CASE CONFERENCE

Psychological management in a case of Somatoform Disorder

Rachna Bhargava , Priti Arun

Abstract: *Somatic complaints are common occurrence in medical setting. However attempts towards management has lacked consensus over approach. There is lack of empirical evidence especially from India. This case illustrates the multimodal approach in management of a case of somatoform disorder characterized by recurrent abdominal pain and vomiting.*

INTRODUCTION

Somatization has been defined as manifestation of distress through somatic symptoms, a tendency to experience and communicate somatic distress and symptoms unaccounted for by pathological findings, to attribute them to physical illness and to seek medical help.[1] Unexplained physical (somatic) symptoms are common presentation in all medical/pediatric clinics (including emergency). Their 12-month prevalence in general population has been reported to be 8.1%. [2] However there is often a lack of recognition of the nature of these symptoms by physician, which may lead to unnecessary investigations and sometimes may lead to functional impairment when symptoms become chronic. In addition, there is wastage of resources in terms of time and money. Wrong treatment may result in iatrogenic complications. Even when they are diagnosed accurately, some patients reject psychological labeling because of their belief in having a physical illness and refuse to seek help from mental health professional and if pushed hard, they indulge in doctor shopping.

THE CASE

Patient V, a 17 year old, male student of 11th class belonging to joint family of upper socio economic status was brought to the Psychiatry OPD by his parents in September 2006 with the presenting complaints of recurrent episodes of abdominal pain accompanied by vomiting for the past two years. The onset was acute and the course episodic. Patient was apparently asymptomatic till June 2005, when he suddenly experienced abdominal pain followed by bouts of vomiting. There was no apparent triggering event. He had 8 such episodes, each having duration of 4-5 days. The frequency reportedly increased from March 2006.

In a typical episode, the patient would have discomfort in abdomen while eating; he would feel heaviness in abdomen, which was followed by spontaneous vomiting. He also reported a decrease in appetite and he would stop having meals. If forced to have food or drink, he would vomit it out. Parents suspected that he tried to induce vomiting though they never saw him do so. He would vomit in seclusion and would flush the vomitus. To cover for the bad odor, he would also have frequent baths. Patient would shout out of pain, cry and cling to his parents and asked parents to massage his abdomen. During these episodes he would also utter statements like "Why me. Why does God punish me when I haven't done any bad things?" "Since doctors are

JMHHB 2008 13(1) : 51-58

not able to cure me, it is better that I commit suicide." He frequently asked for poison or asked his parents to cut his abdomen to rid him of the pain. Beside this, he would repeatedly apologize to his parents for troubling them. It was observed that during these episodes, if his friends came to meet him, he would behave normally and would resume crying/shouting once they left. He would gradually start eating once pain and vomiting subsided after 4-5 days.

Parents did not observe any change in his weight over the 2 years despite these episodes. According to them, he was thin built since beginning and has been finicky regarding food. He was selective, skipped meals and preferred chocolates, ice creams and Chinese food. The patient denied having any thoughts of feeling or being fat and he agreed that he might have lost weight.

Historical reconstruction of events showed that 7 out of 8 episodes were associated with stress (e.g. prior to announcement of the board results, prior to traveling abroad to play a tournament (first time without family members), prior to the visa interview, after witnessing the onset of a major psychiatric illness in a relative).

The treatment history prior to the contact in our psychiatry OPD included two hospital admissions (in June 2005 under Gastroenterology to prevent dehydration and in April 2006 under Pediatrics to conduct investigations like Barium meal and Endoscopy). All investigations were normal and they were referred to Psychiatry department.

The patient had a history of asthma between 3 - 7 years of age. During the same period, he had also experienced episodes of abdominal pain and vomiting lasting 5-6 days each. He was diagnosed to have cyclic vomiting by the Pediatrician who had noted that the child did not get to see the father on a regular basis. Though the interaction with his father remained minimal even after this advice, the episodes subsided on its own.

Family environment and child rearing

The mother is the primary care giver. She had attempted to separate from her spouse twice (when the patient was 3-years and 10-years old) due to interpersonal conflicts with the spouse. To overcome the feeling of financial insecurity, she underwent professional training when the patient was 4-years old and started working when he was 10-years old. She often has to mediate during clashes between spouse, grandmother and children.

The father had lost his own father just prior to marriage and faced financial crisis, property dispute and had to establish his business afresh. He was perceived as abrupt and short-tempered at home, but was noted to be quite charming outside. His interaction with children mainly consisted of do's and don'ts when they were young, and was later largely limited to teasing them (e.g. on patient's thinness) which usually evoked negative reactions from children. He was noted to be fond of fast food, ice creams and chocolates. The patient's parents had become strict regarding outings since he failed in 2 subjects in the 11th class.

