CASE REPORT

Psychosocial Intervention in Person with Somatization Disorder: A Case Study

Joy Doley, Nilesh Maruti Gujar, Arif Ali

Department of Psychiatric Social Work, LGB Regional Institute of Mental Health, Tezpur, Assam. PIN- 784001, India

Abstract

Background: Somatization disorder can lead to social and occupational dysfunctions, increased healthcare use and a high level of dissatisfaction from the healthcare professional. Psychosocial interventions for medically unexplained somatic symptoms are effective in dealing with dysfunction and other psychosocial issues. Aim and objectives: To assess psychosocial problems of a person with somatization disorder and provide psychiatric social work intervention to help the client to overcome those problems. Methodology: The single-subject case study design was carried out with a case of somatization disorder at the outpatient department of LGBRIMH, Tezpur. The client was selected purposefully for the assessment and intervention. The client had explained about the purpose of the case study and written informed consent was obtained before assessment and intervention. The assessment was done before and after intervention using the family assessment device, Bradford somatic inventory, Beck depression inventory, Beck anxiety inventory, perceived stress scale, and the illness attitude scale. Based on the assessment psychosocial intervention was provided to the client. Results**: The client's level of understanding about the illness, functionality was improved. The improvement was seen in the post-test score of somatic complaints, depression, anxiety, stress, and attitude towards illness.** Conclusion: **The outcome of the case study confirms that psychosocial intervention in somatization disorder is effective in managing somatic complaints, anxious and depressive mood, and attitude towards illness.**

Keywords: Somatization, Reattribution Approach, Cognitive Behavior Therapy, Psychiatric Social Work Intervention

Introduction

Somatization is defined as the propensity of a client to experience and report physical/somatic symptoms that have no pathophysiological explanations. All somatoform disorder subtypes share one common feature; predominance and persistence of unexplained somatic symptoms associated with significant

distress and impairment. There is evidence that several behavioral and psychological interventions like supportive intervention, CBT, Dialectical behavior therapy (DBT), and mood monitoring, which can help them to reduce depression, anxiety, stress, and enhance wellbeing among persons with somatization disorder [1-4]. Moreover, Larisch et al.'s [5] study found that psychosocial interventions based on the modified reattribution model for persons with somatization lead to a reduction of physical symptoms, an improvement in physical functioning, and a reduction of depression and anxiety. Overall findings suggest behavioral and psychological interventions are effective in severe somatoform disorder especially improvement in physical and psychological symptoms along with functional improvement. The present case study was an attempt to see the effectiveness of the psychosocial intervention on a person with somatoform disorder.

Methodology

This was a single subject case study. According to Stake [6], case study research focuses on one case and provides an in-depth examination and interpretation to understand that particular case (intrinsic case study). A pre-test – post-test design was used (quasi-experimental) in the case study. The study was carried out at the outpatient department of LGBRIMH, Tezpur. The client was selected purposefully for the present study. The client was explained the purpose of the case study and written informed consent was obtained. Confidentiality and the right to privacy were ensured to the client.

Measures

1. **Family Assessment Device (FAD)** [7]: FAD is designed to measure family functioning as described in the McMaster Model of Family. It is divided into seven scales viz problem solving, communication, roles, affective responsiveness, affective involvement, behavior control, and general functioning.

2. **Bradford Somatic Inventory (BSI)** [8]: The BSI enquires about the functional somatic complaints during the previous month and, if the subject has experienced a particular symptom, whether the symptom has occurred on more or fewer than 15 days during the month (scoring 2 or 1, respectively). The inventory is developed by Mumford and colleagues to examine the somatic symptoms of anxiety and depression, which has transcultural applications. It has 44 questions for women and 46 for men.

3. **Beck Depression Inventory (BDI)** [9]**:** The BDI is a 21-question multiple-choice self-report inventory, one of the most widely used psychometric tests for measuring the severity of depression. Scores between 1- 10 is normal, 11-16 is mild mood disturbance, 17-20 borderline clinical depression, 21-30 moderate depression, 31-40 severe depression and over 40 extreme depression. On this scale patient score 13 which falls under Mild mood disturbance.

