International Journal of Science and Research (IJSR)
ISSN: 2319-7064
ResearchGate Impact Factor (2018): 0.28 | SJIF (2018): 7.426

"I Am Here to Make You Inferior?" - A Case Report of Somatic Symptom Disorder

Dr. Tajgna Kadia, Dr. Kamlesh Patel

Abstract: ***"I am here to make you inferior…"- A case report of Somatic symptom disorder. Somatic symptom disorder is characterized by 6 or more months of a general and non-delusional preoccupation with fears of having a serious disease based on the person's misinterpretation of bodily symptoms. That causes significant distress and impairment in one's life; and a subset of individuals with disorder has poor insight about the presence of this disorder. Persons with this disorder augment and amplify their somatic sensations; they have low thresholds and low tolerance for physical discomfort. They may focus on bodily sensations, misinterpret them and become alarmed by them because of a faulty cognition. A case of 56yrs – old married male was diagnosed as SSD admitted to Psychiatry ward with a history of total duration of 30-35 yrs having complains of multiple physical pains over different part of body mainly over left shoulder pain, backache, body-ache, abdominal pain and excessive worries about to pain and his health. He is spending most of the time and energy for relieving pain by applying hot water bag over different part of body for more than 4-5hrs daily. He also stopped going to work. Over period of time he developed depressive symptoms due to his illness, so he thought death will be better option than life. For all complain he had more than 30-35 consultation to various physician. He had done all investigation, those were normal. His physical and central nervous system examination were normal. He mostly complains about his physical conditions but in therapy we only focused on emotional issue of his life and tried to explain that pain may have underlying emotional background. Combination pharmacological management and Cognitive behaviour therapy were tried. We tried to make him learn about Reassurance, Stress reduction, more adoptive methods of interacting with family and society like Social skill training and gave an insight about his illness.***

Keywords: SSD, Physical pain, Emotional conflict

1. Introduction

Somatic symptom disorder is characterized by 6 or more months of a general and non-delusional preoccupation with fears of having, or the idea that one has, a serious disease based on the person's misinterpretation of bodily symptoms. That causes significant distress and impairment in one's life; it is not accounted for by another psychiatric or medical disorder; and a subset of individuals with somatic symptom disorder has poor insight about the presence of this disorder. It is also known as "hypochondriasis". Persons with this disorder augment and amplify their somatic sensations; they have low thresholds and low tolerance for physical discomfort. They may focus on bodily sensations, misinterpret them and become alarmed by them because of a faulty cognitive scheme[2].

In terms of a social learning model; it is viewed as a request for admission to the sick role made by a person facing seemingly insolvable problems. The sick role offers an escape that allows a patient to avoid noxious obligations, to postpone unwelcome challenges and to be excused from usual duties and obligations. The psychodynamic school of thought holds that aggressive and hostile wishes toward others are transferred into physical complaints. The anger of patients with this disorder originates in past disappointments, rejections, and losses; but the patients express their anger in the present by soliciting the help and concern of other persons and then rejecting them as ineffective[3].

This disorder is also viewed as a defence against guilt, a sense of innate badness, an expression of low self-esteem, and a sign of excessive self-concern. Pain and somatic suffering thus become means of atonement and expiation and can be experienced as deserved punishment for past wrongdoing and for a person's sense of wickedness and sinfulness.

2. Case Report

A 56yrs –old married male educated up to higher secondary was diagnosed as somatic symptom disorder admitted to Psychiatry ward with a history of total duration of 30-35years having complain of multiple physical pain over different part of body like mainly over left shoulder pain after lifting heavy weight which was burning type, radiating towards right shoulder and upper-limb and increasing gradually, mild-moderate in intensity. Patient consulted a local private physician, who prescribed him analgesics, but his pain did not get relieved by that. Due to this incident, patient stopped lifting heavy weight and instead would do paperwork and manage other things at his shop. But the pain remained continuous throughout the day even after avoiding lifting weight. Patient complained about back-pain while walking which was dull aching in nature and radiating towards both legs. He used to walk with slightly bending his body forward which would decrease the pain. He also complained of abdominal discomfort while eating food and drinking liquids which would lead to heaviness in abdomen, nausea and pain over chest region. The chest pain was burning in nature, mild to moderate in intensity, non radiating and associated with "munjharo" and "becheni". It was aggravated by further taking meal and not relieved by taking antacids and H2 blockers. According to patient, He also complained of burning sensation and dull aching pelvic pain which was continuous and not relieved after passing stool or any other medication. Since last year he felt low most of the time throughout the day, he did not like to communicate with family members, nor did he like to do any work. He also stopped going outside his home. He remained in thoughts about his health and frequently worried about his pain. So he felt that death was a better option than living and requested his wife to pray for his death. During that period his sleep was decreased than before. He had difficulty in falling asleep. According to him he was awake most of the night and whenever he would fall asleep he

