Case Report

Role of Psychosocial Factors in Management of Psychosomatic Disorder: A Case Report

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ABSTRACT

Psychosomatic Disorder is an illness which includes mind and body as a whole. The symptoms of these diseases have physical causes which originate from emotional or mental stress, anxiety or depression. Psychological and behavioural factors have been seen to affect the course of many medical illnesses. Psychosomatic disorders (according to DSM II, 1968) are defined as "psychosomatic symptoms that are caused by emotional factors and which involve a single organ system are usually under autonomic nervous system innervations". The combination of both pharmacological and psychosocial factors is used for the management of Psychosomatic Disorders. Failure of the psychiatrist or physician to establish a good rapport is the postulated as a major reason for the ineffectiveness of treatments. This case report presents a young female with psychosomatic disorder.

Keywords : Psychosomatic disorder, Stress, Relaxation, Behaviour therapy

INTRODUCTION

Psychosomatic disorder is now-a-days known as Psychological Factors Affecting Other Medical Conditions (F54) according to DSM-5.[1] German psychiatrist Heinroth first used the term Psychosomatic in 1818. In the year 1978, Hyman G A, Zegarelli E V and Kutscher A H later classified psychosomatic disorders as:

1. **Psycho-neurotic** (basic characteristic of feeling of anxiety): It entails different types of neurotic symptoms, namely:
   - Phobia
   - Obsession
   - Depression and
   - Conversion
2. **Psycho-physiologic** stress induced physiological dysfunction which leads to tissue damage, rather than psychotic withdrawal or any neurotic defenses.
3. **Personality** patterns of actions or behavior in response to stress in an individual, rather than physical, psychological or emotional symptoms.
4. **Psychotic** breakdown of one's personality interfering with the ability to perceive and test one's reality. [2]

Psychological and behavioural factors have been seen to affect the course of many medical illnesses.[3] According to DSM II, "psychosomatic symptoms that are caused by emotional factors and which involve a single organ system are usually under autonomic nervous system innervations.[4,5]

Psychosomatic disorders include migraine, hypertension, joint pain, respiratory diseases, gastrointestinal disturbance, etc. Some psychiatrists have a difference of opinion regarding the etiology of these disorders. Two growing fields on role of the psychological factors in the illness manifestation are: Health psychology and Behavioural medicine. Some believe that each physical parameter is indicative of a special psychic change in an individual, with reference to his/her past experiences and personality. Some others believe hypertension to be related to anger. An example quoted is the inability to overcome past, strong authority in parents, and introjection of anger creating problems with blood circulation.

A recent emphasis on interaction between the psychological, biological and social states of an individual reiterates the history of psychological – physical diseases, with impact of early disturbing and turbulent experiences in an individual's life. Excessive anxiety or worry, or lack of parent's love and overprotection or intensive limitations in childhood can affect a person by refraining him/her from enjoying emotional or social relationships with other children and people of similar age.[2]Many patients with psychosomatic symptoms respond to drug therapy and/or behaviour therapy including psychoanalysis. Often, failure of the psychiatrist or physician to establish a good rapport with the patient is a major reason for ineffectiveness of the treatment.[6]Although the exact etiology for psychosomatic symptoms is not known yet, numerous theories propose certain risk factors such as childhood neglect, sexual abuse, chaotic lifestyle and alcohol and other substance abuse.[7] In view of above literature, this report presents a case of a young woman and her journey through her psychiatric illness.

CASE HISTORY

A 26 year-old married female was referred for a psychiatric opinion. She presented with the complaints of pain in knee joints, pain in arms including small joints of whole body, reduced appetite, weight loss and disturbed sleep. On further inquiry she revealed that she is tensed about her illness, and over thinks that if it will lead to any major disease or any cancer. Her daily routine was disturbed due to the stress caused by these bodily symptoms and was unable to concentrate on her training which is compulsory for the completion of her B.Ed. degree. She stated that the pain had become so bad that she had missed a few days of training and had cancelled an outing with her husband. She was so preoccupied with her illness that her appetite just reduced to half of her actual diet

which eventually leads to weight loss, fatigue and weakness and so feeling of palpitations was present while walking but it occurred hardly two times in the past ten days. During this episode of her illness, she was unable to maintain her proper sleep cycle as she used to have earlier. Most of the times now, she would wake up in the middle of the night thinking about the illness that whether she will get any better or the symptoms will worsen in the future.

Youngest born of three siblings, the patient belongs to the lower socio-economic class and resides in a rural area. She is educated up to B.Ed. and is in training while preparing for further studies. She prefers to be a homemaker. Married for10 years now, she has two children.

She has been experiencing these symptoms for about one and a half year. The symptoms had an acute onset and progressed slowly over time. While the symptoms remained somewhat similar, the patient's perceived stress and fear of physical illness got worse over time. She tried changing her routine and doing other household chores but nothing seemed to help. She sometimes tried to sit and relax without involving in any physical activity but the pain only seemed to become more frequent and severe.

The symptoms were on and off with no other related symptoms such as shortness of breath, tremors, chest pain or headache. There was no history of major mood changes or any substance use. Underlying trauma, tumour, pain during neck movements, vomiting, urinary or fecal incontinence or surgical illness were ruled out. Family history of psychiatric illness of father was present (details of which could not be elicited) and was fully recovered after two years of treatment, as stated by the patient. In her past history, she had no developmental delay and was otherwise well adjusted in new surrounding and environment. Her pre-morbid personality can be mentioned as a good, obedient and hardworking child. She was always a meritorious and disciplined student. In her family, both the parents were reported to have anxious personality and her father had a bit of irritable nature. The parenting style was authoritarian, tending towards punishment and strict discipline. But no significant distress or dysfunction was reported during childhood and adolescence. No apparent stressor in the recent past was identified. However, unsatisfactory response to treatment received so far, along with the costs endured added to her hopelessness and stress.