4. **Beck Anxiety Inventory (BAI)** [10]**:** The BAI is a 21-question multiple-choice self-report inventory that is used for measuring the severity of anxiety in children and adults. The

questions in the scale are used to measure ask about common symptoms of anxiety that the subject has had during the past week. Higher scores indicate more severe anxiety symptoms in the client.

5. **Perceived stress scale (PSS)** [11]: The PSS is the most widely used psychological instrument for measuring the degree to which situations in an individual's life are appraised as stressful. The PSS is a 10-item self-report tool used to provide a global measure of perceived stress in daily life. It is a five-point scale and the responses s range from "never" to "very often. The scoring is done by summing all the 20 items and higher scores indicating higher perceived stress.

6. **The Illness Attitude Scale (IAS)** [12]: The IAS is a 29-item instrument used to assess fears, attitudes, and beliefs associated with hypochondriasis and abnormal illness behavior. Each item is scored on a 5-point Likert scale ranging from 0 (“no”) to 4 (“most of the time”). Two additional items on the IAS (items 22 and 26) provide supplementary information but are not used in scoring. It has reported good psychometric properties.

Case introduction

Index client Mr. R.G. 47 years old, male, Hindu and is educated up to Class V, married, a mechanic by occupation, belonging to lower socio-economic background, hailing from a rural area of Tezpur, Assam. The Client was apparently well 4 years back. The client came to Lokopriya Gopinath Bordoloi Regional Institute of Mental Health (LGBRIMH), Tezpur on an OPD basis with chief complaints of burning sensation in the whole body and eyes, dizziness, tingling sensation, pain in the whole body, and gastritis problem. The mode of onset was gradual with the continuous course and fluctuating progress of the illness. The total duration of illness was 4 years. He has taken treatment from various physicians for the above symptoms. He was worried about his health condition. He also complained about the difficulty in the work functioning. He was unable to do his work as he was doing earlier. He was diagnosed with Somatoform disorder (F45) according to ICD 10.

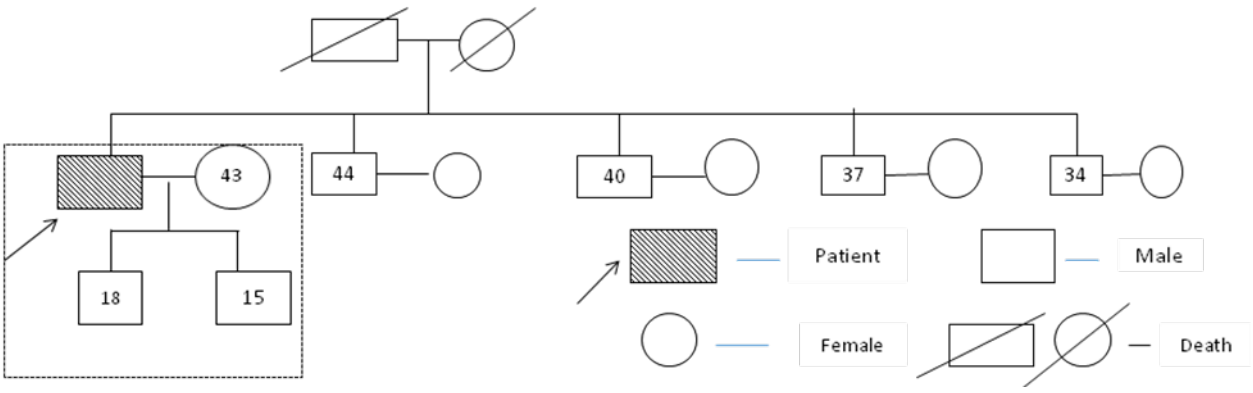

Figure 1. Family genogram

Family dynamics

The parental subsystem, parent-child subsystem, and sibling subsystem are present. Both external and internal boundaries are found to be clear and open in the family. The client was the nominal head and the client's wife was the functional leader in the family and decisions are taken by both of them. Family members used to perform their roles and assigned tasks adequately. Parent-child communication found to be indirect whereas, sibling communication was direct. The presence of cohesion and we feeling was present adequately among family members. Coping and problem-solving ability was inadequate in the family. Primary support and tertiary support are found to be adequate. Secondary support was not adequate.

