CLINICAL RELATIONSHIP BETWEEN NONSPECIFIC AND SPECIFIC SYMPTOMS IN NON-PSYCHOTIC MORBIDITY

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SUMMARY

The phenomenon of non-specific somatic symptom presentation by patients with non-psychotic mental morbidity attending primary care clinics is a well recorded one. The nature of clinical relationship of these symptoms to specific psychiatric phenomena was studied in a group of non-psychotic patients attending a primary care general hospital clinic. It was seen that both types of symptoms occur with equal frequency in these patients. It appears that non-specific symptoms are a preferred mode of presentation of this category of patients rather than the possibility that they totally 'mask' or predominate more than specific psychiatric phenomena.

It has been fairly well established that the rate of psychiatric morbidity in developing countries is as much as in the developed countries. For example in the WHO collaborative study on strategies for extending mental health care in four developing countries, the recorded frequency was 10.6 to 17.7% a rate just below the percentages found in industrialised nations (Harding et al., 1980). With an estimated prevalence of severe mental disorders in India at around 1 to 2% (Wig, 1984) majority of psychiatric morbidity is made up by minor non-psychotic illnesses and it is becoming increasingly evident that large number of patients with psychiatric problems are receiving mental health services from non-psychiatric settings (Yager & Wells, 1984).

However it has been observed that at the primary care level the phenomena in psychiatric patients is of an undifferentiated nature (Sen, 1987). In a general hospital in Sri Lanka, patients presented with several somatic symptoms which were peculiar to them but could not be identified as psychiatric in origin by the medical officers (Nikapota et al., 1981). In common clinical experience emotionally disturbed patients have many bodily complaints and may attribute their disabilities wholly or partly to physical illness (Shepherd et al., 1966). In India, Wig and Singh (1967) pointed out that multiple somatic complaints without demonstrable physical illness continue to be the commonest neurotic presentation in General Hospital Psychiatric Clinics. Such a non-specific clinical presentation of non-psychotic patients could be factor leading to inappropriate medical treatment from the existing health services in India. These non-specific symptoms could be:

(i) Totally "masking" an underlying emotional disorder in which presence of emotional disturbance is inferred more than clinically elicited as seen in psychogenic pain disorder.

(ii) Forming a predominant component of a disorder in which emotional symptoms are less prominent, like in Hypochondriasis and some of the Somatiform Disorders.

(iii) Co-occurring with equally prominent emotional symptoms but are clinically reported by the patient in preference to the emotional symptoms for various reasons unrelated to the psychiatric disorder.

This study was conducted with an aim to
observe which of these 3 possibilities explain the presentation of non-specific symptoms by patients with non-psychotic morbidity especially in a general primary care setting.

MATERIAL AND METHODS

100 new adult patients selected by systematic random sampling from the general outpatient department of Sri Ramachandra Hospital, Porur, near Madras city formed the study group. There were 42 males and 58 females in this group. This group represented the patient population attending this hospital in terms of educational level, occupation, socio-economic class and urban/rural living conditions. Only 39% of them have undergone at least primary school education. Three fourths of them were engaged in labour work and belonged to the low socio-economic class with daily wages ranging from Rs. 8 to Rs. 15. 90% of them were from rural areas around the city and 50% were married.

Symptom Check-list

This check-list administered to the study group, consists of 2 sections with 11 questions each, to be answered in terms of yes and no (see appendix). The Section I scored presence of non-specific symptoms which have to be present for a period of at least 3 months to be considered present and Section II scored specific psychiatric symptoms. The list of these of two types of complaints was formulated mainly from the common complaints given by patients at the general clinic of the outpatient department recorded at a pilot study done by the authors at the same hospital. It also looked into the symptoms scored in the commonly used questionnaires like the Self Report Questionnaire (Harding et al., 1980). In the section I, a dimension of severity of complaints, in terms of total duration or frequency was included as it was observed in a previous study by authors (to be published) that these non-specific symptoms presented by the patients with psychiatric disorder tend to be longer duration (3 months and more).

Examination of this study group

One of the authors initially administered the check-list. The patient was then examined by the other author who conducted a clinical psychiatric interview, blind to the check-list scoring. The patient was referred to the General Physician, who routinely examines all new cases registering at the hospital and refers to appropriate specialists when needed. The diagnosis of physical illness, if present, was recorded. I.C.D,-9 (WHO, 1978) was used for psychiatric diagnosis, keeping in mind its applicability in primary care setting (Sensky, 1986).

RESULTS

Psychiatric Morbidity

Out of 100 patients in the study group, 61 (61%) had a diagnosable psychiatric disorder, 20 (20%) of them having only psychiatric illness (Group A), and the remaining 41 (41%) having both psychiatric and physical illnesses (Group B). 39 (39%) patients of the study group had only physical illness (Group C). There were significantly more females in the psychiatric group (females = 43 and males = 18, $\chi^2 = 10.25$, $p < .001$). There was no significant difference ($\chi = 1.83$) in the mean ages of the psychiatric group (Mean ± S. D. = 35.5 ± 12.7 Yrs) and the physically ill group (Mean ± S. D. = 31.4 ± 11.1 Yrs). There were no cases of psychosis or any other major disorder. Depression was the commonest diagnosis made (26 cases). Other psychiatric diagnoses were—anxiety state (9 cases), adjustment disorder (18 cases), psychalgia (5 cases), hypochondriasis (1 case) and alcohol dependence syndrome (2 cases).

