

Comorbidity of Somatoform Disorders

Hanaa Soliman

All patients presenting to the out-patient psychiatric clinic of El- Minia University hospital over a 4 month- period were screened for somatoform disorders (SDs). 92 Subjects (55 females & 37 males, mean age: 35.7) fulfilled criteria for SDs (ICD-10). The main diagnosis was undifferentiated somatoform disorder (UDS) (76.6%), followed by somatization disorder (SD) (9.5%), persistent somatoform pain disorder PD (8.7%), hypochondriacal disorder (5.4%). The most frequent symptom was headache, followed by pains in the different body parts, autonomic manifestations, abdominal symptoms, conversion symptoms. A semi-structured interview (SCAN) was used to assess psychiatric comorbidity. A concurrent psychiatric diagnosis was established in 85.9% of patients; the commonest diagnosis was current depressive episode (58.7); followed by anxiety disorders in 36.9%; mixed anxiety- depression disorder (6.5%). More than one comorbid diagnosis was the case in 16.5% of the cases.

The total number of somatic symptoms was highest in somatization disorder and least in pain disorder, with undifferentiated somatoform and hypochondriacal disorder occupying an intermediate position. The number of somatic symptoms was highest in mixed anxiety depression disorder and least in patients with no comorbid diagnosis. It was also higher in moderate than in mild depressive episode, and in panic than in generalized anxiety disorder.

Depressed mood was correlated with pain symptoms, while anxiety correlated with autonomic manifestations. Three factors of somatic symptoms: conversion, GIT & pain were identified.

The results are discussed in the light of the current debate concerning comorbidity as well as the validity of the somatoform disorder category.

(Egypt.J.Psychiat., 1997, 20 : 129- 140).

Introduction

Although comorbidity was long recognized as an essential phenomenon in psychiatry (Feinstein, 1970; Wittchen, 1996), the last two decades have witnessed an increasing interest in this phenomenon for better understanding of mental disorders (Merikangas et al, 1996). The advent of structured instruments and nosological disciplines based on categorical models seems to be accompanied by increasing popularity of

the term in both clinical and epidemiological settings. A large- scale epidemiological study of comorbidity in the US revealed that half of the individuals who ever met criteria for any psychiatric diagnosis have met criteria for more than one disorder, and nearly 30% for more than two conditions (Kessler et al, 1994). Though frequently used in research and practice, the term comorbidity remains poorly defined and lacks clear conceptualization (Maser & Cloninger, 1990; Wittchen, 1996). In a recent conceptual analysis, Van Praag (1996) discussed five interpretations of the term, viz disorder

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ders abound; hierarchical order, the offspring of a defective persona; one stem, many branches; and finally nosology abandoned.

A more radical criticism to the concept of comorbidity is presented by Goldberg (1996). He considers comorbidity of neurotic disorders to be an artefact resulting from the use of categorical models that might provide a better fit for severe mental disorders, as psychoses (Kendell, 1975), while the dimensional model is most appropriate for neuroses and personality disorders.

Most of the interest in the issue has been shown in the comorbidity between major depression and anxiety disorders (Maser & Cloninger, 1990; Kendler, 1996). However, somatization seems to emerge as a separate phenomenon in recent research. Though somatization, a term coined by Steckel in 1943, was early recognized, it has become only recently one of the most widely used terms to refer to patients with unexplained physical symptoms. In a trial to group disorders that present mainly with somatization, DSM-II included them in an independent, rather experimental category, the so called somatoform disorders. In the tenth version of International Classification of Diseases (ICD-10), the concept of somatoform disorders is adopted with some minor differences with the DSM system. However, the concept of somatoform disorders has been criticized, as the basis of dividing patient according to their presenting symptoms is superficial (Murphy, 1989). Murphy also argues that most of the defining concepts, including medical help-seeking behavior, numbers of symptoms and hypochondriacal attitudes are best described in dimensional rather than categorical terms. In support of this view, somatization was found to be associated with both anxiety and de-

pression in the World Health Organization (WHO) study (Goldberg, 1996).

