SOMATIC SYMPTOMS IN A COMMUNITY CLINIC

S.K. CHATURVEDI¹
M.P. UPADHYAYA²
SHIVAJI RAO³

SUMMARY

In this cross-sectional study, all subjects attending a community based mental health clinic were examined with the objective to understand the presenting problems and to find out whether somatic complaints were the chief complaint, whether the somatic complaint produced any disability in financial, occupational and social spheres. Also an attempt is made to identify somatizing disorders using Swartz's index.

One hundred fifty eight subjects attending a community neuropsychiatry clinic for the first time were included in the study, of whom 65% had somatic symptoms as the chief volunteered first complaint. Another 12% reported somatic symptoms on enquiry. In 74% the duration was greater than six months. Moderate to severe disability, due to somatic symptoms was caused in nearly 50% of cases in occupational and financial areas. 48 cases (30%) could be identified by Swartz's Index to have somatization disorder. Using DSM-III Criteria, half of these 48 cases met the criteria for somatization disorder. The study emphasizes that somatizing disorders may not be ignored, and due to their high prevalence, disability caused and ease of identification, they could be considered as "priority" disorders in community clinics in developing countries.

Somatic symptoms are well known and inseparable from a variety of illnesses, specifically psychiatric syndromes, chronic medical and neurological illnesses. Very few authors have focussed their attention towards the somatic symptoms and somatization in a primary care or community set up. It has estimated that between 30% to 80% of patient visits to primary care clinics have a psychosomatic origin (Lin et al 1985).

The basic process under the somatic or bodily symptoms is somatization. It is the process by which an individual uses the body or bodily symptoms for psychological purposes or personal gains (Ford 1986). Katon et al (1984) defines somatization as idiom of distress in which patients with psychosocial and emotional problems articulate their distress primarily through physical symptomaticology. It is a powerful idiom of social distress that often elicits care giving, responses from family members and patient's larger social network.

Patients with somatization may have no detectable organic pathology or may amplify existing physiological changes. Somatization occurs in a wide variety of clinical settings. It is often found in patients with depression, panic disorders, somatization disorders, hystronic personality disorders, factitious disorders and malingering (Katon 1982). It is also encountered in psychophysiological disorders and routinely in chronic medical disorders with waxing and waning, where somatization owing to psycho-social and cultural contexts is a
common source of clinical management problem (Katon et al 1984).

The occurrence of somatization varies across the socio-cultural groups and seems to be influenced by environmental stresses. As Barsky (1979) observed, somatization is more common among those who are less educated, of low socioeconomic status, rural background, and among ethnic groups and cultures which discourage the direct expression of emotional distress.

Somatic symptoms have been studied in Indian patients by Goutam and Kapur (1977) and Srinivasan et al (1986). However, there have been no studies to find out the nature and magnitude of somatization in community based neuro-psychiatric health clinics.

In the present study we have examined the somatic symptoms in relation to various psychiatric syndromes in a rural population which is being benefitted from the neuropsychiatric services linked with National Institute of Mental Health and Neurosciences (NIMHANS), Bangalore.

Materials and Methods

This study was conducted at a community based neuropsychiatric clinic - one of the satellite community health centres of NIMHANS. A team of psychiatrists, neurologists, neurosurgeons along with clinical psychologists, nurses and psychiatric social workers, including both postgraduate students and consultants of respective branches, provide regular services on a fixed day every month in collaboration with local health authorities, socio-political and voluntary organizations (Reddy et al 1986).

The clinic population is mainly rural covering a large catchment area. Patients mainly belong to lower socioeconomic and lower middle class groups with traditional Indian cultural and agricultural background. Patients attending psychiatric services included in the study were in the age range of 17-60 years, free from mental retardation, organic psychosis and major physical illnesses. A detailed account of sociodemographic variables were recorded on a specifically designed proforma for the study along with psychiatric diagnosis based on ICD-9 (W.H.O. 1978). The main presenting complaints and clinical features were also recorded. Detailed mental state and physical examinations were carried out. The somatic symptoms were enlisted and Swartz’s somatization Index (Swartz et al 1986) was employed to further identify the somatization disorder. Swartz somatization Index was developed by Swartz et al (1986) to screen for somatization disorders in a community set-up. This is an eleven item index with a cut-off point score of 5. This index has good sensitivity (95%) (Swartz et al 1986). The patients were independently assessed by a senior consultant and a junior consultant to ensure good inter-rater reliability.

