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SOMATIZERS IN PSYCHIATRIC CARE

SANTOSH K. CHATURVEDI[1]
ALBERT MICHAEL[2]
S. SARMUKADDAM[3]

SUMMARY

Somatic symptoms are commonly reported by psychiatric patients. Sixty consecutively selected patients with predominant presenting complaints of somatic (bodily) symptoms were assessed using the Scale for Assessment of Somatic Symptoms. Physical and psychiatric examinations were performed. Somatisation cases were more often from 26-45 years age group, higher education, married and from urban background. Neurotic depression was the commonest diagnosis (62%), another 10% had M.D.P. Depression. Average numbers of somatic symptoms per patient was 4.65. Five or more symptoms were reported by 42% cases. Many cases had severe somatic complaints. The findings are compared with those of other studies on somatisation.

Somatic symptoms occur in all psychiatric illnesses and in some they dominate the clinical picture to such an extent that they exert a crucial influence on the perception of the illness. The result is that many psychiatric patients believe their illness to be physical in origin and this determines their pattern of consultation with the medical services (Lloyd 1986). They present to either General practitioners or medical specialists and describe their illness entirely in physical terms. Every physician is familiar with patients who persistently complain of somatic symptoms that either are devoid of a demonstrable organic basis or are considered to be grossly in excess of what one would expect on the grounds of objective medical findings (Lipowski 1986). This tendency to experience and communicate psychologic (or emotional) distress in the form of physical symptoms and to seek medical help, has been termed somatisation (Lipowski 1968, Kirmayer 1984).

In epidemiologic studies somatisation has been found to be very common in general medical clinic (Bain and Spaulding 1967), family practice (Spaulding 1977), primary practice (Schurman et al 1985) and in psychiatric disorders in primary care (Hankin and Oktay 1979, Parron and Solomon 1980). In primary care depressive and anxiety disorders account for most psychiatric diagnosis and most of these cases present with somatic rather than psychologic symptoms (Bridges and Goldberg 1985, Parker et al 1984, Widmen and Cadoret 1978). Somatization presenting in psychiatric practice which is usually a chronic problem has been termed as persistent somatization by Lipowski (1986).

Assessment of somatic symptoms has been a difficulty most clinicians have felt. Though diagnostic distinctions have been made in the DSM III (A.P.A. 1980), Feighner's criteria (Feighner et al 1972) and Research diagnostic criteria (Spitzer et al 1978), these are useful in identifying somatisation disorder, a clinically uncommon syndrome. However, most studies on somatic symptoms have made qualitative assessments and are usually descriptive in nature.

From India, systematic studies on

1. 2. Department of Psychiatry, NIMHANS, Bangalore 29
3. Statistical consultant, SEARCH, Ghadchiroli, Maharashtra.

non-organic somatic symptoms have been a few (Srinivasan et al 1986, Gautam and Kapur 1977). No standardised assessment of somatic symptom was employed in these. The present study has been conducted to investigate characteristics of somatic symptoms presenting in a psychiatric out patient department using the Scale for Assessment of Somatic Symptoms.

Material and Methods

This study was conducted at the Psychiatry out patient department of NIMHANS, Bangalore. Consecutive cases fulfilling the following criteria were included in the study.

Inclusion criteria:

i) age between 16-55 years.
ii) main volunteered complaint of any bodily symptom.
iii) At least two or more somatic symptoms.
iv) Duration of illness, more than 3 months.
v) Somatic symptoms cause either personal distress, or occupational, social or financial difficulties to such an extent to make the person seek medical help.
vi) Somatic symptoms are the main or chief complaint to seek help.

Exclusion Criteria:

i) Those who had identifiable organic pathology to explain the nature and extent of somatic symptoms.
ii) Evidence of mental retardation, alcoholism or drug dependence.
iii) Evidence of dementia or other organic psychosis.

Sixty consecutive cases who met the above criteria were included for detailed examination. Patients, and their relatives, were interviewed. The scale for assessment of somatic symptoms (SASS) was used to tap information on the somatic symptoms, their duration and severity. S.A.S.S. quantifies the somatic symptoms and has three subscales. It is easy to administer and it adequately records details of somatic symptoms. It has been found to have a good inter-rater and test-retest reliability (Chaturvedi and Sarmukaddam 1987). Psychiatric examination was done in detail and diagnosis ascribed according to International Classification of Diseases, ICD-9 (W.H.O. 1978).