Psychiatric social work intervention

The psychosocial intervention was provided to the client at the outpatient department in the psychosocial unit, LGBRIMH, Tezpur, Assam. The sessions were divided into individual and family level. In the initial phase, the session was planned twice per week, after that one session. A total of 14 sessions were conducted (including assessment and intervention).

Rapport establishment and therapeutic alliance

Building rapport is the first and foremost thing to establish a healthy relationship. The therapist tried to build trust and understanding so that intervention can be carried out adequately as per the requirement of the client. Consent was taken from the client and his significant other to carry out future sessions. It was explained to the client about the need for the interventions, the purpose of carrying out future sessions and the advantages he would gain from the sessions. Confidentiality and a non-judgmental attitude were maintained to make the intervention a fruitful one.

Supportive counseling

Supportive casework intervention was done with the client as well as with the wife. Supportive intervention helps to get relief from distressful emotion and helps to improve symptoms [13-15].

Family psychoeducation

The session focused on providing the family members education regarding the nature and causes of somatization disorder i.e., biological, physical, psychological, socio-environmental factors, early signs and symptoms of mental illness and treatment modalities. The session continued with providing information about adherence to medication which important factor in maintaining and managing the condition. Further, the future session covered the myths and misconceptions regarding mental illness. The importance of work engagement was also discussed with the family members.

Reattribution therapy

The three parts of this brief intervention include a) feeling understood – to elicit physical symptoms, psychosocial problems, mood state, beliefs about the problem, relevant examination and tests, b) changing or broadening the agenda – to summarize physical and psychosocial findings and negotiate, and c) making the link – explanation relating the physical symptom to the psychosocial problem based on timing or physiology (Agarwal et al., 2020) [16]. The main objective of the session was to understand the client's attribution towards

the illness. The client and his significant others attended the session. It also aims to change/broaden the agenda and to help in making the links between physical and psychological symptoms. The stages followed for the therapy is mentioned below:

Stage 1: Feeling understood

In the first step full history was taken from the client to assess the pain he was undergoing. He was asked to narrate a typical day he spent. It is important to respond to the client's verbal and emotional cues while explaining his undergoing pain. The client's beliefs regarding the cause of the symptoms were elicited during the session. The client was also taken for a physical examination and test to rule out if any physical conditions and other comorbidities are present or not.

Stage 2: Broadening the agenda

In the successive session, the results of the physical examination and other investigations were discussed with the client. He was informed that there were no positive physical findings of the illness. The therapist explained how affective symptoms like worries, stress, anxiety, could be the basis for the client's symptoms.

Stage 3: Making the link

In this stage, the therapist linked the client's physical and psychological symptoms. The therapist explained how anxiety/depression can cause a headache. Anxiety also causes muscle tension which then causes pain in the body. A practical example used from the client's perspective like how pain is worse on days when he is under stress. The discrepancy was developed by asking the clients about feelings and symptoms at the moment. At the end of the session, there was a brief revision of the homework on practicing diaphragmatic breathing. Homework was assigned and activity schedule was planned.

Activity scheduling

The activity schedule was planned with the client to make him remain engaged in activities. During the session both the wife and the client were present. The main objectives of the session are to increase the activities of the client and to engage him in the activities that are pleasurable and productive. The daily routine of the client was assessed first. Following this, the therapist planned the activity scheduling with the client in which the primary family members were also involved. The daily routine regarding waking up, getting fresh up, brisk walk, deep breathing, physical exercise, taking breakfast, engaging oneself in productive activities, taking rest, engaging in pleasurable activities, maintaining routine sleep pattern was included in the activity schedule. The wife of the client was asked to monitor and help in following the activities planned for the client.

