Una valutazione della comorbilità tra sintomi ansiosi di panico e sintomi somatici

Un assesment psicosomatico

Agnieszka Woźniewicz[1]

Sommario

Il presente case study descrive la valutazione psicosomatica di un cliente con sintomi di panico in comorbilità con una diagnosi secondo ICD-10 di Disturbo dissociativo [di conversione]. Lo studio ha l'obiettivo di contribuire a una comprensione più dettagliata dei sintomi psicosomatici valutando il cliente attraverso strumenti self-report e un'intervista semi-strutturata. La valutazione psicosomatica è stata eseguita tramite il *Minnesota Multiphasic Personality Inventory-2* (MMPI-2), lo *State and Trait Anxiety Inventory* (STAI), il *Coping Inventory for Stressful Situations* (CISS) e il Genogramma. I risultati hanno mostrato che i punteggi più alti ottenuti all'MMPI-2 erano sulla scala dell'Isteria (Hy = 65), sulla scala della Mascolinità-femminilità (Mf) e sulla scala dell'Ipocondria (Hs = 57). Lo STAI ha mostrato bassi livelli di ansia stato (Punteggio Grezzo [PG] = 36) e ansia di tratto (PG = 40). Il CISS ha mostrato i seguenti punteggi: Coping orientato al compito: PG = 74, PS (Punteggio Standardizzato) = 9; Coping orientato alle emozioni PG = 43, PS = 5; Coping orientato all'evitamento: PG = 39, PS = 5. Il Genogramma ha indicato che la struttura familiare potrebbe rappresentare una fonte di stress per il cliente. L'MMPI-2 ha evidenziato la presenza di una sindrome psicosomatica che potrebbe essere associata allo stress suscitato da un funzionamento familiare alterato. Infine, sono discusse le implicazioni per ulteriori esami psicologici e la terapia.

Parole chiave

Psicosomatica, Sintomi somatici, Valutazione psicologica, MMPI-2, Funzionamento familiare.

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Examining the Comorbidity of Panic Anxiety and Somatic Symptoms

A Psychosomatic Assessment

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Abstract

This case study describes a psychosomatic assessment of a client with symptoms of panic anxiety in comorbidity with ICD-10 dissociative [conversion] disorders. The study aims to contribute a more nuanced understanding of psychosomatic symptoms by assessing a client using self-report tools and a semi-structured interview. The psychosomatic assessment was run via the Minnesota Multiphasic Personality Inventory-2 (MMPI-2), the State and Trait Anxiety Inventory (STAI), the Coping Inventory for Stressful Situations (CISS), and the Genogram. The result showed that the MMPI-2 highest scores were on the Hysteria Scale (Hy = 65), Masculinity-Femininity (Mf) scale, and Hypochondriasis (Hs = 57) scale. The STAI displayed low levels of state (raw score [RS] = 36) and trait anxiety (RS = 40). The CISS showed the following scores: Task-oriented coping: RS = 74, SS (standardized score) = 9; Emotion-oriented coping RS = 43, SS = 5; Avoidance-oriented coping: RS = 39, SS = 5. The genogram indicates that the family structure of the client could be a significant source of distress for the client herself. The MMPI-2 highlighted the presence of a psychosomatic syndrome that could be associated with stress stemming from impaired family functioning. Implications for further psychological examinations and therapy are also discussed.

Keywords

Psychosomatics, Somatic symptoms, Psychological assessment, MMPI-2, Family functioning.

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Introduction

Traditional nosography systems (i.e., the International Classification of Diseases, 10th Revision [ICD-10; World Health Organization, WHO, 1992] and the Diagnostic and Statistical Manual of Mental Disorders [DSM-5; American Psychiatric Association, APA, 2013]) have limited utility in the field of psychosomatics, a conceptual framework that studies the balance between health and disease, also considering the interaction among psychological, social, family, and biological factors (Fava et al., 2017). This case study illustrates a psychosomatic assessment of a client with panic anxiety symptoms and psychosomatic symptoms that satisfy the criteria for an ICD-10 dissociative [conversion] disorder. A psychosomatic assessment carried out via validated questionnaires could help the clinical psychological counselor to better understand the severity of symptoms and help them to suggest to the client an appropriate pathway, which, in the event of psychological symptoms, could be psychotherapy treatment. Reliable support in the decisional process could arise from scientific guidelines, for example, the National Institute for Health and Care Excellence guidelines (NICE) (e.g., Zisman-Ilani, 2021).