would wake up again within 1-2 hours and had difficulty in going back to sleep. His appetite was decreased than before and he would have very little amount of food. Since last few months, the pain was became continuous and severe in intensity which caused great distress in his daily life so much so that he would take bath after 7-8 days due to body ache. He is spending most of the time and energy for relieving pain by applying hot water bag over different part of body for more than 4-5hrs. He also stopped going to work since last few years. According to the patient, during that period He consulted multiple (approximately 30-35) private Physicians, Gastroenterologist, Orthopedics, Rheumatologist, Neuro-physicians, Neurosurgeon, Spine specialist and psychiatrist had undergone numerous investigations which all turned out to be normal. He would take the prescribed medicines only for few days and stop by himself as his symptoms would not get resolved. According to relative in pre-morbid personality; patient short tempered, easy anger outburst, stubborn, prefers company, makes friends easily, long lasting relationships, wanted to centre of attraction, not tolerate others criticism, hard working, religious with good moral fiber. His physical and Central nervous system examination were normal.

3. Discussion

The patient had presented to psychiatry department with complain of multiple physical pain over different part of body mainly over left shoulder pain, backache, body-ache, abdominal pain and excessive worries about to pain and his health with total duration of 30-35yrs. Diagnosis of somatic symptom disorder confirmed with the help of DSM-5 criteria[1]. He admitted in psychiatry ward then longitudinal & detailed history taken; Interdepartmental discussion done about this case in detail. After that various psychological projective test was performed over him & identified his emotional conflicts after that marathon therapy session daily was taken. He mostly complains about his physical condition & we decided to listen about his complains, even also we advice him to write down his all complains in paper; but in therapy we only focused on emotional issue of his life and tried to explain that pain may have underlying emotional background but He was totally denial for that and explained intellectually that he was physically ill. We identified his defence mechanism like rationalization, intellectualization, displacement, repression, passive aggression and projection. We have maintained the admission for 30days, which was never before. He was never took treatment for more than 10days from any consultant. Whenever he asked some question we gave proper answer should be explained in medical term. He was improved also. As soon as he was started feeling some improvement he left the ward. He also maintain follow-up that is from 200km every 15days. It is difficult to treat. Combination pharmacological management (but patient not taking drug regularly) and Cognitive behaviour therapy were tried.

4. Conclusion

We could identify his defence that “I am here to make you inferior…” OR “I don’t want you to win…”. He doesn’t want that any doctor should make him illness free. He was quite intellectually debating with doctor and irritate him so he could left the doctor and said that nobody cure me. We all included nursing staff face his behaviour calmly and happily. We tried to make him learn about Reassurance, Stress reduction, more adoptive methods of interacting with family and society like Social skill training and gave an insight about his illness. We had tried our best. We did not confront his defence mechanism and that would help to patient in improving affect, his depressive symptom, remain cheerful, going for work and decreased the dose of medication. Though it was for short duration but it helps the patient a lot.

References

[1] Diagnostic and statistical Manual of Mental disorders, 5th edition: DSM 5. 2014; 5:311-315.
[2] Kaplan & Sadock’s comprehensive textbook of psychiatry 10th edition. 2017; 10;4684-4728.
[3] Kaplan & Sadock’s Synopsis of Psychiatry; Behaviour sciences/Clinical psychiatry 11th edition. 2015; 11:468-471.