The data were computed and subjected to statistical analysis to find out the frequency distribution of various somatic symptoms.

Results

Table 1 shows the distribution of patients on various sociodemographic variables. Females predominate in the study sample (56%). The maximum number of patients were among the age group of 21 to 30 years (35%) and the second largest presentation was from the age group 31 to 40 years (27%). Patients above age 60 years were very few (4%). Majority of the patients were illiterate or just literate (67%). Those who had education up to high school or above were about one-third (33%). Majority of patients were married (77%) and the others (23%) were either separated, divorced or unmarried. Majority were
housewives (52%) and the others were agriculturists (29%) and professionals (19%).

Table 1
Demographic Profile of the Sample
(N = 158)

| Demographic Variable   | n   | (%) |
|------------------------|-----|-----|
| Sex                    |     |     |
| Female                 | 89  | (56)|
| Male                   | 69  | (44)|
| Age (in years)         |     |     |
| Below 20               | 16  | (10)|
| 21-30                  | 56  | (35)|
| 31-40                  | 43  | (27)|
| 41-50                  | 27  | (17)|
| 51-60                  | 11  | (07)|
| 60+                    | 05  | (04)|
| Education*             |     |     |
| Illiterate             | 49  | (43)|
| Primary & Middle School| 27  | (24)|
| High School and above  | 37  | (33)|
| Marital Status         |     |     |
| Married                | 122 | (77)|
| Others                 | 36  | (23)|
| Occupation*            |     |     |
| Housewife              | 79  | (52)|
| Agriculture            | 45  | (29)|
| Professional           | 29  | (19)|

* Adequate information about education and occupation for 45 and 5 patients respectively was not known.

Table 2
Diagnostic Breakup of Patients
(N=140*)

| Diagnosis (ICD-9 No.)      | n   | (%) |
|----------------------------|-----|-----|
| 1. Schizophrenia           | 16  | (12)|
| 2. Affective Psychosis     | 14  | (10)|
| 3. Anxiety Neurosis        | 27  | (19)|
| 4. Hysterical Neurosis     | 02  | (1 )|
| 5. Neurotic Depression     | 44  | (32)|
| 6. Psychalgia              | 09  | (6 )|
| 7. Psychosis Nos.          | 09  | (6 )|
| 8. Others                  | 19  | (14)|

* No Psychiatric illness was diagnosed in 16 patients and diagnosis was uncertain in 2 cases.

Table 2 shows the diagnosis of the patients screened for somatic symptoms. From the total study sample (N=158) 18 patients were excluded as 16 patients had no psychiatric problems, and two patients could not be assigned any diagnosis at the time of study, sample size was reduced in table 2 from 158 to 140 patients. Neurotic depression was the commonest diagnosis (32%) and the second commonest diagnosis was Anxiety neurosis (19%). In all, 58% of the cases had a neurotic illness. Schizophrenia, Affective Psychosis and other psychoses were diagnosed 12%, 10% and 6% respectively. 14% of the patients shown in the table under the category of “others” had different diagnoses like alcohol dependence syndrome, adjustment reaction, psychogenic pain, bronchial asthma, depression NOS and sleep walking.

Table 3 presents the frequency and distribution of somatic complaints in the study sample. In majority of the patients headache was the main complaint (31%). The next in order of frequency were generalised aches and pains (20%), generalised weakness (13%), and backache (11%). Other somatic complaints

Table 3
Distribution of Somatic Complaints and their Frequency

| Sl. No. | Somatic Complaints Description | Number of Patients |
|---------|--------------------------------|-------------------|
| 1       | Headache                       | 49 (31)           |
| 2       | Chronic Pain                   | 14 (9)            |
| 3       | Backache                       | 18 (11)           |
| 4       | Generalized aches and pains    | 32 (20)           |
| 5       | Pain in eyes                   | 05 (3)            |
| 6       | Pulling of Nerves              | 07 (4)            |
| 7       | Generalized weakness           | 21 (13)           |
| 8       | Multiple somatic complaints    | 07 (4)            |
| 9       | Other somatic/pain symptoms    | 21 (13)           |
like pain in the eyes, pulling of nerves, multiple somatic complaints were reported by a less number of patients. Pain in the eyes was the least frequent symptom (5%).

