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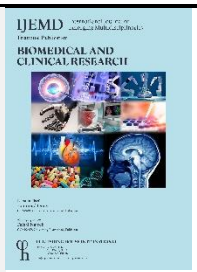

Somatic Symptoms and Related Disorder in an Unmarried Female Undergraduate Student Following Paternal Autocratic Behaviour: A Case Report

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Abstract

This case report aims to unveil the influence of undue paternalistic behaviour on the health of a family member in order to provide insight to the consequences of undemocratic parenting style in the family. The presentation of an "undifferentiated" patient is a common encounter in the Family Medicine Clinics. Therefore, a thorough evaluation and high index of suspicion is vital in managing such cases with thick file syndrome or recurrent hospital visits. These cohort of patients are often at risk of misdiagnosis and/or request for high technology investigations which is unnecessary for the individual and family. A 23-year-old unmarried university female student presented with complaints of crawling sensations in the body, chest pain and intermittent palpitation for six months at a Family Medicine Clinic. She was previously misdiagnosed for other conditions but it turned out to be somatic symptom and related disorder (SSRD). This case clearly revealed the psychosocial influence from a paternal tyrannical behaviour resulting in mental disorder of a family member.

Keywords: Autocratic; Paternalistic behaviour; Somatic symptoms; Undergraduate; Undifferentiated.

1. Introduction:

MM, a 23- year-old unmarried university female student who presented to the GOPC by self-referral on account of crawling sensation and chest pain with palpitation for six months. MM was in stable mental health condition six months prior to presentation when she perceived crawling sensations all. The sensation was described as insect moving in her body worst on the face. The crawling sensations usually began from the head to the lower limbs and back to the head. She had associated generalised throbbing headache which was occasionally relieved by use of acetaminophen. There was history of chest pain and palpitation. The chest pain was described as heaviness in the chest which followed the crawling sensation. There was no difficulty in breathing, cough, pedal swelling or urinary symptoms. She had been having difficulty in sleeping at night which worried her a lot. She had lost interest in the things she enjoyed doing, like reading

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but no history of low mood, loss of appetite or lack of energy. She complained of abdominal discomfort characterized by episodes of nausea and bloating. These symptoms appeared often whenever she had unresolved conflicts with her father who was forcing her to marry SM; a man she did not love. She complained that SM was elderly and in his third order of marriage and might be having extramarital affairs with other women. Her father's insistence affected her concentration in school which led to poor academic performance.

On many occasions she switched off her phone to avoid SM. She often hid in her friends' room to minimise contact with SM. And as well she reduced the number of times she went home to visit her parents during the semester. She was already dating someone unknown to the father.

She had visited several clinics where she was treated for peptic ulcer disease without relief. She had abdominal ultrasound and chest x-ray but no abnormality was detected. Her condition deteriorated due to misdiagnosis. Frustrated with the results from the other hospitals, she decided to visit the tertiary health facility with expectations of correct diagnosis and cure. She never contemplated suicide or had weeping episodes nor delusions. There was no history of auditory, visual or olfactory hallucinations. She had no dizziness, fever, diarrhoea or vomiting. MM past medical history had been unremarkable.

Family and social history: MM was the third among five siblings in a monogamous setting. She had two elder married sisters and two younger brothers. Her two elder sisters married on coercion of their father against their desire. Her two younger brothers were aged 20 and 18 and they were doing well academically. She was a 300 level undergraduate. There was no personal or family history of psychiatric illness. She did not smoke cigarette or drank alcohol. Her father was a politician. They had good family support from both parents but her father was assertive and authoritative in actions and decisions.

Personal history: She was born into a Muslim monogamous family. She related well with her mother and siblings. As far as she knew, she did not have any developmental delay. She started school at six years and completed secondary school at the age of 17 years. She was reserved and had few friends with whom she related well. Her sexual debut was at 21 years with her 30 year old boyfriend – FG, whom she wished to marry instead of SM.

Gynaecologic and Obstetrics history: She attained menarche at 13 years. Her last menstrual period was on 6th June 2017. With a flow of 4 to 5 days in a 28 to 30 days cycle. There was no history of dysmenorrhoea, no vaginal discharge or dyspareunia. She was aware of contraceptives and practiced barrier methods.

General examination: She was young appearing woman.

Mental state examination: She looked worried but well dressed. Her speech revealed a normal thought content. She was oriented in time, person and place. Her judgment was not impaired. She could solve complex arithmetic problems. She had normal memories and discussed intelligently. She had insight into her illness.

Other systemic examinations: were essentially unremarkable

Assessment: Somatic symptoms and related disorder in a 300 level undergraduate who was under pressure to marry against her wish.

Diagnosis: A provisional diagnosis of somatic symptom and related disorder was made. A coexisting depression was considered as a differential diagnosis.

Management: She was informed and educated on the diagnosis. She was told she had a disease that affected the mind called a mental illness which can be triggered by a stressful life event like loss of a

valuable, dysfunctional home, denial of privileges or rights, and sexual abuse. The author agreed her feelings were real and asked for her cooperation in getting the solution to her problem. She was also made to understand that the problem was not life-threatening. She was informed that some patients with similar symptoms had spontaneous improvement. Regular two weekly follow-ups were scheduled to address the symptoms. She was advised to stop worrying excessively and engage more in those activities that made her happy like reading of novels.