To test the validity of the somatoform disorder concept, and to assess its relationship with other categories, further research is needed. This work aimed at assessing the frequency of patients presenting to the outpatient psychiatric clinic (El- Minia university hospital) with somatoform disorders, concurrent psychiatric morbidity in those patients, as well as studying the pattern of somatic symptoms in different somatoform disorders, on one hand, and in concurrent psychiatric diagnoses, on the other.

Subjects and Methods

All patients presenting to the outpatient psychiatric clinic of Minia University hospital over a 4 month- period (January to April 1996) were screened for somatoform disorders, using the diagnostic guidelines of ICD-10. The total number of psychiatric patients was 620, while those fulfilling criteria for somatoform disorders constituted 17.8% of the whole sample (111 subjects). 7 patients refused to participate in the study, and 12 patients failed to complete the procedure, making the number of patients who completed the interview 92. The demographic data are shown in table (1).

All patients fulfilling criteria for somatoform disorders were subjected to thorough physical and psychiatric examination. PSE- 10 part of the Schedule for Clinical Assessment in Neuropsychiatry (SCAN) (WHO, 1992) was the instrument used in psychiatric assessment. The present investigator attended an intensive training course in the application of SCAN. The central principle of the PSE-10 is that the interview, although substantially structured, retains the features of a clinical examination. The interviewer has to make his own judgement about the presence or absence of

symptoms. For the purpose of this study, part one of the SCAN, covering somatoform, dissociative, anxiety, depressive and bipolar disorder, was used.

Analysis of data:

Demographic data and ratings on individual items of the SCAN were subjected to statistical analysis using SPSS (Statistical Package for Social Sciences). In addition to descriptive statistics, t-test for independent samples was done to compare male and female subjects.

Correlation coefficients (Pearson product moment correlation) between anxiety and depressive symptoms on one hand and somatic symptoms on the other were calculated. The relationship between the severity of somatic symptoms, as expressed by the total number of somatic symptoms, and the presence of anxiety and depression was investigated using regression analysis, with the former taken as dependent variable.

In order to examine the structure underlying somatic symptoms, alpha factoring with varimax rotation was carried out.

Results

As seen in table (1), the sample comprised 92 subjects (55 females and 37 males). Age ranged from 19 to 55 years (mean = 35.7, $SD \pm 10.5$). The age in the female group (mean = 37.7, $SD \pm 10.7$) was significantly higher than in the male group (mean = 32.6 $SD \pm 10.7$). The majority of the subjects (70%) came from rural areas, while the rest were urban residents. Illiteracy was the case in 62% (57 subjects). Most of the patients (Number = 67.72%) were married, while the rest were single or divorced. The somatoform disorder diagnosis is shown in figure (1). The main diagnosis was undifferentiated somatoform disorder (70 subjects, 76.6%), followed by somatization disorder (9 patients, 9.5%), and then

persistent somatoform pain disorder (8 subjects, 8.7%) while 5 subjects (5.4%) fulfilled criteria for hypochondriacal disorder. The frequency of somatic symptoms is presented in table (2). The most frequent symptom was headache (95%), followed by pain in the limbs (91%), pain and discomfort in the chest (85%), then autonomic manifestations in the form of tachycardia, shortness in breath, dry mouth (78-70%), then came abdominal symptoms in the form of nausea (65%) and colic (63%). The conversion symptoms, viz numbness, hearing and visual problems, difficulty swallowing, trances, amnesia were next in frequency (51-37%).

The total number of somatic symptoms was highest in somatization disorder and least in pain disorder, with undifferentiated somatoform and hypochondriacal disorder occupying an intermediate position (figure 2).