Case Description

The client is a 27-year-old female graduate, who is white Caucasian Polish, cisgender, has no siblings, is employed in a design office and lives with her parents. She has a male partner (her fiancé) and is planning her wedding. The client is neatly and carefully dressed but is characterized by a childish expression. During the psychological interview, she maintained the ability to stay focused during the conversation and to follow logical reasoning.

The client sought a psychological examination due to the following symptoms: anxiety with panic-related symptoms and worries about the sudden onset of uncontrollable anxiety. She reported that anxiety symptoms appeared for the first time at the age of 13 and developed gradually up to the age of 25, when they reached their highest intensity. Furthermore, the worsening of anxiety symptoms (feeling short of breath and breathing difficulty) was accompanied by the outset of somatic symptoms: trembling hands, numbness of the hands and face, and loss of vision. The possibility of a simultaneous occurrence of anxiety and somatic symptoms was reported by the client as a source of stress and worry. Since the client did not have a past medical history of neurological or medical disorders, she requested medical examinations. As a result, the client was examined by several medical specialists, such as internists and neurologists, and underwent various examinations (e.g., head CT scan, head MRI, comprehensive tests on

blood hormone levels, ultrasound scans of the thyroid gland, kidneys, carotid arteries, ECG, EEG, QEEG). However, she did not receive a medical diagnosis which could explain her somatic symptoms. Therefore, the absence of a medical diagnosis prompted the client to seek a psychological examination.

The client did not report a current or past history of alcohol or addictive substance abuse and did not smoke. She leads a healthy lifestyle, eating scrupulously selected and healthy foods. The client was found to be without a family history of mental disorders and did not have educational issues during schooling. On the other hand, the family history of medical diseases indicates that her great-grandmother suddenly died of a stroke. Moreover, the worsening of anxiety and the outset of somatic symptoms seems to have occurred when the client's mother confided in her about the involvement of the client's father in affairs with another woman. These two events were reported as a significant source of stress.

Concerning her family, the client reported that her relationship with her parents is very open, liberal, and close. The mother has always covered a relational function «as a friend» until the present, and they spend most of their time together, trusting each other with secrets. The client also indicates a close relationship with her father. They often spend time together and share common interests. Sometimes they organize trips for the two of them in which the mother does not participate. When asked how the client feels in their current relationship with her partner (fiancé), she is often absent, reporting that «*it is ok*», explaining that her partner is frequently away for work, adding that in his absence, she mainly spends time with her parents.

The current anxiety symptoms appear to have the features of panic anxiety disorders according to the ICD-10 criteria (F41.0). However, they do not meet the frequency criterion since symptoms occurred two/three times per month during the last six months.

Somatic symptoms (trembling hands, numbness of the hands and face, and loss of vision) without a medical diagnosis indicate a diagnosis of dissociative [conversion] disorders (F44.0) or somatoform disorders (F45.0) (WHO, 1992). In this line, the insurgence of somatic symptoms with no evidence of a physical disorder is in accordance with the (b) criteria of ICD-10 F44.0 [«no evidence of a physical disorder that might explain the symptoms» (WHO, 1992, pp. 153)]. Likewise, the insurgence of anxiety and somatic symptoms associated with a stressful family event (involvement of the client's father in affairs with another woman) is in line with the (c) criteria of F44.0 (i.e., clear association in time with stressful events and somatic symptoms) (WHO, 1992). A differential diagnosis was made with somatoform disorders, excluding this occurrence since the client did not report any irrational beliefs of having a medical disorder despite reassurances by doctors that the symptoms have no physical basis.

With this in mind, the present case study aims to run a functional, psychological assessment in order to enrich the clinical observation collected during the first phase of the interview, following a threefold approach.

1. Examining psychopathological symptoms through a standardized questionnaire (i.e., Minnesota Multiphasic Personality Inventory-2).
2. Measuring anxiety symptoms and coping strategies to stressful events since difficulty in managing stress and anxiety could be associated.
3. Examining whether the reported family functioning is associated with psychological distress.

Relationship between personality traits, somatic symptoms and anxiety symptoms in the MMPI-2

In line with the MMPI-2 framework, symptoms of acute anxiety and somatic complaints are reflective of a profile of clients that report elevated scores on the Hysteria scale (Hy). Furthermore, the association of anxiety symptoms and conversion symptoms is typical of a neurotic triad system, which is called in the MMPI-2 framework a «conversion valley» reflecting a characteristic of a hysterical personality with tendencies to conversion behaviour. Therefore, this score could corroborate the presence of a psychosomatic syndrome. Accordingly, the following hypothesis (H1) was formulated.

