Somatic Presentations of Psychiatric Illness in Outpatient Psychiatric Clinic in Jeddah

Magda K. Fahmy

This study assesses the nature of psychiatric disorders in 50 persistent somatizers (30 females and 20 males), aged between 20-45 years old and referred to outpatients psychiatric clinic in a general private hospital in Jeddah, over a period of 3 months. The somatic symptoms of all persistent somatizers proved not to have any organic basis, and all received medical care during the last 6 months, and showed either minimal or no improvement regarding their somatic symptoms. All of the 50 patients had received a psychiatric diagnosis. Only 4% of this clinic sample fulfilled the DSM III-R criteria for somatoform disorder. The most frequent diagnosis was depression (34%), then anxiety disorders (30%). Sixteen per cent had adjustment disorder and only 2% were schizophrenic. Women with somatization tended to be more illiterate, culturally deprived and depressed. Thirty two per cent had DSM III-R personality disorders. So, persistent somatization is associated with a heterogenous psychiatric diagnosis and different personality disorders.

(Egypt.J.Psychiat., 1996, 19:69-77).

Introduction

Psychiatrists who work in general hospitals are more likely to see patients referred from other hospital departments whose somatic symptoms have no demonstrable organic cause or seem far out of proportion to any abnormalities found (Benjamin and Bridges 1992).

Somatization is a term used to describe the variety of processes that lead patients to seek medical help for bodily symptoms which are attributed to organic disease but have no relevant organic basis (Murphy, 1989).

Somatization is important in medical practice because it is common: as many as one in five new inceptions of illness in primary care and one in three of all referrals to psychiatrists in general hospitals satisfy rather strict research criteria for somatization (Goldberg & Bridges 1988).

De Leon et al (1987) reported that on a consecutive series of patients referred to a psychiatric liaison service from other hospital departments nearly half were somatizers and 15% had somatoform disorders. In another study Katon et al (1984) found that 48% of somatizers had a depressive illness and 29% had a somatoform disorder.

The multiaxial classification in DSM-III-R provides framework to consider the features associated with the diagnosis of somatization disorder. It commonly coexists with other axis I disorders, notably major depression, panic disorder and phobic disorders, especially agoraphobia. It has been viewed as more akin to personality disorder (axis

Magda K. Fahmy, M.D. Lecturer in Psychiatry, Faculty of Medicine, Suez Canal University.

II) than an episode of illness (axis I), since it begins early in life and is by definition chronic (Bass and Potts, 1993). Stern et al (1992), supported this view, when they found that 72 % of patients with somatization disorder had a personality disorder, compared with 36% of psychiatric control subjects with anxiety and depression. Concurrent physical disorders (axis III) are also common and some may well be iatrogenic.

Aim of the work

The aim of this study is to assess the nature of psychiatric disorders in a group of patients referred to outpatients psychiatric clinic in a general private hospital in Jeddah whose somatic symptoms provide not to have any organic basis. Also, to draw attention to the importance of collaborative work between psychiatrists and physicians in this field.

Subjects and Method

Persons with multiple unexplained somatic complaints referred to outpatient psychiatric clinic in a general private hospital in Jeddah over a period of 3 months, aged between 20-45 years and received medical care with and without traditional consultations during the last 6 months, and showed either minimal or no improvement regarding their persistent somatic complaints were included in the study. They were assessed clinically by psychiatic interview and diagnosed according to DSM-III-R critieria. Chart reviews were completed to assess such variables as demographic characteristic, history of medical consultations, hospitalization, non psychiatic medications, surgeries and medical investigations and self-reported organ system involved in somatic symptoms and main somatic complaints, for example: nervous system: headache, dizziness, limb weakness; cardiovascular system: palpitation, chest pain; reproductive system: irregular menstruation, pain during intercourse, impotence.. etc.

Results

This study reviewed 50 patients (30 females, and 20 males) aged between 20-45 years, with no significant differences between the ages of females (32.4 ± 6.61) and that of males (30.7 ± 5.30).

