Somatic Symptoms and Related Disorders (SSRD)

Clinical Practice Guideline

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Patient presents with suspected somatic symptom and related disorder (SSRD)

Key Presenting Features

- Significant disability
- Inability to ambulate/safety concerns
- Intractable pain/need for IV therapy
- Failure of multiple attempts at outpatient management

yes

Admit to Hospital Medicine

If patient has no underlying diagnosis necessitating subspecialty care

Recommendations

We recommend using the following language when discussing the possible diagnosis and use of Appendix A for discussing the purpose and structure of admission.

- Your child is being admitted for unexplained somatic symptoms that are inconsistent with medically explained injury or disease.
- These are real symptoms, not voluntary or produced on purpose.
- Your child is being admitted for shaking spells, difficulty walking, etc that are making it difficult to engage in normal activities at home.
- Your child has physical symptoms that are happening because of miscommunication between the brain and the body. While we cant see the reason for these symptoms on this scan etc, it does not mean that the symptoms are not real.
- We call this a somatic symptom disorder, one diagnosis that we are considering.

no

Patient does not meet inpatient criteria

Discharge to PCP with strong recommendation to see behavioral health provider (CM or SW to print list of local providers) and subspecialty follow up if relevant

Inpatient Management Phase 1

- Review admission goals in appendix A
- Initiate somatic symptom order set
- Consult psychology and/or child and adolescent psychiatry (depending on patient comorbidities) to complete mental health assessment
- Consult relevant medical subspecialties if needed
- Consult PT and OT within 24 hours of admission. PT/OT to see patient after formal diagnosis of SSRD discussed with family
- Conduct judicious work up, avoid unnecessary evaluations

Interdisciplinary Provider Huddle

- Primary team to discuss with all teams via phone or in person to achieve consensus on diagnosis. Coordinate an interdisciplinary huddle/meeting for patients with prolonged admission, involvement of multiple subspecialities, difficulty with discharge due to child/family reluctance or severity of symptoms

SSRD Confirmed

yes

no

Continue medical evaluation

Inpatient Management Phase 2

- Ensure problem list is updated, including the following problem in problem list in addition to other patient specific problems
  - 2160953 – Somatic symptom and related disorders
- Coordinate a Multidisciplinary Family Meeting if needed for those patients with prolonged admission, involvement of multiple subspecialists, difficulty with discharge due to child/family reluctance or severity of symptoms
  - Lead discussion reviewing presenting symptoms, findings or work up and consensus diagnosis using SSRD terminology
  - Meeting should include all consulted subspecialties, psychology, nursing, physical therapy, occupational therapy, case management, social work, outpatient providers (PCP if possible, to call in)
  - Provide patient and family handout (appendix E, or smart phrase .somaticAVS)
  - Review directly with patient if not present at meeting
- Multidisciplinary Management During Hospitalization
  - Subspecialists validate symptoms and address any changes in clinical status
  - Continue somatic symptom plan
  - Begin transition to home plan

Discharge criteria and plan

- Ensure problem list is updated with 2160953 – Somatic symptom and related disorders
- Establish safe outpatient plan with regards to symptom management, PT/OT, behavioral support and school plan; including partial hospitalization if relevant
- Primary team to contact PCP, discussing hospitalization and outpatient plan; will include in written format in discharge summary (use of Appendix D)

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References:

1. Waynik, I., Sekaran , P. A path to successful pathway development. Presented at Pediatric Hospital Medicine Annual Conference; July 2016; Chicago, IL.

2. Ibeziako, P., Brahmbhatt, K., Chapman, A., et al. (2019). Developing a clinical pathway for somatic symptom and related disorders in pediatric hospital settings. Hospital pediatrics, 9(3), 147-155.

3. Sullivan, C., Namerow, L., Giudice, C., Nunes, C. Clinical Pathway: Somatic Symptom and Related Disorders. Presented at Pediatric Hospital Medicine Annual Conference; July 2019; Seattle, WA.

4. Somatic Symptom and Related Disorders (SSRDs) | Children's Hospital of Philadelphia. Accessed August 25, 2025. https://www.chop.edu/conditions-diseases/somatic-symptom-and-related-disorders-ssrds

Appendix A: Functional Plan

The primary provider should place eStar order set with applicable interventions to communicate with nursing and therapists.