TREATMENT

When presenting in our OPD, the patient had been suffering with her symptoms for nearly a year and a half. Over this time period, she has resorted to help from a multitude of physicians from one state to another. She reported a history of unsatisfactory response to previously prescribed medications. A detailed history of the entire course of her symptoms was taken and thorough physical examination was performed along with laboratory tests to evaluate for autoimmune disorders and other underlying organic health conditions. All the investigations including CT scan of the abdomen and thorax, blood investigations and ECG were reported to be normal. The report was positive for Typhoid IgM antibodies and pus cells in urine microscopic examination, diagnosed as enteric fever with urinary tract infection. Antibiotic sensitivity testing suggested few antibiotics which were given along with symptomatic treatment. A psychiatric diagnosis of Psychosomatic Disorder based on DSM-5 criteria was made. The patient was initiated on Amitriptyline 12.5 mg and Chlordiazepoxide 5mg and relaxation therapy was started for further few weeks on follow-up.

Exploration of family interaction may provide major clues for the outcome of psychological treatment of psychosomatic disorders. Hence, her parents and spouse were taught correct communication techniques and referred for family therapy in view of anxiety management. The patient was also taught relaxation techniques and provided supportive psychotherapy for her anxiety. Deep relaxation for 20-30 minutes is known to reduce anxiety and is also good for sleeplessness and fatigue. It can further improve one's self-confidence. The supportive therapy imparted to her was helpful in learning healthy coping styles. She was encouraged to carefully pay attention to her positive and rational thoughts and feelings. The patient responded well to treatment and resumed her training eventually.

DISCUSSION

Believing in the subconscious nature of a patient's psychosomatic symptoms continues to be a challenge for mental health professionals. French philosopher and psychologist of the 1800s, Pierre Janet was crucially important in developing the concept of the subconscious. Consciousness is described as the sensory experiences and thoughts in active awareness, whereas subconscious stores information which is not immediately available to the conscious mind. A disconnection between the conscious and subconscious makes our feelings exist in parallel in both sections, referred to as dissociation. Psychological trauma could cause these symptoms, and psychiatrists are encouraged to be vigilant of this diagnosis, while being compassionate towards the sufferers. [8]

Treating psychosomatic symptoms is often challenging as the demonstrations may not clearly fit into a usual pattern of an illness and its treatment. Psychosomatic disorders can be chronically disabling and may require consistent reassurance. The aim should be at improving the quality of life and one's social participation. Management of such cases is a team work & role of psychiatrist and psychologist is also important in these cases. Most of physical illnesses have added psychosocial stressor therefore looking into these aspects by physician will lead to overall improvement. Research has showed that unintentional social reinforcement by hospital members and close relations encourage the progress of behavioral symptoms, person related with treatment can become discriminative stimuli for social attention and thereby provoke symptom behaviours and by adapting the social boosting, any negative event related with treatment protocols, the recurrence of psychosomatic symptoms can be reduced without any changes in the quality of medical care and social interaction.[9]

Skilled interviewing and examination remain highly important in diagnosing and treating psychosomatic disorders. Treatment of these patients is difficult and prolonged. They respond unprecedented to a psychologically oriented physician who is

able and prepared to take final responsibility for both physical and psychological care. Describing an illness as psychosomatic is not a diagnosis, nor is it an excuse for not making a diagnosis. There are many specific psychiatric conditions, most commonly depression, anxiety and hysteria, which may cause or be associated with somatic symptoms. The specific diagnosis should be made or at least sought in all cases.

It is a poor approach to use the term psychosomatic when describing to patients the results of the diagnostic assessment. The very fact that the patient's conflicts are being expressed in physical symptoms suggests that the symptoms serve a protective purpose. For the physician to tell the patient that his illness is psychosomatic without preparing the ground in terms of the physician-patient relationship may be perceived by the patient as physician not believing in his/her experience. The net result may be loss of confidence in the physician and if repeated, in the medical profession as a whole.

Disastrous results can occur when a number of physicians share clinical responsibility but communicate inadequately. This can lead to conflicting recommendations and an opportunity for unwitting manipulation by the patient. Eventually the patient may develop overt or covert hostility towards individual physician. By the time this stage has been reached management can becomevery challenging.

Too often the psychiatric referral is made as a last resort. Organic disease has been ruled out; hence, it is concluded that the illness must be functional. Some patients (particularly those with illnessphobias- fear of diseases such as cancer or heart disease) are helped and reassured by the exclusion of serious physical disease. Many others however, are extraordinarily threatened by the sudden confrontation with the possibility that their symptom may be psychosomatic. They become hostile and defensive and the attempt to complete the psychiatric evaluation is doomed.

The appropriate time to assess psychiatric and psychosocial factors is early in the course of the disease, along-side other investigative procedures. The possibility of a psychosomatic disorder will have been considered early in the clinicalassessment and differential diagnosis, and this aspect will have been evaluated together with the physical aspects. Under these conditions the patient will find the psychiatric assessmentless threatening, will have time to ponder the possibility that psychosocial factors may be relevant, and will be more ready to accept and act upon these when the final diagnosis is made.[10]

CONCLUSION

This shows that stress disorders can be exhibited in the form of psychosomatic symptoms and hence psychosomatic symptoms need further exploration for a comprehensive treatment. It is felt that most of the patients will benefit from psychological counseling as this will aid in building better coping strategies. Presentation of medically unexplained physical symptoms should be assessed and treated with a multidisciplinary approach keeping in mind the biological, psychological and social aspects.

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