Self-Esteem and Depressive Symptomatology in Children With Somatoform Disorders

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This study investigated levels of self-esteem and self-reported depressive symptomatology in a sample of children diagnosed with somatoform disorder. The somatoform sample, a sample of children with depressive disorders, and a sample of children with no DSM-III-R diagnosis differed significantly on measures of depression and self-esteem. Specifically, the somatoform group consistently scored between the depressed and no-diagnosis groups, although most of the statistically significant differences occurred between the depressed and no-diagnosis groups. Significant differences between the somatoform group and the other groups were found for behavioral self-esteem.

(Psychosomatics 1995; 36:564–569)

Somatoform disorders and functional somatic complaints (physical symptomatology in the absence of identifiable organic causes) have received substantial attention in psychiatric practice and research because of their disabling and pervasive effects. Recurrent somatic complaints without clear physical cause occur in as many as 5%–10% of all children.[1–3] More severe manifestations of somatic symptoms such as conversion disorders also occur in pediatric populations, although the exact incidence of these disorders is unknown.[4]

Six types of somatoform disorders are currently recognized by DSM-III-R:[5] body dysmorphic disorder, conversion disorder, hypochondriasis, somatization disorder, somatoform pain disorder, and undifferentiated somatoform disorder. Conversion disorder, somatoform pain disorder, and somatoform disorder not otherwise specified (NOS) are by far the most prevalent childhood somatoform disorders.[4] Although the somatoform disorder categories differ in type and scope of somatic symptoms, they share in common the characteristic of somatic symptomatology in the absence of identifiable organic cause. Thus, somatoform symptomatology is assumed to be the result of psychological factors.

Empirical attempts to identify these factors have focused largely on stressors and the social environment. Children with conversion disorder, for example, are more likely than psychiatric and normal control subjects to have academic difficulty,[5] have experienced sexually stressful events,[6] have a family member with an illness similar to their conversion symptom,[6–8] and come from conflicted, rigid, or enmeshed families.[3,7,9] However, studies using standardized instruments have yielded less convincing results.[3]

Although a number of studies have investi-

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gated external environmental characteristics of children with somatoform disorders, relatively few have systematically investigated the self-perceptions of the child. This lack of knowledge about self-perception is surprising, especially given the importance of internal psychological factors in the somatic symptomatology. Hypotheses about the self-perceptions of children with somatoform disorder may be divided into two categories.

First, children with somatoform complaints may hold positive self-perceptions if their somatic defenses are deflecting intrapsychic distress (the "belle indifference" hypothesis). Clinically, Regan and Regan[4] have noted that adults with functional somatic symptoms sometimes exhibit an emotional unconcern with their symptoms ("la belle indifference"). However, little evidence now exists that "la belle indifference" occurs widely in children with somatoform disorders.[4]

An alternative hypothesis takes into account that these children have often experienced significant stresses in the etiology or treatment of their disorder.[2,6] These stresses may lead to emotional upset, which is reflected in somatic complaints and other psychological problems (the "stress-distress" hypothesis). The medical consequences of somatoform disorders, such as repeated invasive procedures without clear findings, may lead to feelings of anxiety, depression, and low self-esteem. Furthermore, low self-esteem may be implicated in the development of a somatoform disorder, because children with negative self-views may encounter more stresses and have fewer coping resources, leading them to use primitive somatization defenses.

In support of the "stress-distress" hypothesis, Garrick, Ostrov, and Offer[10] found that high scores on a self-report measure of somatization were significantly related to emotional distress and negative self-concept in a sample of adolescents. Likewise, Robinson, Greene, and Walker[1] found that adolescents with functional somatic complaints had significantly lower scores than healthy control subjects on measures of self-esteem in several areas (i.e., global esteem, school, popularity, athletics). However, neither study focused on DSM-III-R somatoform disorders per se; rather, their samples had less severe somatization symptomatology or functional somatic complaints. Furthermore, their groups consisted entirely of adolescents, but somatoform disorders such as conversion disorder may occur in children as young as age 6 and may peak before age 11.[11] Hence, these conclusions may apply only to milder forms of somatization in older children.

Our study investigated self-esteem and self-reported depression in a sample of children hospitalized because of somatic symptoms, which were later diagnosed as somatoform disorder. Unlike other studies, samples of hospitalized, chronically ill children were used as comparison samples to control for the effects of hospitalization and other medical attention. Consistent with the "stress-distress" hypothesis, we hypothesized that children with somatoform disorder would have lower self-esteem and more depressive symptoms than hospitalized children without a psychiatric diagnosis. A third comparison group of hospitalized, chronically ill children who were diagnosed with a depressive disorder was expected to have lower self-esteem than the somatoform disorder group, because low self-esteem is one of the hallmarks of depression.

METHODS

Participants

The participants in our study, conducted in 1989–1990, were 42 children who were hospitalized for medical symptoms and later diagnosed with a somatoform disorder, a depressive disorder, or no DSM-III-R diagnosis.

Somatoform Disorder Group. The somatoform disorder group consisted of 15 children between the ages of 8 and 14 years (mean age = 11.6 years; 8 male; 15 white) who were referred to a psychiatry consultation service for evaluation and were diagnosed with a somatoform disorder: conversion disorder ($n = 9$); somato-