Another psychiatric diagnosis was established in 79 (85.9%) patients with somatoform disorders (table 3). The commonest diagnosis was current depressive episode (58.7); mild in 31.5% and moderate in 27.2%, followed by anxiety disorders in 36.9%: 21.7% with generalized anxiety disorder and 15.2% with panic disorder. Mixed anxiety - depression disorder was encountered in 6 cases (6.5%). More than one comorbid diagnosis was the case in 16.5% of the cases.

The total number of somatic symptoms in each comorbid disorder is shown in figure (3). It is obvious that the number of somatic symptoms was highest in mixed anxiety depression disorder and least in patients with no comorbid diagnosis. The number of somatic symptoms is also higher in moderate than in mild depressive episode, and in panic than in generalized anxiety disorder, whereas the number of somatic symptoms in gen-

eralized anxiety disorder was slightly less than that in moderate depression.

Depressed mood was significantly correlated with pain in the limbs ($r = .22$, $p < .05$), chest pain ($r = .20$, $p < .50$) and also with amnesia ($r = .24$, $p = .01$).

On the other hand, the presence of anxiety was correlated with tachycardia ($r = .21$, $p < .05$), excessive sweating ($r = .21$, $p < .05$), shortness of breath ($r = .21$, $p < .05$).

Both depression and anxiety correlated with the duration of symptoms, shortness of breath ($r = .21$ & respectively).

Results of multiple regression analysis are shown in table (4). The dependent variable was the total number of so-

matic symptoms and the independent variables were the presence of depression and anxiety items of the SCAN, and the duration of somatic symptoms. The severity of somatic symptoms is related to both anxiety and depression (r square: 0.13) and more so in depression ($p = 0.01$). When the duration of somatic symptoms was added to the analysis, the r square became .30, meaning that the three variables explain 30% of variance.

Factor analysis yielded 3 factors (table 5). The first factor comprised mainly conversion and dissociative symptoms, while the second consisted of gastrointestinal symptoms and the last included pain symptoms. Appendix (Figure I, Figure II, Figure II).

Table 1
Demographic Data

Variable	Females	Males	All subjects
Mean age (Mears (± 50))	37.7 (± 10.7)	32.6(9.7)	35.7 (10.5)
Residence:			
Urban	14	12	26
Rural	41	25	66
Marital status:			
Single	5	12	17
Married	43	24	67
Divorced	3		3
Widowed	4	1	5
Education:			
Illiterate	40	17	57
6-12 years	7	7	14
> 12 years	8	13	21
Work			
Unemployed	3	6	9
House- hold Duties	48		48
Full- time job	2	17	19
Part - time job	2	14	16

Table 2
Frequency of Somatic Symptoms

Symptom	Number	Percent
Headache	87	94.6%
Arm & leg pains	84	91.3%
Chest & heart pain, discomfort	78	84.8%
Tachycardia	72	78.3%
Pain & gases in the stomach	70	76.1%
Shortness of breath	69	75%
Dryness of the mouth	64	69.6%
Nausea	60	65%
Colic	58	63%
Numbness & tingling sensations	47	51.1%
Hearing & Visual problems	45	48.9%
Difficulty swallowing	44	48.8%
Redness of the face	39	42%
Convulsions, trance dizziness	37	40.2%
Sweating	36	39.1%
Difficulty urination	35	38%
Amnesia	34	37%
Paralysis or movement problem	32	34.8%
Sexual difficulties	22	23.9%
Skin problems	13	14.1%

Table 3
Comorbidity of Somatoform Disorders

Comorbid Diagnosis	Depressive episode (mild)		Depressive episode (moderate)		Anxiety Disorder		Panic Disorder		Mixed anxiety depression		No other Diagnosis	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Somatoform Diagnosis												
Undiff. Somat. disorder	23	32.2	20	28.6	17	24.3	10	14.3	4	5.7	7	10
Somatization disorder	1	12.5	4	50	1	12.5	2	25	1	12.5	1	12.5
Pain disorder	5	55.5	1	11.1	1	11.1	1	11.1	0	0	3	33.3
Hypochond. disorder	0	0	0	0	1	20	1	20	1	20	2	40
Total	29	31.5	25	27.2	20	21.7	14	15.2	6	6.5	13	14.1

