel movements. Eleven symptoms were found significantly higher in the adolescents than that of the children at 1-5%level or higher (1) headache, (2) pain, feeling of pressure or tightness of the chest, (3) burning of the hands, feet or all over the body, (4), trembling or shaking of the limbs or body, (5) pain or tension in the neck, (6) feverish sensation or feeling of hotness inside the body, (7) dizziness or giddiness or lightheadedness, (8) heaviness or pressure inside the head, (9) tingling, pin and needles or numbness, (10) burning or thorny sensation in the eyes,(11) menstrual difficulties.

Somatic symptoms are grouped into body systems. It revealed that 411(2.8%) symptoms of pain/skin/musculoskeletal system, which formed the largest category, followed by 318(20%) symptoms of gastrointestinal, 257(16.1%) symptoms of nervous, 222(14%) symptoms of cardiorespiratory system. The rest 32(19%) symptoms were of other systems. No statistical difference was found significantly for each system either between the boys and girls or between the children and adolescents (Table-I).

Table-I: *Somatic Symptoms grouped by system*

System	Gender			Age group		
	Boy	Girl	χ^2 Sig.	Child	Adolescent	χ^2 Sig.
	(n=52)	(n=60)		(n=59)	(n=53)	
Pain/skin/Musculoskeletal	165	246	NS	181	230	NS
Gastrointistinal	158	160	NS	170	148	NS
Nervous	113	144	NS	103	154	NS
Cardiorespiratory	105	118	NS	113	110	NS
Genitourinary	33	48	NS	36	45	NS
Others	141	161	NS	144	158	NS
Total	715	877		747	845	

Table-I: Frequency of somatic symptoms by gender and age group

Symptom	Gender			Age group		
	Boy (N=52)	Girl (N=60)	x^2 Sig*	Child (N=59)	Adolescent (N=53)	x^2 Sig*
1. Discomfort, burning session or pain in the abdomen	42	48	NS	52	38	NS
2. Headache	34	48	<0.01	35	47	<0.01
3. Pain, feeling of pressure or tightness in the chest	35	45	<0.05	38	42	<0.05
4. Body weakness, tiredness, fatigue	33	43	NS	37	39	NS
5. Difficulty in taking breath, hurried respiration	32	41	NS	40	33	NS
6. Burning of the hands feet or all over the body	32	39	NS	30	41	<0.05
7. Pounding or racing of the heart, palpitation	38	32	<0.05	35	35	NS
8. Trembling or shaking of the limbs or body	30	38	NS	31	37	<0.05
9. Pain in the joints or legs and hands	28	38	NS	32	34	NS
10. Excessive sweating of the palms, feet or body	32	33	NS	32	33	NS
11. Pain or tension in the neck	25	38	<0.05	26	37	<0.05
12. Cold feelings of the hands and feet or body	33	30	NS	37	26	<0.05
13. Frequent passing of urine, difficulty in passing urine or retention	31	30	NS	35	26	NS
14. Nausea	28	31	NS	29	30	NS
15. Dryness of the mouth and throat	30	27	<0.05	33	24	NS
16. Feverish sensation or feeling of heat inside the body	26	29	NS	22	33	<0.01
17. Dizziness, giddiness or lightheadedness	25	30	NS	21	34	<0.01
18. Sensation of fleeting or moving pain allover the body	18	28	<0.05	22	24	NS
19. Feeling of hotness in the head or ear	22	24	NS	21	25	NS
20. Pain, difficulty in swallowing as if there is a lump in the throat	20	18	NS	19	19	NS
21. Vomiting or regurgitation	17	19	NS	17	19	NS
22. Heaviness or pressure inside the head	10	22	<0.01	14	18	<0.05
23. Any other pain and aches	12	20	<0.05	15	17	NS
24. Tingling, pin and needles or numbness	11	18	NS	10	19	<0.01
25. Pain, burning or thorny sensation in the eyes	10	18	<0.05	10	18	<0.05
26. Pain in the back or waist	8	18	<0.05	9	17	<0.01
27. Frequent and loose bowel movements	13	8	<0.05	14	7	<0.01
28. Blurring or darkness in vision	7	8	NS	6	9	NS
29. Localized weakness or paralysis	7	8	NS	7	8	NS
30. Having buzzing noise or cracking sound in the head, ear or other parts of the body	5	6	NS	3	8	NS
31. Loss of speech, difficulties in voice	4	6	NS	4	6	NS
32. Loss of touch or pain	4	5	NS	2	7	NS
33. Sensation of something moving in the abdomen	2	5	NS	3	4	NS
34. Excessive gas formation in stomach or indigestion	3	3	NS	1	5	NS
35. Feeling of heaviness of the head, limbs or body	1	3	NS	1	3	NS
36. Hiccough	3	1	NS	2	2	NS
37. Itching sensation in the skin	2	1	NS	1	2	NS
38. Passage of whitish discharge through urine	2	0	NS	0	2	NS
39.Menstrual difficulties	N/A	18	<0.001	1	17	<0.001