Sleep hygiene

As the client had difficulty in sleeping, sleep hygiene techniques were discussed. The client was informed regarding the benefits of sound sleep and its implications on one's health. He was asked to follow a regular time for going to sleep and waking up, daily physical exercises, avoid fluid intake and heavy meals just before bedtime, avoid caffeine intake in the evening and sleep in a quiet and comfortable environment. The therapist also discussed how he can maintain his home environment in getting sound sleep. The client was also asked to inculcate the habits of relaxation techniques like deep breathing before going to bed.

Problem-solving and coping skills training

Simple steps of problem-solving were taught to the client. The therapist emphasizes six steps to effective problem-solving, and they are identify/define problem, generate possible solutions/options, evaluate alternatives, decide on a plan, implement plan and lastly evaluate the outcome plan. The therapist tries to strengthen the client's skills in dealing with the problems. The therapist helped the client to develop coping skills to manage his situation, find options and actions to deal with a problem.

Stress management skills

Stress management techniques were discussed with the client. Jacobson progressive muscle relaxation techniques were demonstrated to the client. Deep breathing exercise by keeping one's mind and soul relaxed was discussed with the client.

Follow up session

A follow session was conducted after one month at OPD of LGBRIMH. The session focused on knowing about how the client was maintaining, monitoring his drug compliances, and work engagement. It was assessed and found that patient is on regular medication, practicing diaphragmatic breathing and has found an alternative job. Two phone calls were also made to the client to know about the client and had a conversation with the clients's wife.

Results

The family assessment revealed unhealthy functioning in the area of problem-solving (2.16) and communication (2.11). It can be observed from the assessment that the family of the client had difficulties solving family problems and they lack healthy communication (Table 1). Table 2 showed the outcome of the psychosocial intervention. In the pretest, depression, anxiety, and somatic symptoms were at a mild level (12, 20, and 23 respectively), perceived stress was at a moderate level (20) and illness attitude showed high hypochondriacal symptoms (78). After the psychosocial intervention, there was a change in post-test scores (depression (6-normal level); anxiety (6- too little anxiety); somatic symptoms (8-normal); perceived stress (8-below average); and illness attitude (low hypochondriacal symptoms).

Table 1. Assessment of the family functioning using family assessment device

Area	Cut-off score	Obtained score	Impression
Problem-solving	2.2	2.16	Unhealthy functioning
Communication	2.2	2.11	Unhealthy functioning
Roles	2.3	3.09	Healthy functioning
Affective responsiveness	2.2	2.5	Healthy functioning
Affective involvement	2.1	3.57	Healthy functioning
Behaviour control	1.9	3.11	Healthy functioning
General functioning	2.0	2.5	Healthy functioning

Table 2. Pre and post-intervention score of depression, anxiety, perceived stress, somatic symptoms and illness attitude

Variables	Pre-test scores	Findings	Post-test scores	Findings
Beck depression inventory	12	Mild	6	Normal
Beck anxiety inventory	20	Mild	6	Too little anxiety
Bradford somatic inventory	23	Mild	8	Normal
Perceived stress scale	20	Moderate High	8	Below average Low
The illness attitude scale	78	hypochondriacal symptoms.	22	hypochondriacal symptoms.