H_1: The client›s anxiety and somatic symptoms are reflective of a psychosomatic syndrome.

Relationship between panic anxiety symptoms and stress coping strategies

According to the cognitive theory of anxiety (Beck, 1976; Beck et al., 1985), panic symptoms could occur in people who tend to wrongly interpret various physical sensations or beliefs as threatening, irrationally leading to a sudden catastrophe (e.g., loss of consciousness, stroke, fear of losing control). In this line, panic-related symptoms typically develop and are sustained via dysfunctional cycles of thoughts, emotions, and sensations (Beck et al., 1985). Therefore, the rapid sharpening of anxiety symptoms could be due to the use of inappropriate methods of coping with stressful situations (e.g., avoidance of stimuli thought to be anxiogenic) (Beck et al., 1985). In accordance, the following hypothesis (H3) was formulated.

H_2: The levels of client anxiety are associated with dysfunctional stress coping styles.

Relationship between anxiety symptoms, somatic symptoms, and family functioning

The client maintains a very close relationship with her parents despite her adult age (e.g., parents who function as friends), highlighting a high involvement of the client in her family life. In line with Minuchin's (1974) approach, the symptoms may be conditioned by adverse family events and could be reflective of the dysfunction of the entire family system. Thus, in the client's onset of symptoms, high sources of stress could be associated with concerns related to the breakdown of the family system (i.e., the client's mother confided in her about the involvement of the client's father in affairs with another woman), creating vulnerability for anxiety and somatic symptoms. Therefore, the following hypothesis (H_3) was formulated.

H_3: The client has suffered an impairment of family functioning associated with psychological distress.

Purpose of the current case study

The aim of the current case study is to run a psychosomatic assessment to better understand the observed comorbidity of symptoms of panic anxiety and ICD 10 diagnosis of dissociative [conversion] disorders. To this end, the client was assessed via the Minnesota Multiphasic Personality Inventory-2 (MMPI-2), the State and Trait Anxiety Inventory (STAI), the Coping Inventory for Stressful Situations (CISS), and the Genogram.

Instruments

Minnesota Multiphasic Personality Inventory2 – Polish Version

The Polish version (Brzezińska et al., 2012) of the Minnesota Multiphasic Personality Inventory-2 (MMPI-2) (Butcher, 2000a; 2000b) was used to assess the intensity of the psychopathological symptoms. It comprises 10 clinical and 15 content scales. The MMPI-2 clinical scales include Hs (Hypochondriasis), D (Depression), Hy (Hysteria), Pd (Psychopathic Deviate), Mf (Masculinity-Femininity), Pa (Paranoia), Pt (Psychasthenia), Sc (Schizophrenia), Ma (Hypomania), and Si (Social Introversion) scales (Butcher, 2000a; 2000b).

State-Trait Anxiety Inventory (STAI) – Polish version

The Polish version (Wrześniewski et al., 2006) of STAI (Spielberger et al., 1983) was used to measure state and trait anxiety via two different scales. Each scale comprises 20 items that are rated on a 4-point Likert scale (Spielberger et al., 1983).

Coping Inventory of Stressful Situations CISS – Polish version

The Polish version (Strelau et al., 2007) of the Coping Inventory of Stressful Situations (CISS; Endler & Parker, 1990, 1999) was used to assesses the degree of the client in engagement with various coping activities during a stressful situation. The CISS assesses Emotion-oriented coping (Emotion scale), Task-oriented coping (Task scale), and Avoidance (Avoidance scale).

Genogram

A genogram (McGoldrick et al., 2008; Sitnik-Warchulska & Izydorczyk, 2018) of the client's family was constructed, considering three family generations (i.e., her parents and grandparents). The genogram was constructed based on a semi-structured interview (McGoldrick et al., 2008; Sitnik-Warchulska & Izydorczyk, 2018) concerning the following information: (1) demographic information; (2) functional information (i.e., data on the medical functioning of family members and emotional and behavioural problems in family members); (3) critical family events; (4) preceding generations (e.g., family health history, family rituals, and social roles in the family); (5) important events (e.g., cause of births and deaths, marriages, divorces and separations, difficulties, diseases in family life, conflicts and crises); (6) emotional relationships; (7) social roles in the family; (8) family adaptation (e.g., resources and ways of solving problems).