The grandmother is religious and dominating. The patient slept in her room since 2 years of age till 16 years of age. She frequently talked about family conflicts with children. She often attempted to impose her thinking on other family members particularly the patient with whom she fussed about eating/food. She often told the patient to leave non-vegetarian food.

Patient's sister is assertive and somewhat dominating. She is able to take a stand against father and grandmother, unlike the patient. She is good at studies and gives dance performances on stage. The patient perceives that the mother is more lenient toward his sister.

Attitudes toward eating in the family

Patient's grandmother and uncle (with whom the patient is attached) are followers of Radhaswami sect. There is long standing conflict regarding vegetarianism in the family. Under the Radhaswami influence, patient's father forced his wife to leave non-vegetarian food initially, however she resumed consuming such food later. However when patient started having episodes again at the age of 16 years, both parents left non-vegetrarian food hoping that this will help him.

Peer relationships

Patient has 4-5 friends, who were reported to be "non studious." A close friend of patient developed similar symptoms after a break in a love affair. Patient has a girl friend but doesn't want to get more involved as she does not fit in his life plan but is afraid of withdrawing because of fear of peer pressure

Personality

The patient is reported to be conscientious but dependent especially at times of making conflictual decisions. He is quiet, inhibited and has low stress tolerance. He is hypersensitive and gets perturbed over minor issues e.g. he stopped playing tennis after a minor dispute with a friend. He gets easily influenced by peers (e.g. outings, pooling car), which had recently become a cause of conflict between the patient and his parents.

The patient's height is 1.8 meters and his weight at the time of examination was 46 kilograms. His Body Mass Index (BMI) was 14.2. No other abnormities were noted on general or systematic examination.

The patient was kempt, though he was dressed casually. Rapport was established. His psychomotor activity was normal. No abnormalities were noted in speech, affect and perception. In thought, there was no abnormality in form and flow. In thought content, the patient was not concerned about weight, but he was perturbed about his abdominal pain "bahut zyada hota hai." His neurocognitive functions, judgment and abstraction were intact and the intelligence was average. Regarding insight, he perceived his abdominal pain and vomiting as physical symptoms and he did not perceive being under weight as an illness – "I have always been like that."

Investigations

Routine hemogram, biochemical and urine tests were within normal limits. Psychological assessment to understand conflicts, interpersonal relationships, fears, needs and wishes, pre-existing coping abilities and body image disturbance Draw-A-Person Test, Sentence Completion Test and Thematic Apperception Test. The findings showed that the patient held conflicting goals in life: he desires a luxurious life which he knows can be achieved only through hard work, but at the same time he feels that being casual (non-studious) is appreciated more by peers. His self-identity was also conflicted, he saw himself as ambitious; but dependent and avoidant; and also as idealistic and religious. Similarly, his protocol showed preoccupation with conflicts in relationship between parents, between self and parental figures, and in heterosexual relationships. He also evidenced an affectional need for father, and for a romantic relationship. Significantly, he did not show any body image disturbance.

SUMMARY

The patient's psyche was beset with a number of conflicts arising from his own personality (ambitious versus comfort-loving); from approach-avoidance regarding romantic relationship; from differences between parental (strictness regarding educational performance) and peer (casualness) values; and from differences between family

members (family's differences regarding non-vegetarianism, parents' marital differences, inadequate relationship with his father). The patient inadequate coping (e.g. lack of assertiveness) at the time when he has to establish his identity made him vulnerable to emotional problems that were expressed through physical symptoms that were modeled on his earlier illness and along the family's preoccupation regarding eating behaviour (Figure 1). He was diagnosed to have unspecified somatoform disorder.

DIAGRAMATIC PRESENTATION OF ISSUES

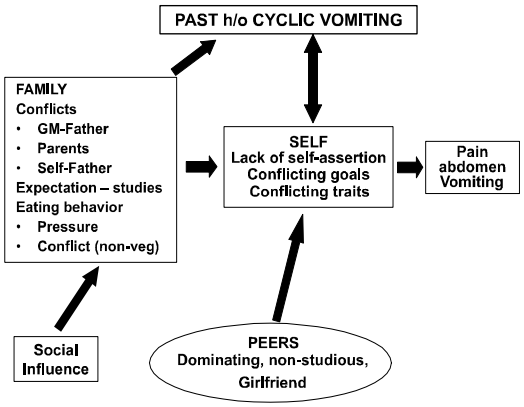

Figure 1

MANAGEMENT

Psychoeducation of parental figures

The parents were informed regarding the psychological nature of the illness and they were reassured that illness could be managed without medicines. They were encouraged to have increase positive interaction with their son, while reducing focus on eating behavior, abdominal pain and vomiting. This included having meals together, family outings, watching TV together, etc.