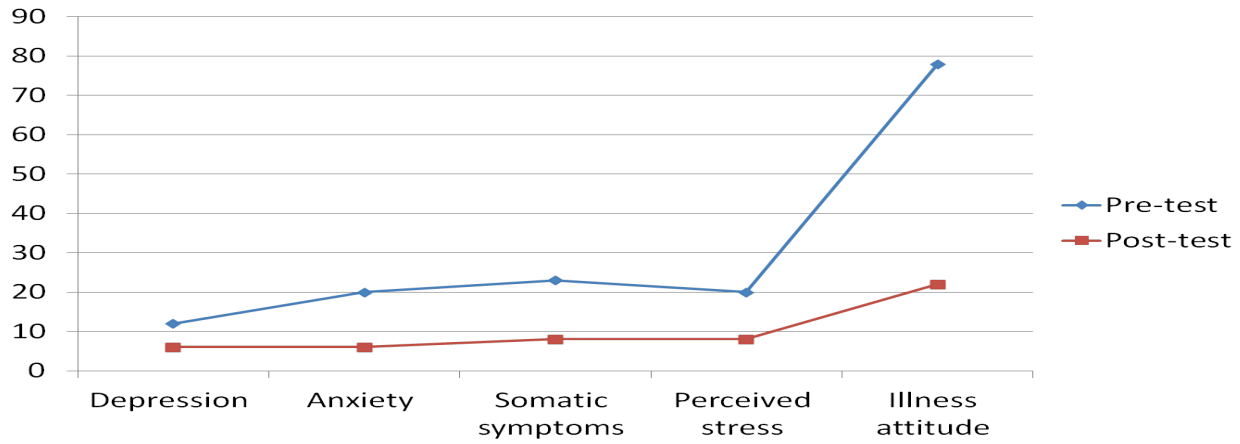

Figure 2. Outcome of psychosocial intervention

Discussion

In the present case study after the psychosocial intervention there was a change in pre-to-post scores of anxiety, depression, perceived stress, and attitude towards illness. We also found that the client and client's family members gained knowledge regarding illness and its treatment. After the intervention, we observed positive changes in the client's mood, feelings, and thoughts. Client reported enhanced social and occupational functioning as he got engaged in a new job. Similarly, in support of the present findings another study reported that psychosocial interventions can improve symptoms and social functioning in a person with medically unexplained disorders [17]. Similarly, Larisch et al.'s [5] study argued that reattribution therapy is effective in the reduction of physical symptoms, an improvement in physical functioning, and a reduction of depression and anxiety. On the other hand, Wilkinson and Mynors-Wallis [18] reported that problem-solving therapy

for the treatment of medically unexplained disorders has shown a reduction in the number of visits to the general practitioner. Moreover, Real et al. [19] reported in their study that brief family therapy can be effective for a person with somatization disorder. The intervention needs to be sensitive enough to deal with those beliefs. As, most non-pharmacological interventions for medically unexplained symptoms focus on cognitive, behavior, coping, and functional consequences of symptoms [20]. The psychosocial intervention aims to change the way that patient (client) perceive their symptoms to help them make their symptoms more manageable and focus on the functionality of the client.

Conclusion

Somatization disorders can lead to impairment and considerable impact on psychosocial functioning. Psychosocial intervention can be effective in dealing with somatoform disorders.

Conflicts of interest

Nil declared

Funding support

Nil

Acknowledgement

The present study acknowledges all the relevant sources involved in the study.

References

[1] Liu J, Gill NS, Teodorczuk A, Li ZJ, Sun J. The efficacy of cognitive behavioural therapy in somatoform disorders and medically unexplained physical symptoms: A meta-analysis of randomized controlled trials. J Affect Disord. 2019;245:98-112.

[2] Chakhssi F, Kraiss JT, Sommers-Spijkerman M, Bohlmeijer ET. The effect of positive psychology interventions on well-being and distress in clinical samples with psychiatric or somatic disorders: A systematic review and meta-analysis. BMC Psychiatry. 2018;18(1):1-7.

[3] Van Dessel N, Den Boeft M, van der Wouden JC, Kleinstaeuber M, Leone SS, Terluin B, Numans ME, van der Horstvan HE, Marwijk H. Non-pharmacological interventions forsomatoform disorders and medically unexplained physical symptoms (MUPS) in adults. The Cochrane Library.2014;11. https://doi.org/10.1002/14651858.CD011142

[4] Koelen JA, Houtveen JH, Abbass A, Luyten P, Eurelings-Bontekoe EH, Van Broeckhuysen-Kloth SA, Bühring ME, Geenen R. Effectiveness of psychotherapy for severe somatoform disorder: meta-analysis. Br J Psychiatry. 2014;204(1):12-9.