She was referred to a clinical psychologist in her school who engaged her in a twice weekly 30 minutes of pychoeducation. The focus of the sessions was for the patient to gain deeper understanding of her problems and how she can take more control and increase the positive aspects of her own live. Other family members were encouraged to dissuade their father's marital preference for MM.

She was started on amitriptyline 25mg to be taken at night for two weeks. This was meant to address the aspect of a likely coexisting depression. She was told that the dose might be adjusted until she experienced the optimal effect. M.M was informed that maximum benefit might not be derived from the medication until after two weeks. She was told of the side effects of the amitriptyline which included dry mouth, drowsiness, weight gain and constipation. She was scheduled for follow-up in two weeks.

First follow-up visit: She returned back with FG after two weeks as scheduled. She felt better and her sleep was subjectively poor. She had tolerated her medication well but occasionally still felt the crawling sensation but had no more chest pain and palpitations. The couple was educated again on the condition and the treatment plan. FG was encouraged to give her the needed support and that they should get the support of respected Islamic scholar and key family members to talk with MM's father. A religio-cultural approach was adopted to resolve the family impasse.

The BATHE acronym technique was used to explore the psychosocial stressors in this case (thus; Background: "What is going on in your life?", Affect: "How do you feel about it?", Trouble: "What troubles you the most about that situation?", Handle: "What helps you handle that?" and Empathy: "This must be very difficult for you"). This technique was utilised during each visit. She was educated on the effects of emotions and stressors on her physical symptoms. She had some sessions of psychoeducation and admitted enjoying the sessions. Her mental state examination was normal. The dose of amitriptyline was increased to 50mg nocte to address the insomnia and a follow-up was scheduled after four weeks.

Second follow-up visit: She came as scheduled. She had improved significantly and no complaints. She understood the explanation of her diagnosis. She was continued on the same dosage of amitriptyline and scheduled for follow up four weekly. Meanwhile, she continued psychoeducation with the psychologist.

Subsequent follow up: She was seen three months after commencement of treatment. She was symptoms free for two months. She was able to recognize the association between her worry, worsening chest pain and palpitations. Her medication was tailed off and she remained well when the drug was finally stopped after six months of commencement of therapy.

Discussion:

Somatic symptom and related disorder (SSRD) is a clinical and public health problem that can lead to social dysfunction, occupational problems and increased healthcare use as seen in index case.[1] SSRD occurs frequently in primary care settings, where about half of all primary care visits for somatic complaints remain unexplained.[2]

The prevalence of somatic symptom disorder in the general population is about 5% to 7%,[1,3] making this one of the most common concerns in the primary care practice.[1,4] Two hospital-based studies in Nigeria revealed prevalence figures of patients with unexplained somatic symptoms of up to 30% and above.[5,6] It is often assumed that SSRD becomes manifest in response to severe psychosocial stress brought about by life events that are personally stressful to the individual.[1,7,8] In the case of MM, the likely stressor was the father's insistence on her marrying an elderly man against her wish and this demonstrates the typical practice in some African homes in spite of their level of civilization. The challenge in the primary care setting is being able to separate medical causes from physical symptoms while considering a mental health diagnosis[2,5]

MM's problem began before the age of 30 years with the complaint of pain affecting two body regions (chest and head), two gastrointestinal symptoms (nausea and vomiting), a sexual issue (dyspaurenia) and a pseudo-neurological symptom (crawling body sensation).[6, 9] MM had physical symptoms that have no physiological explanation resulting in many number of visits to physicians with inefficient physical examinations and laboratory investigations. Her symptoms persisted for months with associated poor academic performance and subsequent dissatisfaction with initial health care providers.[9, 10]

SSRD is likely to be caused by a combination of factors. The commonest triggers of SSRD include psychosocial stressors, such as a chronically stressful family situation; trauma (physical or sexual abuse), family conflicts, marital disharmony or death of a love one. [1,3,10] MM was overburdened by her father's despotic behaviours and actions on the decision of who she was to marry. According to some reviews, a civilized culture projects personal autonomy on marital decisions which is at variance with our report.[11]

Patients with SSRD often present with coexisting depression, anxiety, and substance use disorders.[8,9,10] The insomnia and loss of interest in activities MM experienced were suggestive of a comorbid depression. Hence it was taken into consideration during her treatment and the inclusion of anti-depression therapy (TCA).

The management of MM condition as packaged in psychoeducation should include basic principles of acceptance, non-judgmental approach and a consistent physician reassurance [9] Assuring MM that she was not making up the symptoms while helping her understand why they occurred has been identified as the first step in managing her condition.[5.6] Psychoeducation directed by physicians form the basis for successful treatment of SSRD in primary care settings.[7,8] Identifying the role of her family in her illness condition was another important step in dealing with the root cause of her symptoms[9] MM's boyfriend was therefore involved in the management. He was counselled and requested to give her the necessary support and approach religious leaders to intervene in the index case.

Family doctors and first contact physicians are critical to the successful detection and management of patients with somatic symptom disorder. Patients with SSRD utilize twice the number of medical outpatient visits and inpatient hospitalizations.[1,9] Therefore successful detection of SSD in primary care helps to reduce healthcare costs and improve patients care. Physicians need to be equipped to diagnose and manage such patients using biopsychosocial model like BATHE techniques and cognitive behavioural therapies. It is worthy of note that females suffer from SSRD more than their male counterpart in 10:1, due to a greater desire to respond to clinical symptoms.[12]

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