Principles of differential reinforcement and need for consistency in disciplining children (by the same parent and by different parental figures) was explained. This helped in reducing conflicting cues and in enhancing self-esteem. A couple of sessions with the grandmother helped in reducing intrusions from her, especially regarding pressure on eating. Communication pattern in the family was monitored and some suggestions given.

Individual therapy

An eclectic approach to therapy was followed, which involved using supportive behavioral and cognitive techniques. Initially two sessions per week of 45 minutes duration were held. The goals of the sessions were discussed and were identified as:

1. To increase stress tolerance and deal with unexpected situations without becoming anxious
2. To improve communication skills
3. To build supportive network
4. To focus on nutritional rehabilitation

The patient was encouraged to ventilate and rapport was established. The therapist's consistent position regarding medicines (that they were not needed), helped in the gradual shift of focus from physical complaints to psychological issues. The patient was also encouraged to follow a balanced diet and regular meals (without fuss over meals). The patient was supported through perceived stressful situation. For this, he was encouraged to maintain a diary and note important ongoing/forthcoming events, as the latter were observed to trigger stress reaction from the patient.

The patient was taught the Jacobson Progressive Muscle Relaxation to reduce the general level of anxiety. He was also taught assertiveness techniques. Since the patient often felt that his parents did not understand his problems, while they felt that he did not clarify things adequately, he was taught **DESC** (Describe, Express, Specify, Consequence)

scripting to help him with framing requests.

Example:It was observed that the patient appeared stressed before every outstation trip. On one hand he wanted to spend more time with his friends and on the other he was bothered about missing tuitions.

Describe- You are asking me to come to Delhi for a week

Express – I'll be happy to go for 2 days but after that I'll be uncomfortable because I'll be missing tuitions and a party with my friends

Specify – I want to come back after 2 days

Consequence – If you let me come back, I'll feel that you are trying to understand my needs

Another frequent stress at home was his grandmother's constant intrusion regarding food. Patient learnt the technique **(Broken record)** of repeating his request skilfully to achieve the desired effect without becoming rude.

Example:

Grandmother: I have got fresh orange juice for you.

Patient: I asked you not to disturb me when I am studying.

Grandmother: I thought this would freshen you up. You must be tired.

Patient: I am not tired. Please keep it for me I'll have it later.

Grandmother: The taste will change. Have it now.

Patient: I'll come and have it in the dining room after I finish my topic.

The patient had difficulty in saying 'No' to people and would either depend on mother to communicate it (which still caused him stress) or would succumb to pressure (again resulting in stress). Sessions on **role-play** were conducted to teach him refusal and limit setting skills.

Example:

Patient - I don't want to have tuitions today

Sir- Why? Don't miss the session; we have to cover a lot of syllabus

Patient- I attended a family function yesterday and I am feeling exhausted

Sir –I'll come only for two hours and then I'll go to B's place

Patient – I don't think I'll be able to concentrate for that long, as I am really very tired. I have informed my mother about my condition and she has allowed me to miss tuitions today.

The patient would often feel stressed in many neutral situations because of his assumptions regarding the role of various people. An effort was made to help him think of alternatives to his original assumption and to test its validity **(Cognitive Restructuring).**

Example:

Situation: I was having tuitions the other day and grandmother and sister were having a loud argument

Assumption: My mother knew that I was having tuitions yet she didn't intervene

Patient was asked to think of alternatives to the assumption

Alternatives: Mother may be outside the house at that time

-Mother may have thought that the argument may not last very long

-Mother may have felt that the room was closed and the noise will not get through

-Mother may have thought that I would report if I was getting disturbed

-Mother might have tried to intervene

Patient felt that the fourth alternative was most likely and that he would report such incidents to his mother in the future.

The basic concepts of **Transactional Analysis** i.e. child, adult and parent ego states in human interaction were used to make the parents and

the patient understand their communication pattern. This helped in improving interpersonal relationships.

· Parent to Child

Parent: you are so irresponsible, you simply forgot to bring your sister with you!

Patient: I went to meet the principal with my friends and came back with them. I left the car for her.