[5] Larisch A, Schweickhardt A, Wirsching M, Fritzsche K. Psychosocial interventions for somatizing patients by the general practitioner: a randomized controlled trial. J Psychosom Res. 2004;57(6):507-14.

[6] Stake RE. The art of case study research. Sage Publication Pvt. Ltd. International Educational and

professional Publisher, London, United Kingdom. 1995.

[7] Epstein NB, Baldwin LM, Bishop DS. The McMaster family assessment device. J Marital Fam Ther. 1983;9(2):171-80.

[8] Mumford DB, Bavington JT, Bhatnagar KS, Hussain Y, Mirza S, Naraghi MM. The Bradford Somatic Inventory: A multi-ethnic inventory of somatic symptoms reported by anxious and depressed patients in Britain and the Indo-Pakistan subcontinent. Bri J Psychiatry. 1991;158(3):379-86.

[9] Beck AT, Steer RA, & Brown GK. Manual for the beck depression inventory-II. San Antonio, TX: Psychological Corporation, 1996, 1, 82.

[10] Beck AT & Steer RA. Beck anxiety inventory: BAI. Psychological Corporation. 1993.

[11] Cohen S, Kamarck T, Mermelstein R. A global measure of perceived stress. J Health Soc Behav. 1983;24(4):385-96.

[12] Kellner R. Abridged manual of the Illness Attitude Scale. Albuquerque, NM: University of New Mexico. 1987.

[13] Guthrie E, Creed F, Dawson D, Tomenson B. A randomised controlled trial of psychotherapy in patients with refractory irritable bowel syndrome. Bri J Psychiatry. 1993;163(3):315-21.

[14] Breitbart W, Rosenfeld B, Pessin H, Applebaum A, Kulikowski J, Lichtenthal WG. Meaning-centered group psychotherapy: an effective intervention for improving psychological well-being in patients with advanced cancer. J Clin Oncol. 2015;33(7):749-54.

[15] Hamilton J, Guthrie E, Creed F, Thompson D, Tomenson B, Bennett R, Moriarty K, Stephens W, Liston R. A randomized controlled trial of psychotherapy in patients with chronic functional dyspepsia. Gastroenterol. 2000;119(3):661-9.

[16] Agarwal V, Nischal A, Praharaj SK, Menon V, Kar SK. Clinical Practice Guideline: Psychotherapies for Somatoform Disorders. Indian J Psychiatry. 2020;62(Suppl 2):S263–S271. https://doi.org/10.4103/psychiatry.IndianJPsychiatry_775_19

[17] Kroenke K. Efficacy of treatment for somatoform disorders: a review of randomized controlled trials. Psychosom Med. 2007;69(9):881-8.

[18] Wilkinson P, Mynors-Wallis L. Problem-solving therapy in the treatment of unexplained physical symptoms in primary care: a preliminary study. J Psychosom Res. 1994;38(6):591-8.

[19] Real Pérez M, Rodríguez-Arias Palomo JL, Cagigas Viadero J, Aparicio Sanz MM, Real Pérez MA. Brief family therapy: an option for the treatment of somatoform disorders in primary care. Aten Primaria. 1996;17(4):241-6.

[20] Allen LA, Woolfolk RL, Lehrer PM, Gara MA, Escobar JI. Cognitive behavior therapy for somatization disorder: a preliminary investigation. J Behav Ther and Exp Psy. 2001;32(2):53-2.

Corresponding Author
Dr. Arif Ali, Assistant Professor,
Department of Psychiatric Social Work,
LGB Regional Institute of Mental Health,
Tezpur, Assam. PIN- 784001, India

Email: arifalipsw@gmail.com