A CLINICAL STUDY OF SOMATIZING PATIENTS ATTENDING
PSYCHIATRIC OUTPATIENT CLINIC

R. K. CHADDA¹, M. S. BHATIA²

SUMMARY

Patients presenting with bodily symptoms without any demonstrable physical basis were studied. Somatisation was observed in more than 80% of the sample studied. A higher percentage of somatisers were found in females, age groups 35-44 and above 55, unmarried and illiterate groups. Housewives formed the largest group of somatisers amongst different occupations. Common diagnoses amongst somatisers were neurotic depression, hysterical neurosis, anxiety neurosis and endogenous depression.

Somatisation refers to a tendency to experience and communicate somatic distress and symptoms unaccounted for by pathological findings, to attribute them to physical illness and to seek medical help for them (Lipowski, 1988). The phenomenon is very common in medical as well as psychiatric practice and has been reported from all over world. Somatisation is found more commonly in developing countries (Lambo, 1960; German, 1972; Kirmayer, 1984). In western population such symptoms are usually reported by the patients from lower socio-economic status and immigrants from the non-western countries (Eskobar et al., 1987; Lipowski, 1988).

A large number of psychiatric patients in developing countries present with physical symptoms without any demonstrable physical basis. Such patients are very common in the medical practice and are often misdiagnosed as having physical illness and subjected to a variety of unnecessary investigations.

It would be interesting to study the diagnostic status of such patients and whether these patients differ from the one's presenting with psychological complaints. In its ‘Strategies for Research on Mental Health’, Indian Council of Medical Research (ICMR) has also stressed the need for studies on this aspect, as these patients form a bulk of population attending various medical clinics.

This study was done keeping in view the above mentioned issues with the following aims:

1. To study the frequency of physical symptoms in patients attending psychiatric outpatient clinic of a general hospital and their diagnostic status.
2. To study whether the somatising patients differ from non-somatising patients in any significant way.

METHODOLOGY

Sample consisted of 200 consecutive new patients attending the psychiatry outpatient clinic of Guru Teg Bahadur Hospital, Delhi. A detailed psychiatric examination was done and socio-demographic details recorded on a proforma designed for the study. A list of physical symptoms (modified from somatisation symptoms list of DSM III-R) was adapted to screen for physical symptoms. Only those physical symptoms were recorded as indicative of somatisation, which fulfilled criteria for somatisation given by Bridges and Goldberg (1985) i.e. the patient must a) seek medical help for somatic symptoms and not for psychological manifestations of psychiatric disorder b) attribute their symptoms to

¹ Lecturer & Incharge, Department of Psychiatry, University College of Medical Sciences & G. T. B. Hospital, Shadara, Delhi-110032.
² Lecturer.
physical illness and c) report, when properly interviewed, symptoms that justify psychiatric diagnosis.

The data was collected on first clinical interview. Diagnoses were made according to ICD-9. 11 patients were found to have no psychiatric illness and were therefore excluded from the study. Another 16 patients, who had a diagnosis of organic brain syndrome and drug or alcohol dependence, were also excluded from the study. Thus 173 patients formed the sample for analysis.

RESULTS

Socio-demographic details of the sample are given in the Tables 1-4. 140 (80.97%) patient presented with somatisation of them 79 (45.7%) were males and 94 (54.3%) were females. Somatisation was more common in females (Table 1). A high percentage of somatisation was also found in the age groups 35-44 and 55 and above (Table 1). A statistically significant relation was found between age and somatisation. 70.5% of the patients were unmarried, 24.9% married and 4.6% were widows, widowers. Somatisation was found to be significantly more common in unmarried, widow widowers.