Table (1) shows that the educational levels of males are relatively higher than females, but without statistically significant differences (P = 0.00215).

Table (2) shows that the majority of females (80%) are housewives, and 60% of males have their private business work.

Table (3) shows that the majority of males and females (80%) are married.

Table (4) shows that all patients before referral (100%0 were subjected to medical consultations, and most of them (84%) received nonpsychiatric medications, and 22% were subjected to the hazards of surgical interference, inspite of no demonstrable organic basis.

Table (5) shows that 84% of patients seeked traditional care during the course of their illness, either before (18%), after (84%) or in association (56%) with other medical treatment.

Table (6) shows that most patients had problems involved more than one system in the body, and the average number of organ systems involved in females were 3.8, while that of males were 2.55. As can be seen in Table (6), the main systems involved in females were pulmonary (86.66%) then gastrointestinal systems (76.66%), while in males the main systems were cardiovascular (70%) then reproductive (60%) systems.

According to DSM-III-R criteria, Table (8) shows that, only two persistent somatizers (4%) fulfilled crieria of the DSM III-R for somatization disorder.Of 50 persistent somatizers, 15 patients (30%) met criteria of anxiety dis-

Table (1)
Educational Levels of Both Male and Female Persistent Somatizers

Education	Male (T = 20)		Female (T = 30)		Total %	
	N	%	N	%		
No school	1	5	12	40	13	26
Primary school	7	35	10	33.3	17	34
High School	8	40	7	23.3	15	30
College	4	20	1	3.33	5	10
	20		30		50	

X^2 9.416
P<0.00215

Table (2)
Occupation of Both Male and Female Persistent Somatizers

Occupation	Male (T = 20)		Female (T = 30)	
	N	%	N	%
Housewife	–	–	24	80
Student	2	10	–	–
Unskilled worker	1	5	–	–
Employee	5	25	6	20
Private business	12	60	–	–

Table (3)
Marital status of Both Male and Female Persistent Somatizers

Marital status	Male (T = 20)		Female (T = 30)	
	N	%	N	%
Single	2	10	2	6.66
Married	11	80	24	80
Divorced / Widowed	2	10	4	3.33

Table (4)
Medical Interventions Experienced by Persistent Somatizers

Intervention	N	%
Medical consultation	50	100
Non psychiatric medication	42	84
Medical hospitalization	15	30
Emergency room service	27	54
Surgical procedure	11	22

Table (5)
Traditional Care Experienced by Persistent Somatizers

Traditional care	N	%
Yes	42	84
No	8	16
Before medical intervention	9	18
After medical intervention	42	84
With medical intervention	28	56

Table (6)
Organ systems Involved in Somatic Symptoms Reported by Persistent Somatizers

System	Male (T = 20)		Female (T = 30)	
	N	%	N	%
Nervous	4	20	12	40
Cardiovascular	14	70	8	26.66
Pulmonary	7	35	26	86.66
Reproductive	12	60	7	23.33
Musculoskeletal	3	15	18	60
Dermatologic	2	10	21	70
Gastrointestinal	9	45	23	76.66

Table (7)
Frequency of 10 Most Common Symptoms Reported by Patients

Rank	Symptom	N	%
1	Shortness of breath	33	66
2	Intolerance of food	32	64
3	Chronic fatigue	23	46
4	Palpitation	22	44
5	Joint pain	21	42
6	Chest pain	20	40
7	Headache	16	32
8	Abdominal pain	15	30
9	Impotence	12	24
10	Pain in extremities	12	24

Table (8)
Psychiatric Diagnoses of Persistent Somatizers According to DSM-III-R Criteria