- Pain assessment using FLACC scale vs comfort scale (assessed with vital signs, likely every 8 hours unless clinically requires this more frequently)
- Establish sleep-wake cycle (example lights on at 8 am, lights off at 9 pm)
- Out of bed for every meal
- Promote activities of daily living (hygiene, wearing own clothes)
- Walks on unit per ambulation order (if appropriate)
- Homework ad lib

- Consults:
  - Physical therapy
  - Occupational therapy
  - Psychology (if admitted to hospital medicine)- to complete mental health assessment
  - Child and Adolescent Psychiatry (if admitted to subspecialty or the weekend) – to complete mental health assessment
  - Child life – to provide patient with age appropriate activities and facilitate visual daily schedule
  - Social Work
  - Case Management

- Consider the following subspecialty consults:
  - Child and Adolescent Psychiatry (if admitted to hospital medicine and patient requires initiation of medication)
  - Pain Team

Appendix B: Family Meeting Script

It is key to have representation from every subspecialty participate in the informing meeting, including primary team, psychology and each subspecialty service consulted on the case or saw the patient as an outpatient in the context of the patient's presenting symptoms. It is helpful to review or bring records of completed and pending diagnostic studies completed inpatient/outpatient/outside facilities, including lab studies and imaging.

As we said at the beginning of your son/daughter's admission, after all of the specialists have consulted and completed your child's medical workup, we come together as a multidisciplinary team to discuss what we have found to be contributing to your child's symptoms and what the evidence-based treatment is for the condition. We want to give you a chance to ask questions and to be sure that you feel comfortable about our assessment and treatment plan.

We want to share with you a summary of your child's symptoms, why we consulted with these specialists, what diagnoses we are considering and what our findings did or did not support. Please tell us along the way if we have any part of the history wrong, or if there is anything you do not understand. Please let us know if there is any medical condition or diagnosis that you feel we have not adequately addressed.

Primary Team Review:

- Your child presented with: ____
- Prior work up included: ____

Each Subspecialist Review:

- The differential diagnoses that are consistent with your child's symptoms include: ____
- The work up that we performed included ____, and revealed ____.
- Therefore, the following diagnoses were ruled in/out: ____.
- Given these findings and with the input from our specialists, we think your child's symptoms are best understood as ____. In our experience, symptoms due to ____ respond best to the following treatment approach: *(specify as applicable)*
    - Cognitive behavioral therapy
    - Medical management: ____
    - Behavioral management: ____
    - Outpatient support (PT, OT, psychiatry)
    - Close follow up with your pediatrician to continue following your symptoms
    - Continued follow up with relevant subspecialists

    *Include positive signs, such as Hoover sign to help illustrate diagnosis as well

Note: If a somatic symptom disorder is being considered, the attending leading the meeting should use the actual term (functional neurologic disorder rather than "stress") and ask psychology to give a formulation of potential contributors (which are not always known at the time of admission).

Appendix C: Facts for Families

What are somatic symptom and related disorders (SSRDs)?

Somatic symptom and related disorders (SSRDs) occur when there are problems with the body's communication system. Youth with this condition have physical symptoms that can be upsetting but are not harmful. Symptoms may look like other illnesses but there is no disease or damage. These symptoms are called "somatic symptoms." Somatic symptoms are real, they are not imagined or faked.

When the brain and body work together correctly, they continually send messages back and forth. These messages interpret what we feel and tell us how to react. The messages are sent through a complex pathway that includes the brain, spinal cord, and nerves. When a child has a SSRD, the messages between the brain and body can be too strong, too weak or sent on the wrong path.

Everyone has experienced somatic symptoms from time to time. Examples include feeling butterflies in the stomach when nervous or muscles tightening with anger. Most of the time these symptoms are mild and pass on their own. For youth with somatic symptom and related disorders, their symptoms interfere with daily life. Children or teens may miss school or stop participating in activities they once enjoyed.

It can be helpful to think of the symptoms experienced in the body as a fire alarm. When working correctly, a fire alarm alerts people to danger and sends a warning. Similarly, physical symptoms often warn that something is wrong inside the body. However, with SSRDs, the symptoms are like a fire alarm that continues to go off when there is no fire.

What are symptoms of somatic symptom and related disorders?

SSRDs look different for each person. It is common to have more than one symptom. Symptoms may change or worsen over time. They may come and go or be constant. Sometimes these symptoms may also be called functional neurological symptom disorders (FNSD) or disorders of brain gut interaction (DGBI).

Examples of somatic symptoms may include:

- Pain, headaches, difficulty moving
- Fatigue, dizziness, memory problems
- Changes in vision or hearing
- Trouble breathing or shortness of breath
- Weakness, numbness, trouble walking
- Abnormal movements, fainting, shakiness
- Stomach aches, nausea, vomiting
- Trouble swallowing or feeling a "lump" in throat

Though somatic disorders are not easily explained by a test or medical diagnosis, they are real, often upsetting, and interfere with daily life. SSRD treatment aims to repair communication between the brain and body. This will improve the child's ability to function and participate in daily life — at home, at school and with friends.

Appendix C: Facts for Families – Cont.

