CASE STUDY OF A CHRONIC SOMATISING DISORDER

The difficulty of managing a patient with a chronic somatising disorder is highlighted in the case of Rebekah, an unhappily married middle-aged woman with children. She presented initially to her doctor with gait (walking) disturbance and over several years had multiple medical problems, with the most prominent symptoms being transient losses of vision, pain in the chest upon eating, and urinary incontinence. She was given a diagnosis of multiple sclerosis and this diagnosis was perpetuated in every correspondence from her doctor, which always began with "Please see Mrs X. who has multiple sclerosis". Eventually a neurologist reviewed this diagnosis with appropriate brain-imaging techniques and concluded that she did not have multiple sclerosis. Thus her medical symptoms were unexplained by any identifiable physical disease.

Rebekah was then referred to a psychologist and arrived at her first appointment in a wheelchair. Over the course of being seen regularly for two years, her symptoms improved. Management included facilitating good communication with all health professionals and discouragement of further medical investigation and surgical intervention (she had already had a number of unsuccessful surgical procedures performed on her gastrointestinal system and urinary tract). Psychological treatment began with an assessment of her symptoms and history, which included experiences of childhood sexual abuse. Treatment then focused on clarification and redefinition of the nature of her physical symptoms (reattribution), family sessions to facilitate open and healthy communication and support, relaxation techniques (since stress was found to play a role in exacerbating her symptoms), and providing opportunities for expressing distressing emotions. Her physical symptoms improved, as did the need for medical consultations. At the end of two years of treatment, she was beginning to participate again in the sort of activities that she had once enjoyed.

Rebekah's diagnosis was never fully resolved. Whether this was somatisation disorder depended on whether the symptoms were deliberately feigned or not. The possibility that it was a factitious disorder always remained a possibility. Furthermore, despite the best judgment being that she did not have multiple sclerosis, she did have physical symptoms, and the possibility that there was a physical cause for each of these could never be fully dismissed. Working with chronic somatising disorders requires that doctors, psychologists, and patients alike are able to tolerate these uncertainties regarding diagnosis and causal mechanisms.