Table 4
Relationship between Anxiety, Depression and Somatization (Regression Analysis),
Dependent Variable: Number of Somatic Symptoms

Variable	Beta	T	Significance
Anxiety	.28	2.95	.004
Depression	.30	3.32	.001
Duration of Somatic Symptoms	.40	4.57	.000
Total R Square	.30		

Table 5
Results of Factor Analysis

Factors	Loadings
Factor (1)	
Hot or cold sweats	.72
Problems with passing water, frequency	.58
Problems with movement, paralysis	.56
Convulsions, trances	.56
Problem with sight, hearing	.43
Factor (2)	
Churning or discomfort in stomach	.74
Stomach or bowel pain	.60
Vomiting	.58
Factor (3)	
Chest or heart pain	.75
Palpitation, pounding heart	.57
Pain in arms, limbs, joints	.46
Headache	.42

Discussion

In the present work, the majority of patients were illiterate, living in rural areas. This was generally representative of the patients seeking help at our clinic. The assumption that patients with low socio-economic status coming from rural areas tend to express their emotions in physical, rather than psychological complaints was stressed in some studies (Kroenke & Price, 1993), but was not confirmed in others (Oharej & Odejide, 1994). To conclude that this is true of our culture, it needs further research on the symptom profile of urban subjects belonging to higher social classes. It was noted, however, that patients could communicate their emotional complaints freely and could respond well to questions on subtle aspects of emotional experience. It might also be noted that the rural - urban dichotomy is not so sharply demarcated in this country, where urbanization of the country-side and ruralization of cities are taking place.

Female patients outnumbered males in the presentation of somatoform disorders. This is consistent with population studies that showed consistently higher somatic symptoms in females (Kirmayer

& Robbins, 1991; Katon et al, 1991). Against the argument of the latter authors that this might be due to differences in help - seeking behaviour, with females resorting more to medical consultation, is the fact that the percentage of women in the original whole sample was not higher than men, while it was higher in patients with somatoform disorders. Depression which was the commonest concurrent diagnosis might explain the higher number of women, as affective disorders are known to occur more in woman. This is consistent with the finding, in the present research, that the age difference between male and females was statistically significant, with age being higher in the latter. The age of onset of depression in females is higher than that in males.

Patients with somatization disorder were predominantly women (87.5%), a finding which has been consistently documented since its description by Briquet in 1859 (Lipowski, 1988) and supported by recent epidemiological studies (Swartz et al, 1986). On the other hand, the hypochondrical patients in the present sample were exclusively males with relatively higher level of education. This is in contradiction with the findings of Barsky et al. (1990) that hypochondri-

asis was only slightly predominant in males. However, it needs a larger sample to generalize on such finding, since only 5 patients met the criteria for this disorder. Those had higher educational level than patients belonging to other groups, and thus were more likely to have access to medical information, which might explain their expression of distress in terms of well known medical entities.

The commonest diagnosis in this sample was the undifferentiated somatoform disorder (97.6%). This is in agreement with the findings of Escobar and coworkers (1987) that a less severe form of somatization is commoner than somatization disorder. Katon et al. (1991) have found that almost 60% of the high utilizers of primary health care suffered from a less severe form of somatization. Swartz et al. (1986) also defined a subsyndromal form of somatization that was associated with higher rates of seeking health care, but an intermediate level between somatization in general population and patients with somatization disorder. The assumption that the undifferentiated somatoform disorder is a less severe form of somatization disorder is further supported by the fact that, in the current study, the somatic symptom profile in both disorders was not generally different, though the number of somatic symptoms was higher in the latter. Moreover, this form was present more in female, uneducated subjects which is characteristic of somatization disorder as well (Escobar et al., 1987).