Frequency distributions of somatic symptoms according to their severity were computed. Mean scores on the subscales and total scale were also calculated. The quantification was done using the criteria of duration of symptoms (during per week or day) as well as severity (mild, moderate, severe). Criteria for severity were: mild - symptom of low intensity without affecting biological functions (sleep, appetite, libido), social or occupational functions; moderate-disturbance of sleep, appetite and libido, but not of social or occupational function; severe: Disruption of biological and social functions.

Results

Characteristics of sample: The sociodemographic and clinical characteristics are described in tables 1 and 2 respectively. Males were over represented (57%). Nearly 70% cases were aged between 26-45 years. Nearly one third of the cases were illiterate and 40% had education upto or above matriculation. There were 83% married and 70% urban background cases.

80% had a duration of illness more than six months and nearly half the sample had a duration longer than two years. There was no precipitating factor in 72% of the cases. Onset was insidious in 77% cases. Only 6 cases (10%) had previous

Table 1
Socio Demographic Characteristics

Variable	n	%
Age (in years)		
15 – 25	9	(15)
26 – 35	28	(47)
36 – 45	13	(22)
46 – 56	10	(16)
Sex		
Male	34	(57)
Female	26	(43)
Education:		
Illiterate	18	(30)
Below Matric	18	(30)
Matriculate	18	(30)
Above Matric	6	(10)
Marital Status:		
Single	10	(17)
Married	50	(83)
Background:		
Rural	18	(30)
Urban	42	(70)

Table 2
Clinical Characteristics

	n	(%)
Duration of Illness:		
Less than 6 months	12	(20)
6 months – 2 years	20	(34)
2 – 5 years	14	(23)
More than 5 years	14	(23)
Precipitating Factor		
Absent	43	(72)
Present	17	(28)
Onset		
Acute, Sub Acute	14	(23)
Insidious	46	(77)
Past Illness:		
Absent	54	(90)
Physical	3	(5)
Psychiatric	3	(5)
Course of Illness:		
Constant	21	(35)
Improving	25	(42)
Deteriorating	14	(23)

physical or psychiatric illness. The course of illness had remained constant or was worsening in 58% of the cases and improving in another 42% of the cases.

Neurotic (and/or reactive) depression was the commonest diagnosis (62%). Another 10% had M.D.P. (depression) and 16% had anxiety neurosis.

Description of Somatic Symptoms

The number of Somatic symptoms, which were the predominant feature of patients' presentation, ranged from 2 to 13. Average number of symptoms was 4.65. 42% cases had five or more symptoms, 33% had four somatic symptoms and 15% had three symptoms. Only six cases had two somatic symptoms (Table 4). The frequency of the occurence of different somatic symptoms is given in Table 5. The commonest somatic symptoms were sleep, appetite disturbance (83%), weakness of body or mind (72%), headache (67%), fatiguability, lethargy (37%), burning sensations (35%) and giddiness (27%). Thirteen cases (22%) had whole body pain or generalised (multiple) aches and pains. Infrequent somatic symptoms were feelings of heat and cold, and tingling, numbness.

Severity of these somatic symptoms is presented in Table 6. Frequent somatic symptoms which were severe (disrupting

Table 3
Clinical Diagnosis

	n	%
Depression (Neurotic or reactive)	37	(62)
Anxiety Neurosis	10	(16)
M.D.P. (Depression)	6	(10)
Others*	7	(12)

(* Includes one case each of prolonged Depressive adjustment reaction, unspecified personality disorder, Schizo-affective psychosis, obsessive compulsive neurosis, hysterical neurosis, mixed neurosis and post traumatic personality change).

