ORIGINAL RESEARCH PAPER

Psychology

ROLE OF GENETICS AND STRESSORS IN SOMATIZATION DISORDER: A CASE REPORT

KEY WORDS: Genetics, Family stressors, Somatisation.

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ABSTRACT

Somatisation disorder is also known as " Briquet's Syndrome." It is characterized by multiple minor physical complaints which leads to the patients to believe that they are sick. The present case focuses on the importance/role of genetics and stressors in the development of somatisation disorder. Mrs. X forty four years old female, married, having two children, studied upto 10th standard , belonging to middle socio economic status, hailed from urban area of Chennai in India. Patient was brought to Institute Of Mental Health, Chennai, Tamil Nadu with the presenting complaints of multiple pain in various regions of her body for 2 and half years, increased anger outburst, over thinking and sleep disturbance for an year and crying spells for 6 months with a history of suicide attempt in the patient and a history of mental and neurological illness in the family. On day while walking down the stairs she slipped and hit her head. Post this incident after 3 months; she developed complaints on various regions of her body. Findings revealed no brain abnormality at present, despite that she continued to experience pain on different sites, for which she was prescribed medications. At the same time she was undergoing stressors in the family such as financial crisis, her elder son's wedding being called off. She had negative thoughts and worry about her son's future. From the case report it could be concluded that genetics and stressors could be a predisposing factor making the patient vulnerable in developing somatisation disorder.

INTRODUCTION:

The word some means "body". Somatoform disorders involve physical illness or ailment with largely psychosocial causes. When a physical ailment has no apparent medical cause, doctors may suspect somatoform disorders. People with such disorders do not consciously or purposefully produce their symptoms. They genuinely believe that their problem is medical.

Somatisation disorder is also known as " Briquet's Syndrome". It was first described by French Physician Pierre Briquet in 1859. Briquet described patients who came to see him with seemingly endless lists of somatic complaints for which he could find no medical basis. It is characterized by multiple minor physical complaints which leads to the patients to believe that they are sick. Individuals with these disorders have a several history of somatic complaints beginning before age 30. Some of the causes could be genetics and personal distress. Co-morbidity of somatisation disorders are anxiety and mood disorders.

CASE REPORT:

Mrs. X forty four years old female, married, having two children, studied upto 10th standard , belonging to middle socio economic status, hailed from urban area of Chennai in India. Patient was brought to Institute Of Mental Health, Chennai, Tamil Nadu with the presenting complaints of multiple pain in various regions of her body for 2 and half years , increased anger outburst , over thinking and sleep disturbance for an year and crying spells for 6 months.

History revealed that the patient was doing well two and half years back. one day while walking down the stairs, she slipped and hit her head against the stairs. Immediately she was consulted in a private hospital and prescribed medications for 3 days. Post this incident after three months, she complained of pain in various regions of her body such as head, knee, joint for which she had multiple consultation with general physician. In October 2017, she was taken to Neurology department in Stanley hospital where she was diagnosed with a minor nerve issue and was prescribed medications. She continued to experience pain and developed different pain on different sites, every single day. She was advised to undergo CT & MRI scans in Stanley, findings revealed no brain abnormality at present. Despite the findings, she experienced pain in knee, shoulder, neck region and experienced a burning sensation on the lower part of the body and felt it progressing towards the chest. She wears a clip only on occasions such as marriage or hospital otherwise she would experience swelling in her head. Neurologists in Stanley Department had assured, she was healthy but patient denied it and believed that the scans had failed to identify the problem with her body. Later, she was referred to Psychiatry department in Stanley hospital by Neurologists.

She volunteers to carryout household chores but the family members restrict her due to her illness, because of which she would get fierce and has broke television remote and utensils.

Her elder son's wedding was called off by the bride's family considering the patient's financial status. She blames herself for this and worries about the future of her son. Despite the marriage being called off and being warned multiple times, her son continues to be in contact with the girl. The girl had frequently enquired him about his family assets and his share. This had put the patient under constant pressure and she fears whether he would elope against their will.

Meanwhile she started developing sleep disturbance wherein she could fall asleep only when she lies down in a straight uptight position. When she changes her position i.e by leaning on one side she would feel her one side of her head being very heavy and as if it is going to burst, following this, thought about her son would pop making it difficult for her to fall asleep.

Her husband had availed loan to improve his business and they had invested the money all they had in the business. However they hadn't benefited much out of it and fears whether they would end up losing all the money in the business. On thinking about all these events she begins to cry and stated that sometimes she is unable to control her tears. In august 2018, she had developed extra pyramidal symptoms hence she stopped taking medications without the psychiatrist's consultation. Her condition worsened hence she was brought to Institute Of Mental Health for further treatment.