Criteria for somatization disorder were fulfilled in 8.7% of the patients. Population based studies found the prevalence of somatization disorder to range from .03 (Escobar et al., 1987) to .7% (Canion et al., 1987). On the other hand, the rate is higher in patients admitted to general hospitals, with 9% meeting the criteria of somatization disorder (de

Gury et al., 1987). However, the rate of somatization disorder in the present study is close to that found by Lobe et al (1996) in primary health care (9.5%).

Headache was the most frequent symptom, followed by pain in the limbs, pain and discomfort in the chest, then autonomic manifestations in the form of tachycardia, shortness in breath, dry mouth, then came abdominal symptoms in the form of nausea and colic. The conversion symptoms, viz. numbness, hearing and visual problems, difficulty swallowing, trances, amnesia were next in frequency.

The first factor yielded in factor analysis was mainly composed of conversion and dissociative symptoms. This is a rather interesting finding, since the nosological system used in the present study (ICD-10) does not include conversion as a part of somatoform disorders. This supports the inclusion of conversion disorder in somatoform disorders in DSM-III & IV. Meanwhile, this factor comprised both conversion and dissociative symptoms, which suggests that their separation under different categories in the DSM system is unjustified.

Somatization disorder commonly coexists with other DSM axis one diagnosis, notably major depression, panic disorder and phobic disorders (Bass & Potts, 1993). The rate of concurrent psychiatric diagnosis was high in the present sample (85.9%). In patients with no concurrent diagnosis, a profile of depressive subsyndrome was noticed. In the WHO collaborative study on psychological problems in general health care (Sartorius et al., 1996), nine percent of patients suffered from a "subthreshold condition". The main diagnosis was current depressive episode followed by anxiety disorders.

When somatic symptoms were analyzed according to the concurrent diag-

nosis, the highest number was encountered in patients with mixed anxiety-depression disorder. This might be explained by the fact that this group of patients, with no enough symptoms to fulfill the diagnosis of either anxiety or depression, tend to express their distress more in somatic than psychological terms. It might also be attributed to the cumulative effect, since they have elements of both anxiety and depression, with their related physical symptoms. The severity of depression was also correlated with the number of somatic symptoms, with patients suffering from moderate depression showing higher number of somatic symptoms than those with mild depression. Correlation of depression and somatization is further supported by the results of regression analysis, where the total number of somatic symptoms was influenced by the severity of depression ($\beta = .30, p < .001$). Analyzing the somatic symptom profile in patients with depression showed that pain symptoms were characteristic of that profile. On the other hand, two thirds of patients with persistent somatoform pain disorder fulfilled the criteria of a current depressive episode. Depressed mood, as a symptom, also correlated with pain symptoms, but not with other somatic symptoms. This correlation between depression and pain was confirmed by Blumer and Heilbronn (1982). A number of writers have stressed the importance of viewing pain as a multidimensional experience with more similarity to emotional states than sensory processing (Pearce & Miles, 1993). Tyrer (1996) expressed the view that comorbidity between pain and depression seems to be a true one. According to Von Korff and Simon (1996), most research on pain and depression has been carried out in highly atypical pain clinic populations late in the natural history of the pain problems. The au-

thors stress the need to study patients early in the natural history of the pain condition for a better understanding of the psychology of pain. In spite of the few number of patients with psychogenic pain disorder in the present work, it lends support to the association of pain and depression in patients with relatively recent history of pain.

Psychological anxiety correlated with somatic symptoms that are considered part of the anxiety phenomenon, e.g. sweating, shortness of breath, tachycardia. It seems that checklists of somatic symptoms contain symptoms known to be part of both depression and anxiety, and their separation, as such, would lead to false positive cases with somatoform disorders. The presentation with somatic symptoms as a primary complaint does not seem to be enough for their separation as a diagnostic category.