Table 4
Number of Somatic Symptoms

Number of Symptoms	n	%
Two	6	(10)
Three	9	(15)
Four	20	(33)
Five	16	(27)
More than five	9	(15)
Range of Symptoms	2–13	
Average number of symptoms	4.65	

Table 5
Frequency of Somatic Symptoms

Site of Symptom:	n	(%)
Headache	40	(67)
Backache	9	(15)
Abdominal Pain	12	(20)
Pain limbs	11	(18)
Whole body or Generalised	13	(22)
Qualitative symptoms:		
Burning sensation	21	(35)
Feeling of heaviness, movement, 'Gas'	6	(10)
Tingling, numbness	4	(7)
Heat and/or cold Sensations	2	(3)
Palpitations, Breathlessness	17	(28)
Other Somatic Symptoms:		
Weakness of body or mind	43	(72)
Giddiness, fainting	16	(27)
Fatiguability, lethargy	22	(37)
Trembling	13	(22)
Biological function disturbances	50	(83)

Table 6
Severity of Somatic Symptoms

Symptom	Frequency	Mild	Moderate	Severe
Headache	40	10	1	29
Backache	9	1	4	4
Pain Abdomen	12	6	3	3
Pain Limbs	11	3	2	6
Generalised Aches	13	2	2	9
Burning Sensation	21	4	3	14
Heaviness, Fullness	6	4	1	1
Tingling, numbness	4	3	1	0
Heat & cold sensation	2	1	1	0
Palpitations	17	8	6	3
Weakness of body/ Mind	43	8	10	25
Giddiness, Fainting	16	5	1	10
Lethargy, fatiguability	22	6	10	6
Trembling	13	6	1	6
Biological functions	50	23	16	11

social, occupational and biological functions) were headache (48%), weakness of body and mind (42%), burning sensation (23%) and generalised aches (15%). On the other hand, if severity of the symptoms is seen in the cases reporting the symptoms, it can be noted that many somatic symptoms have severe degree of the symptom. Regarding headache 29 of the 40 cases (73%) reporting headache, had severe intensity. Similarly 69% of cases of generalised aches, 67% of those reporting burning sensations, 63% of giddiness, fainting cases, 58% of those reporting weakness of body or mind, 55% of pain limb cases and 44% of backache cases reported their symptoms to be severe. Symptoms of mild intensity, which reported to the clinic were pain abdomen, feeling of heaviness, tingling or numbness and palpitations.

Discussion

Gautam and Kapur (1977) had studied somatic symptoms at the same centre as that of the present study. However, their inclusion criteria were liberal and included patients who reported one (or more) somatic symptom. They reported that nearly 30% of patients attending psychiatric clinic had one or more somatic symptom. Though there is an over-representation of males, in this report it is a reflection of the clinic trend rather than true association.

In the present study, somatizers have been found to occur in 26-45 years age group (70%), less educated (90%) (matric or below). Religion and family type were not studied which was done by Gautam and Kapur (1977).

Somatisation may occur at any age, but it appears to be most common in the middle aged, this has been reported by other studies as well (Kellner 1985, Katon et al 1984, Fine 1977). Contrary to the common belief it is not excessively frequent among the elderly (Lipowski 1986). Also the sex distribution in the present study is similar to that reported by Slavney and Teitelbaum (1985) and Gautam and Kapur (1977).

The presenting somatic symptoms are protean in nature and can draw attention to any organ in the body (Lloyd 1983). The commonest somatic complaints have been found to be pain (in abdomen, chest or head), dizziness, weakness, fatigue, palpitations, numbness etc., (Lloyd 1986, Gautam and Kapur 1977, Srinivasan et al 1986). The current study also has confirmed the presence of these features as very common. Many, in the present study, had also lack of sleep, appetite and libido. The findings in Table 6 are very interesting, and indicate treatment seeking due to different symptoms. Headache, generalised aches, burning sensations, weakness, giddiness were of severe intensity in the cases who reported these, on the contrary, symptoms like palpitations, numbness, pain abdomen, trembling, sleep and appetite disturbances were reported more frequently, even when mild in intensity. This reflects that symptoms related to heart or neurological problems are perhaps perceived are more serious as compared to headaches, weakness and generalised aches and pains.

Our findings regarding diagnosis are also similar to those of other studies. Neurotic illnesses are very commonly diagnosed in patients with non-organic somatic symptoms, Lastly it must be remembered that somatization constitutes a major clinical and economic problem and maladaptive mode of coping with life stress.

Patients with somatic symptoms should neither be ignored, nor neglected due to the nature of their symptoms. Treatment may not be very easy in many cases, nevertheless efforts based on scientifically sound multipronged approaches may be beneficial.

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