Table 4 shows disability in patients as a result of various somatic complaints in occupational, financial and social areas.

Table 4
Disability due to Somatic Complaints

| Nature of Disability | Occupational (N = 72*) (%) | Financial (N = 41*) (%) | Social (N = 52*) (%) |
|----------------------|--------------------------|------------------------|----------------------|
| Severity             |                          |                        |                      |
| Mild                 | 20 (27)                  | 12 (24)                | 12 (23)              |
| Moderate             | 32 (44)                  | 13 (32)                | 24 (46)              |
| Severe               | 10 (15)                  | 7 (17)                 | 4 (08)               |
| No Deficit           | 10 (14)                  | 9 (22)                 | 12 (23)              |

* Exact or Definite evaluation of disability in the above spheres could not be determined in all the 158 cases.

It may be noted that in quite a large number of patients the information regarding their functioning in various areas was not supplemented and hence the disability has been assessed in 72, 41 and 52 patients in occupational, financial and social areas respectively. Moderate deficits in all the three areas social (44%), financial (32%) and occupational (46%) was one of the most important and common finding. Mild and severe deficits were less common. Severe deficit was noted in a few patients and mostly affected the financial capacity, rather than social and occupational areas. Another group of patients showed no deficit in any of the three capacities.

Forty four per cent of the patients had a least one somatic complaint, while 48% had 2 or 3 somatic complaints. Patients having five or more somatic complaints were only 8%. 41% of the patients had a duration of illness between 1 month to 1 year. 16% of patients had a duration between 1 to 2 years, while 25% of patients had a 2-5 years duration of illness. 16% of patients had more than 5 years duration of illness. 48 patients (30%) could be identified using the Swartz Index to have the evidence of somatization disorder. 110 patients (70%) scored below the cut-off point on Swartz Index. Out of these 48 cases who were identified as somatization disorder according to Swartz Index, 24 cases met the criteria for somatization disorder according to DSM III (APA, 1980) i.e., they had a duration of illness greater than 2 years and were below the age of 30 years at the time of onset of illness. 24 patients who scored above the cut-off point of Swartz Index either were above 30 years age at the time of onset of illness or had a duration of illness less than 2 years and hence could not be diagnosed as somatization disorder according to DSM III.

Discussion

In this study, somatic symptoms were the chief volunteered first complaint in 102 of the 158 cases (64.6%). Another 20 cases also reported somatic complaints on further inquiry. In all, distressing somatic complaints for which treatment was sought was reported by 77.2% of the population. Somatic symptoms and somatization in patients attending primary health care and community services have been reported by Harding et al (1980), Escobar (1987), Gautam and Kapur (1977), Lin et al (1985) and Srinivasan et al (1986). However, our study was carried out in an unique mental health facility based in the community (Reddy et al 1986). Despite such a high prevalence of somatization
and the amount of disruption caused by them, unfortunately, somatization has not attracted the attention of community mental health service organisers in developing countries.

Geil and Harding (1976) had pointed out that little was known with regard to developing countries as to: a) the extent and duration of disability resulting from mental disorder; b) the burden the mentally disordered place on their immediate environment; and c) the problems created by those with psychiatric illness in terms of frequency of attendance at health services and reduced work efficiency. Our efforts have been to get some information of these important issues in the community mental health clinic specifically with regard to somatization. It can be noted that 77% of the clinic population suffered primarily from somatization, and that in 74% of the cases the duration was more than six months. Around 50% of cases had moderate to severe difficulties in financial and social spheres due to their somatic problems. Somatization is unquestionably associated with frequent health seeking behaviour, though this aspect was not examined by us in the present study. In more than 85%, work functioning was affected at least to some extent in terms of absenteeism, loss of pay, inability to work etc. The occupational disability was moderate to severe in 60% of the cases. Giel and Harding (1976) admitted that psychoneurotic conditions, which may present with somatic symptoms, made up the bulk of mental disorder both in rural and in urban communities. But, contrary to their observation, we have found that these were perceived as psychological problem (since they attend 'mental' health clinic) and their environment did consider them to be so, due to their disability in occupational and social spheres, and the financial burden.

In this study, young female patients (housewives and/or agriculturists) predominate, as found in other studies as well (Harding et al 1980, Gautam and Kapur 1979). Majority of the patients had a diagnosis of neurosis. Psychotic illnesses were less commonly diagnosed in this community clinic population.