The concept somatization was criticized by Kirmayer (1984) as the product of Western mind - body dualism. The artificial differentiation and separation of mental manifestations into "psyche" and "soma" was also criticized by Manson (1996). It is only because clinicians expect patients to adopt an exclusively psychological idiom for their distress that they treat the persistence expression of distress in physical terms as a special diagnostic category (Kirmayer, 1996). Results of regression analysis showed that somatization is related to both anxiety and depression and also to the duration of symptoms. However, all those factors explained only 30% of the variance, meaning that other factors contribute to the phenomenon. This supports the view that somatization is a common final pathway for expression of different types of psychological distress.

Limitation of the study:

To elucidate the problem of comorbidity of somatoform disorders, whether

in the sense of disorders abound or one stem, many branches (van Praag, 1996), it is not sufficient to carry out a cross-sectional research, as was the design of the present study. Longitudinal studies are essential.

The comorbidity profile in somatizing patients in a primary care and general practice setting are also important, as studies in a psychiatric setting include biased sample with over representation of psychiatric diagnosis. The effect of the setting on diagnostic patterns, through the operation of selection factors and diagnostic biases, has been stressed by Bridges and Goldberg (1985).

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Les Troubles Psychiatriques Associés aux Désordres Somatoformes

On a recherché les troubles somatoformes chez les malades à la clinique universitaire de Minia. pendant 4 mois, 92 malades (55 femmes et 37 males) ont reçu cette diagnose, selon ICD-10. Pour l'examen clinique, un interview semistructuré (SCAN) a été utilisé.

Les résultats ont montré que les symptômes somatiques les plus fréquents étaient mal de tête, douleur, des manifestation autonomiques et de la conversion.

Les désordres psychiatriques confirmés par l'interview presents dans 85.9% des cas; les diagnostic les plus fréquents étaient un épisode de dépression (58.7%), trouble de l'anxiété (36.9%). Plus q'une diagnose psychiatrique associée étaient present chez 16.5% des cas.

On a trouvé qu' il ya une corrélation entre la dépression et les symptômes de douleur, tandis que l'anxiété a été associées aux manifestations autonomiques.

Les résultats mettent en doute l'indépendance nosologique des troubles somatoformes.

الأمراض النفسية المصاحبة للاضطرابات شبه الجسدية

أجرى هذا البحث فى العيادة النفسية لكلية طب المنيا فى الفترة من بداية يناير، حتى نهاية أبريل ١٩٩٦، بهدف دراسة الاضطرابات شبه الجسدية والأمراض النفسية المصاحبة لها، حيث استخدمت مقابلة شبه مقننة لتحديد التشخيص، وقد وجد أن ٩٢ من المرضى يعانون من اضطرابات شبه جسدية، وكان التشخيص الغالب هو النوع غير المتميز منها. وكانت الأعراض الجسمية الأكثر شيوعاً هي الصداع والالام فى أجزاء الجسم المختلفة وأعراض اضطراب الجهاز العصبى المستقل، تليها الأعراض التحويلية. وقد وجد أن ٨٥,٧ ٪ من المرضى يعانون من مرض نفسى مصاحب، وكان التشخيص السائد هو نوبة إكتئابية فى ٥٨,٧ ٪ واضطراب القلق فى ٣٦,٩ ٪ فى الحالات، وقد تلقى ١٦,٥ ٪ من الحالات، أكثر من تشخيص نفسى مصاحب. وأظهرت النتائج وجود ارتباط دلى دلالة إحصائية بين الإكتئاب كعرض وبين أعراض الالم، وكذلك بين مظاهر اضطراب الجهاز العصبى المستقل وأعراض القلق. وتشير النتائج إلى عدم مصداقية هذه الفئة التشخيصية (اضطرابات الجسدية) كمجموعة مستقلة من الأمراض النفسية.