Diagnosis	Male (T = 20)		Female 30 (T = 20)		Total	
	N	%	N	%	N	%
Somatoform Disorder						
1- Somatization disorder	1	5	1	3.33	2	4
2- Somatoform pain disorder	2	10	1	3.33	3	6
3- Conversion disorder	-		1	3.33	1	2
4- Hypochondriasis	2	10	1	3.33	3	6
Anxiety Disorder						
1- Panic disorder	5	25	3	10	8	16
2- Phobias	4	20	3	10	7	14
Mood disorders						
1- Dysthymic disorder	2	10	11	36.66	13	26
2- Major depression	1	5	3	10	4	8
Adjustment disorder (with depressed mood or with mixed anxiety and depressed mood)	2	10	6	20	8	16
Schizophrenic Disorder	1	5	-	-	1	2

Table (9)
Sixteen Persistent Somatizers Met DSM-III-R Criteria of Personality Disorder

Type of Personality Disorder	N
Histrionic	3
Antisocial	1
Borderline	1
Dependent	2
Obsessive	1
Avoidant	1
Personality disorder (NOS)	7
"Not otherwise specified"	16

orders (panic or phobic disorders) and 17 patients (34%) met criteria of mood disorder (major depression or dysthymic disorders), and 8 patient (16%) had adjustment disorder (either with depressed mood or with mixed anxiety and depressed mood), and only one patient (2%) had schizophrenic disorders.

Table (9) shows that, of 50 persistent somatizers 16 patients (32%) fulfilled the criteria of DSM-III-R axis II personality disorders, which included 7 patients "not otherwise specified," NOS. Most patients in the NOS group had characteristics from diagnoses in cluster B (antisocial, borderline, histrionic, narcissistic), but did not meet the criteria of a specific personality disorder.

Discussion

This study shows that somatization disorders are frequently unrecognized or misdiagnosed. Most physicians are frequently misled by the tendency of patients with mental disorders to present with somatic complaints.

All the fifty persistent somatizers who were referred for pychiatric consultations over a period of 3 months and whose somatic symptoms had no demonstrable organic cause; had received a psychiatric diagnosis.

A number of investigators working in developing countries have observed

the tendency of patients with mental disorders in these societies to present with physical complaints (German, 1987). As regards our Arab countries, Chaleby (1986) claimed that among Saudi arabians, the somatic presentation of psychiatic disorders is extremely common.

El-Eslam (1975) have reported that this phenomenon is culturally related and linked with a lower level of sophistication. This is to some extent confirmed in our study; as we found that 30 somatizers (60%) were either illiterate or only finished their primary education, compared to only 5 somatizers who could finished their higher eudcation. Before referral for psychiatric consultation 42 somatizers (84%) seeked traditional care during the course of their illness, and it seems that traditional care is a common cultural phenomenon in Saudi Arabia. So, most patients regardless of age, sex, occupation or education preferred to seek help by traditional ways especially after failure of non psychiatric medication. An important finding which reflects their attitudes and concepts about psychiatry and which needs more clarification in future studies; however it could proof El-Eslam (1975) previous findings.

Females somatizers represented 60% of our sample size. Our study shows that Saudi female somatizers are considerably more illiterate and culturally deprived than males. As of thirty female somatizers 40% were illiterate (Table 1), and 80% were housewives (Table 2). A picture which may reflects the profile of Saudi female somatizers more than it signifies the demographic differences between male and female somatizers, which will need further studies.

However, recently in California, Golding et al (1991) studied clinical characteristics of women and men with multiple unexplained somatic symptoms and reported that there was no reason to believe that men and women with somatization disorder show differences in demographic or clinical characteristics, or psychiatric comorbidity. So, future studies are important, as Table 6 shows that, the average number of organ systems involved in females were more than that of males (3.8 and 2.55 respectively), also the main systems involved in females were different from males (pulmonary then gastrointestinal in females and cardiovascular then reproductive in males). A finding which may suggests some cultural differences inspite of methodological differences and leaves a question about the relationship between gender and the somatic presentations of psychiatric disorders.