Assessment Results

Minnesota Multiphasic Personality Inventory 2 (*MMPI-2*)

Results of the MMPI-2 were found to be in the range of T 36-65, with all the scales falling within the average range, with the exception of the Hy, D, and Mf scales. The highest score was observed on the Hysteria Scale (Hy = 65), the second highest score on the Masculinity-Femininity (Mf) scale and the third highest score on the Hypochondriasis scale (Hs = 57). It reflected the so-called «conversion valley» well, characteristic of a hysterical personality with tendencies to conversion behaviour. Thus, H_1 was confirmed (i.e., the client's anxiety and somatic symptoms are a psychosomatic syndrome reflecting the «conversion valley» of the MMPI-2).

The State-Trait Anxiety Inventory (*STAI*)

The examined woman exhibits an average level of state anxiety (raw score [RS] = 36) and trait anxiety (RS = 40), which shows low levels of anxiety.

Coping Inventory for Stressful Situations (CISS)

Results observed from the CISS indicate that the client used a disadaptive style of coping with stress, mainly focused on problem-solving oriented to tasks (R = 74, Standardized Score [SS] = 9). In this view, the client also used coping styles focused on emotions (RS = 43, SS = 5) and avoidance (RS = 39, SS = 5) equally. Hence, H_2 is confirmed (i.e., levels of client anxiety are associated with dysfunctional coping styles in stressful situations).

Genogram

The data obtained from the genogram indicated that divorce is a significant problem in the family on her father's side. As the client claims, «it all started with my grandfather», who had three wives and eight children. A few years ago, the client's grandfather left his grandmother for another woman. Data from the genogram also highlighted a conflict between her grandfather and the rest of the family. Her grandfather is regarded as a traitor and excluded from all family celebrations. The genogram also confirmed the client's father had an affair, about which the client learned from her mother. Thus, according to the client's family functioning, the involvement of the father in affairs with another woman could be a source of relevant concern and stress (H_3 is confirmed, i.e., the client has suffered an impairment of family functioning associated with distress).

Discussion

Taking into account the specificity of the ailments reported by the client, i.e., symptoms of ICD-10 panic disorder accompanying a diagnosis of ICD-10 dissociative (conversion) disorder, a psychosomatic assessment was run. It encompassed the MMPI-2, the STAI, the CISS, and the genogram.

The result obtained from the MMPI-2 confirmed the first hypothesis, highlighting the presence of a psychosomatic syndrome having the characteristic of hysterical and conversion behaviour in the form of the «conversion valley».

The results observed from the STAI showed that the client showed low levels of anxiety measured on the STAI. Differently, the CISS showed high scores for task-oriented coping during stressful situations, followed by equally high scores for coping styles focused on emotions and avoidance. This confirmed H_2, and it could be hypothesized that the client has her peak of anxiety impairment during problem-solving activities (task-focused style of coping). Furthermore, higher levels of coping styles focused on emotions and avoidance are in line with the cognitive theory of anxiety disorders (Beck, 1976; 1985; Clark, 2006). According

to this framework, the maintenance and exacerbation of panic-like symptoms are sustained by the client's use of selective focus on anxiety symptoms (coping styles focused on emotions) and behavioural avoidance of anxiogenic stimuli (coping styles focused on avoidance). The result is the creation of «a vicious circle of avoidance», characterized by strong selective attention to body sensations that trigger anxiety, followed by safety behaviours (avoidance strategies) to guard against a sudden catastrophe such as collapse or death, or illness (Wells, 1997).

Lastly, divorce is a significant problem in the family on her father's side, confirming that the marital problem of parents associated with the high involvement of the client in the family structure could be a significant source of distress for the client herself. Thus, Hypothesis 3 is confirmed, too. It is in line with the theory of structural therapy by Salvador Minuchin (1987), which conceives that mental life also reflects the social environment in which the subject lives. Accordingly, the most important social group for the subject is their family, and changes in the family structure cause changes in the individual. Thus, data from the genogram suggest that a significant source of stress could be gained from the functioning of the client's family of origin. It could be hypothesized that to safeguard the integrity of the family and prevent the breakdown of her family of origin (i.e., separation of parents), the client has difficulty leaving her family home, despite her adult age.

Conclusion and suggestions for psychological therapy

Results of the psychological assessment highlight the presence of low anxiety symptoms associated with dysfunctional coping strategies for managing stressful situations. Furthermore, the MMPI-2 clearly showed the presence of a psychosomatic syndrome that could be associated with stress aroused from dysfunctional family functioning.

According to these results, the clinical psychological counselor could suggest psychotherapy treatment (NICE, 2022). For example, they could suggest cognitive psychotherapy for the client (Beck, 1976; 1985; Clark, 2006) to ameliorate and manage anxiety symptoms, and family therapy to target the overall family functioning and treat the client's psychosomatic symptoms.

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