· Adult–Adult

Parent: Why didn't you bring your sister with you? She is a girl and we have appointed the driver recently. Do you think it was safe to leave her alone with him?

Patient: No, I didn't think about it and I will be more careful the next time.

With therapy over a period of one and a half years the patient showed improvements in following areas.

· Presenting symptoms: Patient reports that he has had no vomiting since November 2007; also, the duration and frequency of pain had reduced considerably. Weight increased to 54kg.

· Eating behaviour: He is reported to have a normal appetite, is open to a variety of foods, demands food, has a balanced diet, and has stopped hiding food.

· Personal functioning: both patients and parents reported improvement in decision-making and appropriate expression of disagreement. They also reported that he was better organized in studies and his performance in tests had improved.

· Peer relationships: he had made new friends with whom he feels that he relates better and he has realized difference in perceptions with old friends. He also parted with his girl friend amicably.

· Family relationships: He is attempting to communicate with father and verbalizes his discomfort with him if required. He is also reported to be more assertive with his grandmother.

Further sessions are being conducted to improve the patient's relationship with his father, parents' marital relationship and to resolve conflicts within the patient's psyche.

DICUSSION

The prevalence of psychosomatic complaints in children and adolescents has been reported to be between 10 and 25%.[3,4] Common medically unexplained symptoms found in adolescent populations include headaches, abdominal pain, back pain, fatigue, dizziness, numbness and tingling sensations in the limbs, and gastrointestinal symptoms. [5] In particular, pain among children and adolescents has been identified as an important public health problem.[6]

The most important diagnostic concern in medically unexplained symptoms is the exclusion of general medical conditions. However, it is also important for physicians to address psychological and other psychosocial factors that may play a role in the etiology or maintenance of such symptoms.[5] Characteristics that favor psychosomatic basis for symptoms include vagueness of symptoms, varying intensity, inconsistent nature and pattern of symptoms, presence of multiple symptoms at the same time, chronic course with apparent good health, delay in seeking medical care, and lack of concern on the part of the patient. Potential sources of stress in children and adolescents include schoolwork, family problems, peer pressure, chronic disease or disability in parents, family moves, psychiatric disorder in parents and poor coping abilities.[3] It is important to resolve these symptoms as common childhood unexplained symptoms are predictors of symptoms in adulthood. [7, 8]

The biopsychosocial approach offers a means of working toward healing the whole person. [9] A comprehensive evaluation should include

assessment of genetic factors, e.g. risk of somatization and physical illnesses in families of somatizers; personality traits in family members that may predispose to somatization [10]; family factors, e.g. health issues and health beliefs of the family, presence of family models, parental attention to child's symptoms (reinforcement), general family environment, perceived marital conflict and stress, perceived lack of support, cohesion and adaptability, problems in family communication, traumatic childhood experiences, and tendency toward overprotection[3,7,10]; and individual factors, e.g. somatisation as a psychological defense, use of somatisation to maintain proximity to important attachment figures,[11] somatizing complaint as a anger coping strategy,[12] alexithymia, reactive temperament traits (fear and anger-frustration), and perceptual sensitivity,[13] psychobiological sensitization and health worry.[14] After a comprehensive evaluation is performed, an overall intervention plan should be presented to the child and family. Nonpharmacologic interventions should be considered before any psychopharmacologic intervention is instituted.[15]

Traditionally, treatment has been conceptualized as a two-step process, with symptoms removal by encouragement and suggestion[16-18] being followed by other psychological interventions. A rehabilitative approach emphasizing a return to usual activities, and a discouragement of "sick role" behaviors has been encouraged, with the responsibility for "coping" with the symptom being primarily the patient's. [19] Most agree that helping the patient and family to view the symptom as less threatening is beneficial and allows a shift of attention to take place toward treatment-related issues.[20]

Behavioral methods are widely used.[18] Positive reinforcement is a common technique. [21] A cognitive–behavioral approach including relaxation training, hypnosis, and biofeedback have been described. [21,22] Clinicians have also relied on traditional individual psychotherapeutic approaches, but systematic studies have not been accomplished. Similarly, there is active interest in the use of family therapy, [23] but adequate research is yet to be accomplished. Providing children and families with techniques to use when experiencing pain decreases alterations in normal daily activities and improves long-term health outcomes.[24] Interventions that focus on the child's cognitive processes associated with abdominal pain and the family's response to the pain have increased efficacy over standard education and reassurance.