Table 7 shows the most frequently reported symptoms in this clinic sample. The symptoms pattern is different from that obtained in previous studies among Chinese subjects (Kleinman and Kleinman, 1985) and among African subjects in Nigeria (Gureje and Obikoya, 1992) and both are also different from that obtained from American subjects in a community study in the United States (Escobar et al. 1987). Of course, comparison is difficult between the present study and the previous three studies, but it can reflect some cultural differences.

Persistent somatization is associated with a heterogenous psychiatric diagnoses (Table 8), the most frequent diagnosis was depression (34%), then anxiety disorder (30%) either panic or phobic disorders. 18% of persistent somatizers, received a diagnosis of somatoform disorder, and only two patients (4%) fulfilled the DSM- III-R criteria of somatization disorder. 16% had adjustment disorder and only one patient (2%) was schizophrenic. For women with persistent somatization we found that 46.66% of them were depressed (had either dysthymia or major depression), compared

to only 15% of the male sample. So, women with somatization tended to be more depressed.

This study is consitent with other studies of patients with persistent somatization, Bass and Potts (1993) assumed that, the psychiatrist should not think first of the somatoform disorders, but consider more common psychiatric disorders such as depression, panic, and other anxiety disorders and adjustment disorders. Fink (1995) also reported that persistent somatization is associated with a broad spectrum of heterogenous psychiatric diagnoses and syndromes. Gureje and Obikoya (1992) found that somatization was more significantly associated with female sex; specially for those who were aged 40 years or older and had depression or dysthymia or generalized anxiety disorder.

Although somatization disorder has some validity as a clinical syndrome and is classified as a mental illness, some of its defining features are those of a personality disorder. For example, it begins early and persists throughout life. A high percentage of British psychiatrists regard somatization disorder as a combination of personality disorder and neursis (Stern et al 1993).

In our clinic sample (Table 9), we found nearly one third of the persistent somatizers (32%) fulfilled the criteria of DSM-III-R axis II, personality disorders. The personality disorders belonging to cluster B were specially common, but most of those patients had symptoms from more than one diagnostic category. The high percentage of somatizers with personality disorder "Not otherwise specified" "NOS" is in accordance with observation made by Fink (1995). Whereas the previously reported high frequency of histrionic personality disorder (Morrison, 1989), was not supported. The same as with Rost et al (1992) who reported that the 4 most frequent personality disorders among persistent somatizers patients were avoidant, then paranoid, self-defeating and obsessive-compulsive. So, as Kaminsky and Slavney (1976) have remarked, it is likely that personality gives the condition both its stability and its recalcitrance to treatment".

The results of this study indicate that persistent somatization is linked with a lower level of sophistication and relatively more in illiterate and culturally deprived women and is associated with a heterogenous psychiatric diagnoses and different personality disorders.

Also, this study draws attention to the importance of collaborative work between psychiatrists and physicians in this field. Specific skills must be taught to trainee physicians about how to deal with normal investigation results in somatizing patients, how to look for signs of disease rather than relying on patient's reported symptoms, how to explain the psychological causation of somatic symptoms, how to refer the patient to a psychiatrist in severe cases and how to reassure the patient.

References

Bass C., and Potts S. (1993) Somatoform disorders. In: Kenneth Granville and Grossman (eds.) Recent Advances in Clinical Psychiatry. Churchill Livingstone.

Benjamin S, Bridges K. (1992) The sepial needs of chronic somatizers. In : Benjamin S, House, A, and Jenkins P. (eds) Defining needs and planning services. Gaskell Press, Royal College of Psychiatrists, London.

Chaleby K. (1986) Somatic presentation of psychiatric disorders in an outpatient group of Saudis. *Egypt. J. Psychiat.*, **9**: 186-199.

De Leon J., Saiz-Ruiz J. and Chinchilla A. (1987) Why do some psychiatric patients somatize? *Acta. Psychiat., Scand.* **76**: 203-209.

El-Eslam M.F., (1975) Culture bound neurosis. Soc. Psychiatry. 10: 25-29.