Forty eight cases (ie. 30%) were identified using Swartz’s somatization Index and had more than five somatic complaints (Swartz et al 1986). Of these 48 cases, 24 (50%) met the criteria for somatization disorder according to DSM III (APA, 1980). These 24 cases had a duration of somatic problems of 2 years or more, and the onset of illness was prior to 30 years age. The other 24 cases who scored above cut-off score of Swartz Index either had a duration of illness less than 2 years or had onset of illness after 30 years age.

Our observations clearly indicate that in a community set up mental illnesses present mainly as somatic complaints. Further, the somatization leads to tremendous loss to the individual, his family and work place. In developing countries, community psychiatry programmes cannot afford to ignore somatization problems. One of the possible reasons why such problems were not taken as ‘priority’ illness was the difficulty in identification of such disorders. However, we have found the use of ‘Swartz Index’ quite easy and applicable in the community centres. Similarly screening symptoms are provided in the DSM III-R (APA, 1987) for diagnosis of somatization disorders. Ford (1986) had cautioned that somatization results in increased utilization of medical services
and can lead to tremendous financial loss, besides time lost from work or disability payments. Our findings emphasize that similar problems arise in a developing country also. Somatization is worthy of study from a financial perspective as well as from concern for more appropriate and effective clinical care (Ford, 1986). Finally, our experience shows that it is possible to identify somatizing syndromes without much difficulty, and that much more attention needs to be given to them than at present, in developing countries.

References

AMERICAN PSYCHIATRIC ASSOCIATION (1980), Diagnostic and statistical manual of mental disorders, 3rd Edition Washington, D.C., A.P.A.

AMERICAN PSYCHIATRIC ASSOCIATION (1987), Diagnostic and statistical manual, 3rd Edition Revised, DSMIII-R, Washington, D.C., A.P.A.

BARSKY, A.J. (1979), Patients who amplify bodily symptoms, Annals of Internal Medicine, 91: 63-70.

ESCOBAR, J.I. (1987), Cross-cultural aspects of somatization trait, Hospital and Community Psychiatry, 38(2): 174-179.

FORD, C.V. (1986), The somatizing disorders, Psychosomatics, 27: 1-8.

GAUTAM, S.K. & KAPUR, R.L. (1977), Psychiatric patients with somatic complaints, Indian Journal of Psychiatry, 19: 75-80.

GEIL, R. & HARDING, T.W. (1976), Psychiatric priorities in developing countries, British Journal of Psychiatry, 128: 513-522.

HARDING, T.W., DEARANGO, M.V., BALTAZAR, J., CLIMENT, H.H., IBRAHIM, A., LADRADO - IGNACIO, L., SRINIVASAMURTHY, R. & WIG, N.N. (1980), Mental disorders in primary health care: a study of their frequency and diagnosis in four developing countries, Psychological Medicine, 10: 231-241.

KATON, W. (1982), Depression: Somatic symptoms and medical disorders in primary care, Comprehensive Psychiatry, 23: 274-287.

KATON, W., RIES, R.K. & KLEINMAN, A. (1984), The prevalence of somatization in primary care, Comprehensive Psychiatry, 25: 208-215.

LIN, E.H., CARTER, W.B., ARTHUR, M. & KLEINMAN, A. (1985), An exploration of somatization among Asian refugees and immigrants in primary care, American Journal of Public Health, 75: 1060-1064.

REDDY, G.N.N., CHANNABASAVANNA, S.M., GOURIE DEVI, M., DAS, B.S., PRABHU, G.C., SHARIEFF, I.A., KALIA PERUMAL, V.G. & REDDAMMA, K. (1986), Extension of mental health services by satellite clinics as a model, NIMHANS Journal, 4: 71-75.

SRINIVASAN, K., SRINIVASAMURTHY, R. & JANAKIRAMAIAH, N. (1986), A nosological study of patients presenting with somatic complaints, Acta Psychiatria Scandinavica, 73: 1-5.

SWARTZ, M., HUGHES, D., GEORGE, L., BLAZER, D., LANDERMAN, R. & BUCHOLZ, K. (1986), Developing a screening index for community studies of somatization disorder, Journal of Psychiatric Research, 20, 335-343.

WORLD HEALTH ORGANIZATION (1978), International classification of diseases, ICD - 9. W.H.O. Geneva.