Educational status of the somatisers and non-somatisers is shown in the Table 2. A higher prevalence of somatic symptoms was

### Table 1. Age* & Sex** distribution of somatisers and non somatisers (N=173)

| Age (in yrs.) | Somatisers (N=140) | Non-Somatisers (N=33) | Total (N=173) |
|---------------|--------------------|-----------------------|---------------|
|               | Male   | Female | Total | Male | Female | Total | Male | Female | Total |
| 1. less than 15 | 2      | 3      | 5     | 3    | 3      | 6     | 5    | 6      | 11    |
| 2. 15-24      | 25     | 3      | 28    | 4    | 2      | 6     | 20   | 15     | 35    |
| 3. 25-34      | 19     | 27     | 46    | 8    | 4      | 12    | 27   | 31     | 58    |
| 4. 35-44      | 16     | 22     | 38    | 0    | 3      | 3     | 16   | 25     | 41    |
| 5. 45-54      | 3      | 11     | 14    | 5    | 0      | 5     | 8    | 11     | 19    |
| 6. 55 & above | 3      | 5      | 8     | 0    | 1      | 1     | 3    | 6      | 9     |
| total         | 59     | 81     | 140   | 20   | 13     | 33    | 79   | 94     | 173   |

*X^2 = 11.73, d.f. = 5, p < 0.5, **X^2 = 2.96, d.f. = 1, N.S.

### Table 2. Relation between education and somatisation * (N=173)

| Education Level | Somatisers (N=140) | Non-somatisers (N=33) | Total (N=173) |
|-----------------|---------------------|-----------------------|---------------|
|                 | Total               |                       |               |
| 1. Illiterate   | 42                  | 6                     | 48            |
| 2. Literate     | 13                  | 4                     | 17            |
| 3. Primary      | 15                  | 5                     | 20            |
| 4. Middle       | 16                  | 6                     | 22            |
| 5. Matric       | 23                  | 4                     | 27            |
| 6. Inter/Diploma| 13                  | 2                     | 15            |
| 7. Graduate     | 15                  | 4                     | 19            |
| 8. Masters/Professional | 3 | 2 | 5 |
| total           | 140                 | 33                    | 173           |

*X^2 = 5.08, d.f. = 7, N.S.

### Table 3. Relation between income and somatisation* (N=173)

| Income       | Somatisers (N=140) | Non-Somatisers (N=33) | Total (N=173) |
|--------------|--------------------|-----------------------|---------------|
|              | Total              |                       |               |
| 1. Nil       | 25                 | 9                     | 34            |
| 2. 0-199     | 15                 | 1                     | 16            |
| 3. 200-499   | 50                 | 12                    | 62            |
| 4. 500-999   | 34                 | 8                     | 42            |
| 5. 1000-1499 | 9                  | 0                     | 9             |
| 6. 1500 & above | 7               | 3                     | 10            |

*X^2 = 5.81, d.f. = 5, N.S.*
found in the illiterate, though it did not reach statistical significance.

Distribution of somatisers and non-somatisers in different income groups is shown in Table 3. A higher percentage of somatisation was observed in the income groups 0-199 and 1000-1499, but it did not reach statistical significance.

Table 4 shows the occupational status of the sample. A higher percentage of somatisation was seen in the farmers, skilled workers and the housewives, though it did not reach statistical significance.

| Occupation          | Somatisers (N=140) | Non-somatisers (N=33) | Total (N=173) |
|---------------------|--------------------|-----------------------|---------------|
| 1. Professional     | 1                  | 1                      | 2             |
| 2. Semi professional| 1                  | 1                      | 2             |
| 3. Clerical         | 17                 | 4                      | 21            |
| 4. Business         | 14                 | 4                      | 18            |
| 5. Farmer           | 5                  | 0                      | 5             |
| 6. Skilled worker   | 8                  | 1                      | 9             |
| 7. Unskilled worker | 4                  | 2                      | 6             |
| 8. House wife       | 68                 | 9                      | 77            |
| 9. Student          | 15                 | 4                      | 19            |
| 10. Unemployed      | 7                  | 7                      | 14            |

X²=20.08, d.f.=9, N.S.