Escobar J.I, Burman M.A., Karno M., and Golding J.M., (1987) Somatization in community. *Arch. Gen. Psychiat.*, **44**: 713-718.

Fink P. (1995) Psychiatric illness in patients with persistent somatization. *Br. J. Psychiat*, **166**: 93-99

German G.A., (1987) Mental Health in Africa II. The nature of mental disorder in Africa today. Br. J. Psychiat., **151**: 440-446.

Goldberg D.P., and Bridges K. (1988) Somatic presentations of psychiatric illness in primary care settings. *J. Psychosom. Res.* **32**: 137-144.

Golding J.M., Smith G.R., and Kashner T.M. (1991) Does somatization disorder occur in men? Clinical characteristics of women and men with multiple unexplained somatic symptoms. *Arch. Gen. Psych.*, Mar. Vol. 48 (3) 231-235.

Gureje O., and Obikoya B. (1992) Somatization in primary care: pattern and correlates in a clinic in Nigeria. *Acta Psychiatr. Scand.* **86**: 223-227.

Kaminsky M.J. and Slavney P.R. (1976) Methodology and personality in Briquet's syndrome: a reappraisal. *Am. J. Psychiat.*, **133**: 85-88.

Katon W., Ries R.K., and Kleinman A. (1984) A prospective study of 100 consecutive somatization patients. *Comp. Psychiat.*, **25**: 305-314.

Kleinman A., and Kleinman J. (1985) Somatization: The interconnections in Chinese society among culture, depressive experiences, and the meaning of pain. In: Kleinman A., and Good B. (eds.) Culture and depression. Berkeley: University of California Press.

Morrison J. (1989) Histrionic personality isorder in women with somatiation disorder. *Psychosomatics*, **30**: 433-437.

Murphy M.R. (1989) Somatization-Embodying the problem. *Br. Med. J.* **298**: 1331-1332.

Rost K.M., Akins R.N. and Brown F.W. (1992) The comorbidity of DSM II-R personality disorders in somatization disorder. *Gen. Hosp. Psychiat., Sep.* Vol. 14(5): 322-326.

Stern J., Murphy M., and Bass C. (1992) Personality disorders in patients with somatization disorder: a controlled study. *J. Psychosom. Res.*

Stern J., Murphy M., and Bass C. (1993) Attitudes of British psychiatrists to the diagnosis of somatization disorder: a questionnaire survey. *Br. J. Psychiat.*, **162**: 463-466.

Les présentations somatiques de maladies psychatriques chez les patients visitont régulerement les cliniques psychiatriques à Geddah

Cette étude cherche la nature des symptoms somatiques au point de vue psychiatique chez 50 patients agé entre 20-45 ans souffrant de symptomes somatiques et referrent au clinique de psychiatrique à l'hôpital du Geddah Seoudia.

Les résultats ont montré que toutes ses symptoms sont présentés plus que 6 mois, toutes les patients on treaté avec des remédes. Mais condition n'est pas imprové.

Les patients sont diagonsés, celon DSM-IIIR depression, anexité, mal adaptable désordre et personalité désordre anisi que cette étude a montré qu'il ya une relation signifante entre les symptomes somatiques, le type de depersonalité et le degreé d'éducation.

أعراض الجسدنة فى مرضى نفسيين مرتادين لعيادة خارجية فى جدة

قامت الباحثة بدراسة وتقييم الأعراض والتشخيصات الطبنفسية فى خمسين مريضاً من المرضى المحولين لعيادة طبنفسية فى مستشفى خاص بجدة – السعودية، وقد أظهرت النتائج أن هؤلاء المرضى تنطبق عليهم السمات التشخيصية لاضطرابات الإكتئاب والقلق والهلع والتأقلم والفصام .

وتناقش الباحثة الدلالات والنتائج وعلاقتها بدرجة التعليم واضطرابات الشخصية والمؤشرات المساعدة فى التشخيص، كما تقدم توصيات إكلينيكية و بحثيه.