*x^2 with Yates' correction

Distribution of the types of somatoform disorders revealed that undifferentiated somatoform disorder and somatoform autonomic dysfunction were two most prevalent somatoform disorders with 33(29.5%) cases for each followed by 24(21.4%) cases of persistent somatoform pain disorder, 17(15.2%) cases of somatization disorder and only 2(1.8%) cases of hypochondriacal disorder. The rest 3(2.7%) cases were of other somatoform disorders. It revealed that both somatization disorder and persistent somatoform pain disorder were significantly higher in the girls than that of the boys (Table-II). It revealed that somatoform autonomic dysfunction and undifferentiated somato-form disorder were significantly higher in the children than that of the adolescents whereas somatization disorder was found higher in the adolescents than that of the children, which was highly significant. Among the cases, few symptoms of anxiety and depression were recorded along with somatic symptoms in 22(19.64%) cases but they did not fulfill the criteria of anxiety and depressive disorders (Table-III).

Table-II: *Diagnostic categories of somatoform disorders by gender*

Diagnosis	Boy		Girl		χ^2 Sig.
	n=52	%	n=60	%	
Somatization disorder	5	9.61	12	20.00	<0.001
Undifferentiated somatoform disorder	16	30.77	17	28.33	NS
Hypochondriacal disorder	1	1.92	1	1.66	NS
Somatoform autonomic dysfunction	19	36.54	14	23.35	NS
Persistent somatoform pain disorder	9	17.31	15	25.00	<0.01
Other somatoform disorders	2	3.85	1	1.66	NS

Table-III: *Diagnostic categories of somatoform disorders by age group*

Diagnosis	Child		Adolescent		χ^2 Sig.
	n=59	%	n=53	%	
Somatization disorder	4	6.78	13	24.53	<0.001
Undifferentiated somatoform disorder	21	35.59	12	22.64	<0.01
Hypochondriacal disorder	0	0.00	2	3.77	NS
Somatoform autonomic dysfunction	23	38.98	10	18.87	<0.01
Persistent somatoform pain disorder	10	16.95	14	26.42	NS
Other somatoform disorders	1	1.70	2	3.77	NS

Parental overprotection was single abnormal psychosocial situation found most frequent (33.9%) followed by inappropriate academic pressure (16.1%). Inappropriate parental pressure and failure in examination or loss of academic year were found 10.1% for each. Two (1.8%) cases of sexual abuse were explored (Table-IV).

Analysis of the global assessment of the patients' psychosocial disability at the time of clinical evaluation revealed that any form of disability was found in all cases. Slight social disability was the largest category found in 38(33.9%) cases. Second largest category was moderate social disability found in 31(27.7%) cases. Moderate social functioning was recorded in 22(19.6%) cases and serious social disability was found in 21(18.8%) cases. Among the domains, major areas of impairment or difficulties were of academic and peer relationship.

Table-IV: *Associated abnormal psychosocial situation**

Situation	n=112	Percentage
Parental overprotection	38	33.93
Inappropriate parental pressure	12	10.11
Inappropriate academic pressure	18	16.07
Failure in examination/loss of academic year	12	10.11
Changes in school or relocation	10	8.93
Intrafamilial discord among adults	10	8.93
Parental mental disorder	7	6.25
Loss of love relationship	5	4.46
Discorded relationship with peers	6	5.36
Anomalous parenting situation	9	8.04
Upbringing by relatives other than parents	6	5.36
Upbringing by a single parents	3	2.68
Second marriage of father	3	2.68
Serious illness of family member	9	8.04
Sexual abuse	2	1.78
No abnormal situation identified	28	25.00

* more than one situation were recorded

Discussion

A large proportion of children and adolescents who consult physicians especially paediatricians are suffering from somatoform disorders which has been reflected from the source of referral in the present study. The presenting symptoms were somatic and distinction of psychiatric from general medical condition can pose considerable difficulties that may cause difficulties in referral of the cases of somatoform disorders. Other cause of difficulties might be due to stigma and negative attitude about mental disorder exists in the parents and caregivers. It has also been observed that onset and continuation of the somatic symptoms bear a close relationship with unpleasant life evens or with difficulties or conflicts, the patients and caregivers usually resist attempts to discuss the

possibility of psychological causations. Even then, somatoform disorders constituted 20.5% of the total child and adolescent patient population of the studied center and widely distributed among genders and age groups, which is considerably large in number and indicates its significant prevalence in Bangladesh.

It has been observed from sociodemographic characteristics that more or less, somatoform disorders are wide spread among with somatoform disorders irrespective of social and educational background. However, trend of increasing prevalence was observed in the older children. Again, of the 9 cases with monosymptomatic presentation, all were of child age group. Further, adolescent patients reported significant excess of somatic symptoms in the present study and undifferentiated somatoform disorder, and somatoform autonomic dysfunction were found higher in the children and somatization disorder was found higher in adolescents which are certainly related at least in part with developmental factors that capability of expression of symptoms increases with age. Diagnostic criteria are another factor that could be more possible to fulfill by older young people and much more for older girls. This is possibly one reason of more prevalence of somatization disorder in adolescent girls, and undifferentiated somatoform disorder in child of both sex found in this study.