Appendix

ICD 10 Somatoform Diagnosis

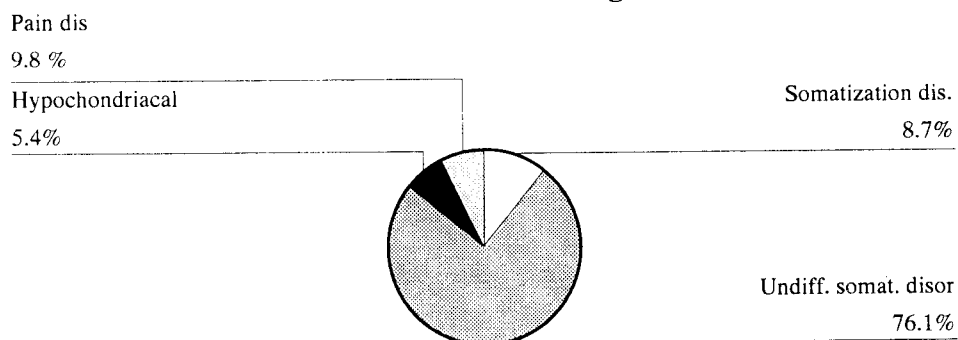
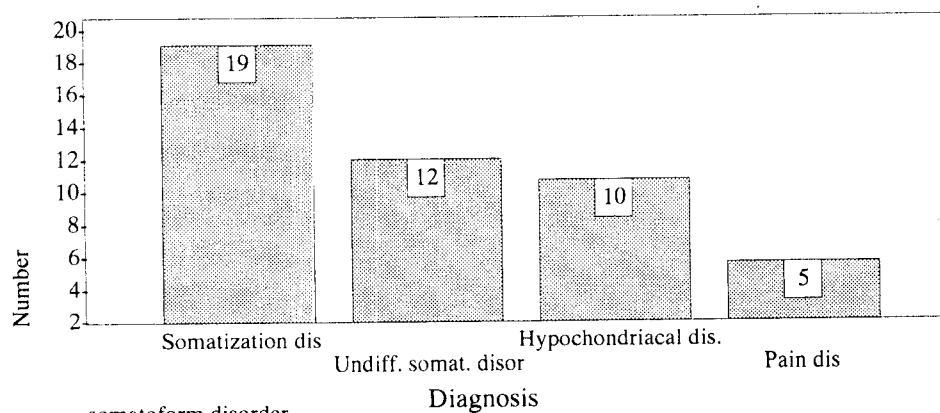


FIGURE (I)
Mean Number of Somatic Symptoms



somatoform disorder
diagnosis

FIGURE (II)

Somatic Symptoms and Comorbid Diagnosis

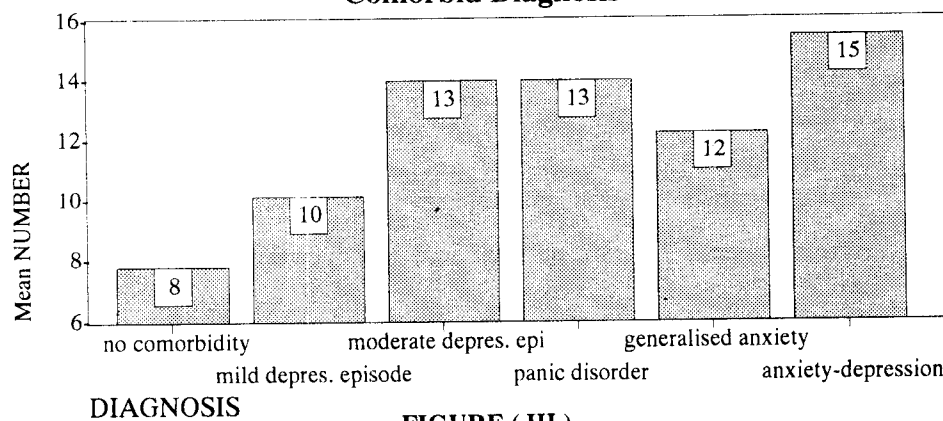


FIGURE (III)