A majority of the sample was formed by different neurotic disorders with neurotic depression leading the list (Table 5). Common diagnoses among the somatisers were neurotic depression, hysterical neurosis, anxiety neurosis and endogenous depression. All patients with a diagnosis of neurotic depression and hysterical neurosis presented with physical symptoms.

A variety of physical symptoms referring to different body systems were reported by the patients. Headache, subjective weakness (lethargy and lack of energy were the other terms used by the patient) and vague somatic complaints were the three most common symptoms reported by more than 40% of the sample and more than 50% of the somatisers. Fifteen physical symptoms most frequently reported by the sample in descending order of frequency are shown in Table 5.

| Symptom                | Percentage |
|------------------------|------------|
| 1. Subjective weakness | 45.09      |
| 2. Headache            | 44.51      |
| 3. Vague somatic complaints | 42.20      |
| 4. Palpitation         | 27.83      |
| 5. Pain in extremities | 27.23      |
| 6. Chest pain          | 18.49      |
| 7. Fis                 | 12.14      |
| 8. Giddiness/Dizziness | 11.56      |
| 9. Heaviness in head   | 10.40      |
| 10. Pain abdomen       | 8.67       |
| 11. Gas abdomen        | 6.94       |
| 12. Tremor in hands   | 6.94       |
| 13. Irregular bowel habits | 6.36       |
| 14. Numbness of peripheries | 6.36     |
| 15. Irregular menstr. Cycles | 3.78       |

51% of the patients were referred from other clinics of the hospital, majority of them (44%) from the department of medicine. Others were self-referrals. Hospital referrals formed 65% of the somatiser group.
DISCUSSION

The phenomenon of somatisation has been reported from all over the world, more commonly from the third world countries and cultures, where physical symptoms rather than psychological distress are considered as indicative of disease. This cultural belief makes a patient to adapt the somatic symptoms, which he thinks would receive social sanction as an illness and help him in getting a label of sick person (Teja and Narang et al., 1971).

Physical symptoms lacking adequate medical basis are ubiquitous in all medical care settings (Brodger and Goldberg, 1985; Schurman et al., 1985; Wallen et al., 1987). About 3% of these symptoms have been reported to be due to an underlying psychiatric disturbance (Bain and Spalding, 1967; Prakash and Sethi, 1978). USA's 1980/1981 National Ambulatory Medical Care Surveys found that 72% of the patients, who received a psychiatric diagnosis each had one or more physical symptoms as a presenting complaint (Schurman et al., 1985). Our study found a higher percentage of 80.5, which is not unexpected considering the Indian culture.

Socio-demographic factors such as sex and socio-economic status are commonly related to somatisation. Females have a higher tendency to somatise as compared to males (Barsky and Klerman, 1983; Kirmayer, 1984). A similar finding was found in this study. In a recent work, patients aged 40 and above were found to have significantly more somatisation symptoms than the younger ones (Escobar et al., 1987). We also found a higher prevalence in the patients above 35.

Somatisation symptoms are more common in individuals from lower socio-economic status, non-western cultures and people with a lesser psychological sophistication. Amongst the non-western immigrants in the western countries, people with a low level of acculturation have been found to somatise more as compared to those with medium and high levels (Escobar et al., 1987).

Somatic symptoms are a final common pathway through which psychological disturbances and organic pathology express themselves and which prompts the patient to seek medical attention. The patients presenting with somatic symptoms without a demonstrable organic basis are found to suffer usually from depressive or anxiety disorders. American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, 3rd edition (DSM III) included a new diagnostic category of somatoform disorders for the patients, whose presenting symptoms suggest physical illness, occur in the absence of demonstrable organic findings and lack any known pathophysiological mechanisms. Studies using DSM-III have also found that a majority of such patients suffer from dysthymic (depressive) and anxiety disorders (Fishbain et al., 1986; Large, 1986; Saxena et al., 1988). In another Indian study using ICD-9, neurotic depression and anxiety neuroses were the most common diagnoses in the patients presenting with physical symptoms without organic basis (Srinivasan et al., 1986).