In the present study, 39 somatic symptoms had been recorded. Most commonly reported somatic symptoms across sex and ages included abdominal pain or discomfort, headache, chest compression, fatigue, breathing difficulties and palpitation. Nearly similar findings have been reported in other studies[6,7]. Abdominal discomfort or pain was the most common symptom in both the boys and girls. Nevertheless, no significant sex difference in frequency of somatic symptoms were reported which is consistent with the findings of a similar representative clinic study[7]. Abdominal discomfort or pain was also most frequent symptom in children and headache was the most frequent symptom in adolescents. These findings are fairly consistent with the findings of other studies[6-9]. Recurrent abdominal pain followed by headache appeared to be the most prominent physical complaints in the prepubertal child[6,8,9]. In a similar report, younger children showed higher rates of abdominal symptoms than adolescents[7]. In this study, higher rates of other pain and aches, body weakness, and tingling, pin and needles or numbness were reported in the adolescents. Findings of other studies indicate that limb pain, aching muscles, fatigue and neurological symptoms increase with age[10,11].

In this study, some specific somatic symptoms such as burning sensation of the hands, feet or allover the body, feverish sensation, sensation of fleeting or moving pain all over the body, feeling of hotness in the head or ear, buzzing noise or cracking sound in the head, ears or other parts of the body, sensation of something moving in the abdomen, passage of white discharge through urine (in adolescent boy) were remarkably found in the cases. Again expressions of few somatic symptoms were difficult to specify or translate into English, hence were not considered for the diagnoses.

These observations indicate that the type and frequency of somatic symptoms of somatoform disorders are different across culture. Therefore, cultural factors need to be investigated in depth.

In the present study, 75% cases had some sorts of associated abnormal psychosocial situations with the predisposition, onset, and course of the disorders. Parental overprotection was found single largest factor of the abnormal qualities of upbringing to contribute in somatization possibly expressed mainly in the form of attention seeking and maladaptive coping behaviour. Inappropriate academic pressure was found second most frequent situation that need to be considered as an increasing cause of the somatoform disorder and may also for other disorders in childhood and adolescence. Other abnormal psychosocial situations found in the cases in this study were also important as causal influences. Particularly, parental mental disorder was found in 7 cases (4 parents had somatoform disorders, 2 parents had depressive disorders and 1 parent had anxiety disorder). Similar findings have been reported in several representative studies. Somatizing children have been found to share similar physical symptoms with family members, and anxiety and depression were found more common in the parents of somatizing children[6,10,12,13]. These findings are further evident of genetic and family contributions to the development of somatoform disorders and its comorbidity. Sexual abuse experienced in childhood has been associated with the development of somatization disorder[14] and is suggested to lead to increased reports of subjective physical complaints in children and adolescents.[15] In the present study, sexual abuse was reported in 2 cases (adolescent girls) of somatization disorder that seemed to be strongly related with the genesis of this disorder.

In this study, 20% cases of somatoform disorders was associated with anxiety and depressive features. For these cases,somatization could be the early manifestation of anxiety or depressive disorder or comorbidity. In a broad based community study in a representative sample of adolescents and young adults, it was found that somatoform conditions and disorders were often comorbid or associated with the development of other mental disorders specially anxiety and depressive disorders[16]. In a large scale four year follow up community study in 13-16 years olds, it has been reported that the young teens with high level of somatic complaints had as much risk of later depression[17]. However, longitudinal studies on somatoform disorders in children and adolescents and its adult outcome across the cultures are needed to evaluate these assumptions appropriately.

In the present study, some degrees of social disabilities were found in all cases particularly in the domains of academic and peer relationship. Impaired academic functioning was the serious consequence that further caused inability to attend school or school refusal in some cases. Somatoform conditions were found to be associated with remarkable impairments and disabilities reported in a prominent study on somatoform syndromes and disorders in a representative sample of 14-24 year olds[16].

It may be mentioned here that the subjects of this study represent a fraction of the young population of Bangladesh. Population profile coming for treatment to public health care set up and those coming for private consultation in Bangladesh might not be the same. This is a limitation in generalizing the data and comparison studies between two categories of population will help in evaluating the findings of the study. In some cases, there was inadequate evidence to come to a firm decision on the causal role of abnormal psychosocial situations mostly because of subjective information. There was possibility of unexploration of many information in a clinical consultation set up. Similar possibilities remained to assess psychosocial disabilities. Studies by applying structured instruments on these aspects may be more informative. It is true that up to the date somatoform disorders are poorly understood. Better understanding of the biosychosocial cause of the symptoms may yield pragmatic, cost-effective approaches to treatment of somatoform disorders.

Findings of the present study suggest that somatoform disorders in children and adolescents are frequent in clinical practice irrespective of age and sex. The disorders also cause of medical consultations for many times and have strong negative impact on the patients' daily level of functioning. It can be predicted from the findings that these disorders are considerable among this population, impairing and possibly associated with the development of other psychiatric disorders. Better understanding of the Somatoform disorders can promote early diagnoses and timely treatments and improve the quality of life by preventing negative consequences. There is need for broad based and culture specific studies of somatoform disorders in children and adolescents in Bangladesh.

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