REFERENCES

1. Lipowsky ZJ. Somatization: the concept and its clinical application. *Am J Psychiatry* 1988; 145: 1358-1368.
2. Fröhlich C, Jacobi F, Wittchen HU. DSM-IV pain disorder in the general population. An exploration of the structure and threshold of medically unexplained pain symptoms. *Eur Arch Psychiatry Clin Neurosci* 2006;256(3):187-96.
3. Brill SR, Patel DR, MacDonald E. Psychosomatic disorders in pediatrics. *Indian J Pediatr* 2001; 68(7): 597-603.
4. El-Metwally A, Halder S, Thompson D, Macfarlane GJ, Jones GT. Predictors of abdominal pain in schoolchildren: a 4-year population-based prospective study. *Arch Dis Child* 2007; 92(12): 1094-8.
5. Albrecht S, Naugle AE. Psychological assessment and treatment of somatization: adolescents with medically unexplained neurologic symptoms. *Adolesc Med* 2002; 13(3): 625-41.
6. Roth-Isigkeit A, Thyen U, Stöven H, Schwarzenberger J, Schmucker P. Pain among children and adolescents: restrictions in daily living and triggering factors. *Pediatrics* 2005; 115(2): e152-62
7. Hotopf M. Childhood experience of illness as a risk factor for medically unexplained symptoms. *Scand J Psychol* 2002; 43(2): 139-46
8. Jones GT, Silman AJ, Power C, Macfarlane GJ. Are common symptoms in childhood associated with chronic widespread body pain in adulthood? Results from the 1958 British Birth Cohort Study. *Arthritis Rheum* 2007; 56(5): 1669-75.
9. Kreipe RE. The biopsychosocial approach to

adolescents with somatoform disorders. *Adolesc Med Clin* 2006; 17(1): 1-24.

10. Campo JV, Fritsch SL. Somatization in children and adolescents. *J Am Acad Child Alolesc Psychiatry* 1994; 33(9): 1223-1235.
11. Garralda ME. Somatisation in children. *J Child Psychol Psychiat* 1996; 37(1): 13-33.
12. Miers AC, Rieffe C, Meerum Terwogt M, Cowan R, Linden W. The relation between anger coping strategies, anger mood and somatic complaints in children and adolescents. *J Abnorm Child Psychol* 2007; 35(4): 653-64.
13. Muris P, Meesters C, van den Hout A, Wessels S, Franken I, Rassin E. Personality and temperament correlates of pain catastrophizing in young adolescents.*Child Psychiatry Hum Dev* 2007; 38(3): 171-81.
14. Verkuil B, Brosschot JF, Thayer JF. A sensitive body or a sensitive mind? Associations among somatic sensitization, cognitive sensitization, health worry, and subjective health complaints. *J Psychosom Res* 2007; 63(6): 673-81.
15. Slater JA. Deciphering emotional aches and physical pains in children. *Pediatr Ann* 2003; 32(6): 402-7.
16. Proctor JT. Hysteria in childhood. *Am J Orthopsychiatry* 1958; 28: 394-407
17. Rock N. Conversion reactions in childhood: a clinical study on childhood neuroses. *J Am Acad Child Psychiatry* 1971; 10:65-93.
18. Laybourne PC & Churchill SW. Symptom discouragement in treating hysterical reactions of childhood. *Int J Child Psychother* 1972; 1:111-123.
19. Schulman JL. Use of a coping approach in the management of children with conversion reactions. *J Am Acad Child Adolesc Psychiatry* 1988; 785-788.
20. Turgay A. Treatment outcome for children and adolescents with conversion disorder. *Can J Psychiatry* 1990; 35: 585-589.
21. Mizes IS. The use of contingent reinforcement in the treatment of a conversion disorder: a multiple baseline study. *J Behav Ther Exp Psychiatry* 1985; 146:239-241.
22. Klonoff EA, Moore DJ. “Conversion reactions” in adolescents: a biofeedback-based operant approach. *J Behav Ther Exp Psychiatry* 1986; 17: 179-184.
23. Mullins IL, Olson RA. Familial factors in the etiology, maintenance and treatment of somatoform disorders in children. *Family systems Medicine* 1990; 8:159-175.
24. Scholl J, Allen PJ. A primary care approach to functional abdominal pain. *Pediatr Nurs* 2007; 33(3): 247-54, 257-9.

Rachna Bhargava, Senior Lecturer
Priti Arun, Professor
Department of Psychiatry
Government Medical College & Hospital, Chandigarh

Corresponding Author:
Rachna Bhargava
Department of Psychiatry
Government Medical College & Hospital, Chandigarh
Rachna_bhargava@hotmail.com