Causes of SSRDs

Many different factors may contribute to symptoms of SSRDs including a triggering event such as an injury or illness, sensitivity to sensations in the body, behavioral habits (i.e., activity level, diet, or exercise), daily activities such as attending school, how others respond to symptoms, social support or stressors, and psychological or emotional factors like stress. These symptoms are not on purpose and they are real, the child or teen is not faking it. Other factors like age, genetics, or hormones may also play a role. It is often a combination of these risk factors that lead to SSRDs. Sometimes the symptoms build up over time, or the specific reason for symptoms is unclear. Thankfully, with the right approach, SSRDs are treatable.

Treatment for SSRDs

It is important to recognize that SSRDs are treatable conditions. The goal of treatment for all SSRDs is to break the symptom cycle, repair the brain-body connection, and help the child or teen return to functioning.

The best outcomes are seen with a return to daily schedules and activities, even when the child or teen is having symptoms. Once youth with SSRD and their families understand that using their bodies in a normal way is not harmful (even if uncomfortable at first), they can often work through their symptoms with an outpatient treatment plan. In some cases, a more intensive treatment program for SSRDs is needed.

The treatment plan may include the following:

Cognitive behavioral therapy, which is key to teach skills to improve brain-body communication, improve coping with symptoms, and to support return to functioning.

Physical therapy and occupational therapy to help muscles strength and movement

Small, gradual steps to improve function

Return to school with the help of accommodations and supports from teachers, school counselors, and nurse

Return to after school activities as soon as possible (spending time with friends, sports, clubs)

Regular check-ins with your healthcare team to monitor treatment

Parents or caregivers can help their child or teen by doing the following:

Encourage regular practice of coping skills and relaxation strategies

Support your child or teen's efforts to focus on healthy function, and less on physical symptoms

Work with the school and other programs to gradually support return to activities

Learn ways to manage your own distress that develop as a concerned family member

The best outcomes are seen when the child takes part in therapy, begins treatment early, and receives support and compassion from their family, school and medical team to support return to function.

Appendix D: Facts for Pediatricians - Discharge Summary Document on Somatic Symptom Related Disorders

After thorough assessment by a multidisciplinary team at Vanderbilt Children's Hospital, your patient has been diagnosed with an illness categorized as a Somatic Symptom and Related Disorder (SSRD). This is a group of serious but non-life-threatening conditions in which physical symptoms occur due to dysregulation of brain-body interaction. The symptoms of SSRD are real and distressing, but not dangerous. They may limit your patient's ability to function optimally at school, with friends, in activities, and at home.

Risk factors for development of SSRDs include co-existing medical conditions (including neurological disorders), family history of health disorders, physical injury, exposure to illness, female gender, cognitive impairment/low IQ, perfectionistic temperament, and psychological trauma.

Risk factors for ongoing symptoms once a diagnosis is made include excessive attention to and high concern about symptoms, belief of lack of control over actions and health, and reinforcement of symptom experience (e.g., removal of a chore, academic, or sport expectation).

SSRDs look different for each person. It is common to have more than one symptom, and symptoms may change over time. They may come and go or be constant. SSRDs are a broad category of illness, and naming can vary based on the organ systems affected. Other diagnostic terms that are more specific include functional neurological symptom disorders (FNSD) or disorders of brain gut interaction (DGBI).

It is important to emphasize to patients and families that **SSRDs are treatable** conditions. The goal of treatment for all SSRDs is to break the symptom cycle, repair the brain-body connection, and help the child or teen return to functioning.

The best outcomes are seen with a **return to daily schedules and activities, even when the child or teen is having symptoms.** Once youth with SSRD and their families understand that using their bodies in a normal way is not harmful (even if uncomfortable at first), they can often work through their symptoms with an outpatient treatment plan. In some cases, a more intensive treatment program for SSRDs is needed.

Treatment for SSRDs involves focus on increasing functioning through physical therapy, occupational therapy, and **gradual stepwise return to typical school and other activities. Improving health behaviors** including increased hydration, adequate nutrition, sleep hygiene, and regular physical activity (working toward 30-minutes daily) will support recovery. Additionally, **cognitive behavioral therapy** can help to support youth learning skills to help improve brain-body interaction by "winding down" the dysregulated or overactive nervous system.

We recommend pediatricians validate the youth's experience, be intentional and name the diagnosis (SSRD, FNSD, or DGBI), and help parents become their child's "coach" supporting use of strategies to improve function (i.e., coping skills, health behaviors).

Maximizing school and returning to function is the cornerstone of treatment, and we sincerely appreciate the school's efforts in making necessary temporary accommodations to promote participation in school as much time as possible. Sometimes this may include scheduled breaks to practice coping skills (vs calling and going home) or gradual re-entry to a ½ day prior to a full day (or more gradually if necessary).