Symptom check-list scores

The scores on the check-list were analysed for the following:
(1) **Between group differences:**

Differences in the mean scores in sections I & II between the psychiatric and physically ill groups.

(2) **Within group differences:**

The two psychiatric groups A & B were examined for intra group differences in proportion of the total number of items scored in each of the two sections of the check-list.

The following are the results obtained:

(1) **Between group differences:**

The mean scores of the three patient groups—A, B and C, on each of the two sections of the check-list was compared using analysis of variance (ANOVA). In both section I (non-specific symptoms) and section II (specific psychiatric symptoms), the variance ratio \( F \) was highly significant at less than 1% level of significance (See Tables I & II). This means that the three groups differ significantly in their mean scores from one another. Testing out which of the group means differ significantly by finding the 'Critical Difference' (C.D.), it was seen that both groups A (pure psychiatric) and B (combined illness) differ significantly from group C (pure physically ill) on both the section of the check-list (see Table I & II). There was however no difference between the groups A & B.

(2) **Within group differences:**

(i) **Group A:** The maximum total score possible in each section is 220 (No. of patients × No. of items = 20 × 11). There was no significant difference (\( z < 1.63 \)) in the proportions of non-specific symptoms (116/220) and specific psychiatric symptoms (133/220) scored.

(ii) **Group B:** The maximum total score in each section is 451 (No. of

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**Table I.** Inter-group comparison of mean scores using ANOVA non-specific symptoms

| Source of variation | Sum of squares (SS) | Degrees of freedom (d.f.) | Mean S.S. (SS/d.f.) | F ratio | Patient group | Mean | Difference | Critical difference |
|---------------------|---------------------|---------------------------|--------------------|---------|---------------|------|------------|---------------------|
| Between groups      | 641.32              | 2                         | 320.66             | 52.13*  | A             | 5.65 | 1.69                   | 1.75               |
| Within groups       | 596.64              | 97                        | 6.25               |         | B             | 7.54 | 5.59**                 | 1.45               |
| Total               | 1237.97             | 99                        |                    |         | C             | 1.95 | 3.90**                 | 1.76               |

**Patient groups:**
- A—Psychiatric illness only.
- B—Combined psychiatric & physical illness.
- C—Physical illness only.

**p < .001**

**Table II.** Inter-group comparison of mean scores using ANOVA specific psychiatric symptoms

| Source of variation | Sum of squares (SS) | Degrees of freedom (d.f.) | Mean S.S. (SS/d.f.) | F ratio | Patient group | Mean | Difference | Critical difference |
|---------------------|---------------------|---------------------------|--------------------|---------|---------------|------|------------|---------------------|
| Between groups      | 816.00              | 2                         | 408.00             | 47.82*  | A             | 6.65 | 0.30                   | 2.07               |
| Within groups       | 836.45              | 97                        | 8.62               |         | B             | 6.95 | 5.95**                 | 2.06               |
| Total               | 1652.51             | 99                        |                    |         | C             | 1.00 | 5.65**                 | 1.69               |

**Patient groups:**
- A—Psychiatric illness only.
- B—Combined psychiatric & physical illness.
- C—Physical illness only.

**p < .001**
patients × No. of items = 41 × 11). There was no significant difference (z = 0.76), in the proportion of non-specific symptoms (290/451) and specific psychiatric symptoms (279/451) scored.

**DISCUSSION**

Non-specific symptoms are common in the community and Leighton concluded that about a third of all complaints referable to a system of the body have roots mainly in psychological factors (Creed and Murphy, 1982). The majority of patients attending General Practitioners Clinics reported rather ill defined somatic complaints like headache, pain in the chest, anorexia, undue fatigue, dizziness, weakness and loss of control of limbs (Shepherd et al., 1966). Somatic symptoms were present in about half the cases and excessive concern with bodily function in a quarter of the general practice population (Goldberg et al., 1976). Bodyache, lassitude, fatigue have been found very common among those with psychiatric problem in a general hospital population (Bagadia et al., 1986). In a primary care clinic in India, Sen (1987) found that non-specific symptoms ‘Can't think clearly’, ‘daily work suffering’, ‘always tired’ on the Self Report Questionnaire explained the difference between psychiatric cases and non-cases more than a specific symptom like ‘feeling unhappy’.