There was no history suggestive of fever, vomiting, confusion, disorientation, memory disturbance, epilepsy, talking to self, laughing to self, hypertension, diabetes, loss of interest in pleasurable activities and substance abuse. She got married at the age of twenty one which was arranged by elders with

mutual consent and moved to a village in Andhra Pradesh. Since the initial time of marriage they had frequent conflicts due to lack of provision for proper restroom, television and financial crisis. Later they moved to Chennai and started a carpentry shop, however she stated that her marital life wasn't very cordial. In 2007, due to difference of opinion between herself and husband she tried to hang herself, which according to the patient's husband was an attention seeking act. At present, the flow of communication is moderate between the family members with history of psychiatric illness in patient's father and history of neurotic disorder in her sister.

Premorbidly, she used to welcome responsibilities but made decisions with difficulty. Easily bored and discouraged. She was confident, outspoken but was sensitive to criticism. Sometimes she used to day dream like her elder son getting married and settling in life. There was no use and abuse of alcohol, tobacco and drugs. On MSE, negative thoughts and worry about her son's future were present.

Psychological assessments were conducted to assess the level of depression and interpersonal conflicts. On BGT, her Visuo perceptual gestalt function was found to be adequate.. On Bhatias, she has obtained a raw score of 48, IQ of 101 indicating average intelligence. On MHQ, she has obtained a significant score in the area of depression. On HAM-D, depression was evident characterized by depressed mood, somatic symptoms and guilt. On SCT, significant complaints were found in the areas of family and Interpersonal relationship. On RIBT, she has given a total of 35 responses indicating average productivity with quick mentation time with mediocre form level. She has given five popular responses indicating touch with reality. On content analysis human detail responses with no human responses indicate anxiety about interpersonal relations. From the psychogram, it was evident that the is largely influenced by her own imagination drives and needs. There is no bizarre or contamination responses suggestive of no gross psychopathology at present

DISCUSSION:

Somatization can be conceptualized as a process which appears fundamentally as a way of responding to stress. Another concept is somatosensory amplification, where somatic symptoms are experienced as intense, noxious or disturbing.It has three elements i) hypervigilance (to bodily sensations) ii) selecting out some sensations (which are weak) and iii) intensification by cognition and affect, making them more alarming (Barsky AJ,1998). Here the patient Mrs. X experienced a fall and progressively developed multiple complaints which differed on each day, irrespective of the medical findings being negative she continued to believe in her condition. In addition to this, her life circumstances had several stressors such as her son's wedding being called off , conflicts in the family and financial crisis which also closely took place at the same time as she experienced a minor fall. According to model proposed by (Barsky AJ,1998) , the patient's somatic complaints could be a way of responding to the stressors.

Etiological considerations include patho-physiological mechanisms ((Barsky AJ,1998). Patho- physiological mechanisms involve genetics and other physiological contribution in the development of somatisation disorder, evidence from the patient's history indicates presence of mental illness in the father and presence of neurological disorder in sister which could make the patient vulnerable to develop a neurotic or psychotic condition. Significant conflicts from the initial stage of marriage , financial crisis and her son's wedding being called off contribute to the strains in Interpersonal dynamics which again plays an important role in the development of somatisation disorder.

The diathesis–stress model is a psychological theory that attempts to explain a disorder, or its trajectory, as the result of an interaction between a predispositional vulnerability and a stress caused by life experiences. The diathesis, or predisposition, interacts with the individual's subsequent stress response. Her condition could have resulted as a result of interaction between diathesis- history of mental illness and neurotic disorder and stressors in her life.

Linda Gask (1995) proposed a model for understanding functional somatic symptoms. The following comprises the model:

1. Symptoms which are in excessive (disproportionate to) the "real disease"
2. Anxiety disorders and Depressive disorders presenting with physical symptoms
3. No known physical or common mental disorders to account for the somatic symptoms
4. Acute and dramatic presentation of physical symptoms without a medical cause
5. Concern and conviction of a disease when none exists
6. Deliberate feigning of diseases

The patient Mrs. X presents with dramatic representation of complains of pain which do not account for a physical symptom and the complaints are disproportionate to the real disease. The presenting complaints of the patients are supported with this model. The disorder is far more common in women than in men, and usually starts in early adult life (ICD-10) , which again supports the patient's illness.

On conclusion the patient's manifestation of presenting complaints could be her way of reacting to present stressors in family. Presence of mental illness and neurotic illness in the family could be a factor contributing to the patient's illness.

The patient could benefit through Psycho education, Pharmacotherapy, autogenic muscle relaxation, family counselling, individual counselling and Cognitive behavioural therapy.

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