Somatisation symptoms have been reported to be extremely common among depressed patients in all cultures and have been called "Core" symptoms of depression (Wider and Cadoret, 1979). In our sample, all the patients with diagnosis of neurotic depression and 83.3% with diagnosis of endogenous depression presented with somatisation. Such a high percentage can be explained on the basis of Indian culture and larger number of females and patients from lower socio-economic group in our sample.

Subjective weakness, headache and vague somatic complaints were the three most common physical symptoms seen in our patients. Headache and other pains are the commonly reported somatic symptoms in the earlier works (Lipowski, 1988). Subjective weakness, vague somatic sensations, lack of energy and lethargy are some of common symptoms reported by neurotic patients in India.
REFERENCES

Bain, S. T. and Spaulding W. B. (1967). The importance of coding presenting symptoms. Canadian Medical Association Journal, 97, 953-959.

Barsky, A. J. and Klerman, G. L. (1983). Overview: hypochondriasis, bodily complaints and somatic styles. American Journal of Psychiatry, 140, 273-283.

Bridges, R. N. and Goldberg, D. P. (1985). Somatic presentation of DSM-III psychiatric disorders in primary care. Journal of Psychiatric Research, 29, 563-569.

Ekobor, J. I.; Burnam M. A.; Karmo, M.; Forsythe, A. and Golding, J. M. (1987). Somatisation in the community. Archives of General Psychiatry, 44, 719-718.

Fishbain, D. A.; Goldberg, M. A. and Meagher, B. R. (1986). Male and female chronic pain patients categorised by DSM-III—Psychiatric diagnostic criteria. Pain, 26, 181-197.

German, G. A. (1972). Aspects of clinical psychiatry in Sub-Saharan Africa. British Journal of Psychiatry, 121, 461-479.

Indian Council of Medical Research (1982). Strategies for research on mental health, New Delhi.

Kirmayer, L. J. (1984). Culture, affect and somatisation. Transcultural Psychiatric Research Review, 21, 159-188.

Lambo, T. A. (1960). Further neuro-psychiatric observations in Nigeria. British Medical Journal, 2, 1696-1701.

Lange, R. G. (1986). DSM, III diagnosis in chronic pain. Journal of Nervous and Mental Diseases, 174, 295-303.

Lipowski, Z. J. (1980). Somatisation: The concept and its clinical application. American Journal of Psychiatry, 145, 1358-1368.

Krauskh, R. and Sethi, B. B. (1978). Hypochondriacal symptoms in medical patients and their psychiatric status. Indian Journal of Psychiatry, 20, 240-243.

Saxena, S.; Nepal, M. K. and Mohan, D. (1984). DSM-III Axis I diagnoses of Indian psychiatric patients with somatic symptoms. American Journal of Psychiatry, 145, 1023-1024.

Schurman, R. A.; Kramer, P. D. and Mitchell, J. B. (1985). The hidden mental health network. Archives of General Psychiatry, 42, 89-94.

Srinivasan, K.; Murthy, R. S. and Janakiramaiah, N. (1986). A nosological study of patients presenting with somatic complaints. Acta Psychiatrica Scandinavica, 73, 1-5.

Teja, J. S.; Narang, R. L. and Agarwal, A. K. (1971). Depression across cultures. British Journal of Psychiatry, 119, 253-260.

Wallen, J.; Pincus, H. A. and Goldman, H. H. (1987). Psychiatric consultations in short term general hospitals. Archives of General Psychiatry, 44, 713-718.

Wider, R. B. and Cadoret, R. J. (1979). Depression in family practice: Changes in patterns of patient visits and complaints during subsequent developing depressions. Journal of Family Practice, 9, 1017-1021.