It is frequently reported that general practice depressions are especially likely to present with complaints that are partly or wholly somatic in nature (Blacker and Clare, 1987). Watts (1970) studying depressed primary care patients, found that the commonest presenting symptoms were, tiredness, shortage of energy, feelings of being weak, feeling rundown, headache, backache, insomnia, pain in chest, giddiness, pain in trunks, arms and legs. Some of the somatic symptoms presented by psychiatric patients are autonomic features of anxiety, but it is not fully understood why these and other bodily sensations should often be the focus of the patients’ concern when consulting the general practitioners (Goldberg et al., 1976). Whatever the reasons, it is no new phenomenon as shown by the lengthy coverage of physical symptoms of neurosis in many older text books on neuroses like that by Dejerine and Gauckler in 1913 (Gelder et al., 1985). Blacker and Clare (1987) commenting on the presentation of non-specific somatic symptoms in depressions, found that it does not seem to be that depressive features are absent or that these disorders are true marked depressive but the key symptoms are obscured by a great deal of ‘somatic noise’.

This study attempted to answer why patients with non-psychotic morbidity frequently present with non-specific somatic complaints and posed 3 possibilities (vide supra). The results show that the 3rd possibility i.e., the non-specific symptoms co-occur with equally prominent emotional symptoms but are clinically reported by the patients in preference to emotional symptoms for various reasons unrelated to the psychiatric disorder, seems applicable in explaining this phenomenon. This conclusion is drawn from the observation of the results which show that the psychiatric patients have both types of symptoms to the same degree.

**Why non-specific symptoms**

The reason why psychiatric patients should present with somatic complaints in preference to specific psychiatric phenomena has been variously explained. Shepherd et al. (1966) attributed them in part to the doctors’ perception and patients’ cultural background with the minor somatic complaints being the signals of distress acceptable to both. Goldberg & Blackwell (1970) applied the ‘illness behaviour’ concept of Mechanic to explain this phenomenon of
patients presenting with psychiatric illness symptoms of a physical rather than psychiatric nature. They explained 3 reasons why patients do so. One is in terms of social learning, patients may have learned that doctors deal with physical illness and so expect them to produce physical symptoms. The patients expect that the doctors would ultimately get to the bottom of their problems (which, however, frequently fails to occur). Second is that the somatic symptom has been present for sometime, and occurrence of psychiatric illness worsens it, thus making it a focus of concern at medical consultation. Thirdly is that the patient feels that it is more acceptable to be physically ill than emotionally ill to avoid the stigma of being thought as a 'Psychiatric case'. Citing Leff's scheme for historical development of the words that denote unpleasant emotional states, Sen (1987) found in his study group, that the degree of undifferentiated experience, or its lack, cuts across somatic and psychological experience and the unidirectional Leff's scheme could not explain why most Indians express their distress in mostly undifferentiated terms, especially when the parent language viz., Sanskrit, from which the majority of lingua franca have developed, contains words exemplifying almost every shade of emotion. He has proposed a model to explain this phenomenon with a limited application to extramural patient settings, on two dimensions of psychologization-somatization and differentiated-undifferentiated experiences.

Hence the phenomena of non-specific symptoms presented by psychiatric patients, especially the minor emotional disorders at primary care level is seen to be an usual phenomenon. They seem to be a more acceptable mode of signalling psychiatric distress and do not mask or occur more frequently than the specific psychiatric phenomena and this illness behaviour takes roots in the socio-cultural and linguistic characteristics of the patients as well as mutual expectations of the doctor and the patients in the clinical situation.

From the results obtained in this study, it appears feasible that cases with non-psychotic mental morbidity can be detected in primary care facilities by a screening method just by enquiring about presence of certain non-specific somatic symptoms of a certain duration (3 months and more). Such a screening method will have an advantage over other methods which require elicitation of specific psychiatric phenomena because the non-specific symptoms are both easily and readily reported by the patient and can as easily be elicited and interpreted by primary care personnel. Attempts at developing such a screening instrument has been made by the authors and it has been found to be applicable in general care clinics with satisfactory results (Srinivasan and Suresh, 1988).

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APPENDIX -I

**Symptom check-list**

Score the following items in terms of ‘Yes’ or ‘No’.

**Section I (Non-specific symptoms)**

Does the patient have any of the following symptoms often or continuously for past 3 months or more:

1. Generalised body aches and pains
2. Headache
3. Pain in the chest
4. Shortness of breath
5. Unduly tired, fatigued
6. Feeling giddy, dizzy
7. Feeling weak
8. Unable to work as before
9. Sleep difficulties
10. Loss of or reduced appetite
11. Forgetfulness

**Section II (Specific psychiatric symptoms)**

Does the patient have any of the following symptoms:

1. No able to mentally cope with work.
2. Often worried about self/family work/money/future/etc.
3. Feeling tense.
4. Restless or nervous at times.
5. Feeling mentally dull.
6. Disinterested in work/entertainment/daily routine/outing/etc.
7. Feeling like “running away from everything”.
8. Fear afraid that something bad is going to happen.
9. Have palpitation, tremulousness/excess sweating/dry mouth/shortness of breath.
10. Feel sad, hopeless, useless and feeling it is better to die.
11. Unable to think clearly/feeling confused in mind/unable to decide.