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SOMATIC PRESENTATION OF PSYCHIATRIC DISORDERS IN AN OUTPATIENT GROUP OF SAUDIS

By

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ABSTRACT

The phenomenon of somatization in Saudi Arabia is considered in a review of 270 case records of patients who presents to the hospital during a period of four months. A high rate (56%) of conversion of psychic problems into bodily symptoms was found. Males and females showed an equal tendency to somatize; young, single, student and professional, and patients with an associated chronic physical disease were less likely to somatize than the others. Psychotic patients presented with somatic symptoms less frequently than patients with depressive or anxiety disorders; patients who reported psychosocial stresses as influencing their symptoms showed a greater tendency to somatize.

INTRODUCTION

Somatization is definied by specific criteria in the American Psychiatric Association's Diagnostic Statistical Manual [DSM III], but the word is freely used in psychiatric literature and its meaning varies with its context. In psychoanalytic literature somatization means a defensive conversion of psychic derivatives into bodily symptoms (Zetzel et al., 1973). Occasionally the word is used to describe the expression of psychiatric symptoms in a bodily language regardless of the etiology or the dynamic nature of this expression. This last meaning is the one used in this paper.

Somatization disorders are frequently unrecognized or misdiagnosed. The diagnosis depends on patients

repeatedly seeking medical advice for vague, multi-system symptoms that are often without clear physical cause (Quill, 1985). Somatization has also been diagnosed as masked depression (Kielholz, 1973; Casper et al., 1985) where the mood disturbance may not be readily apparent and the patient presents with chronic pain, insomia, weight loss, or other physical complaints.

Western literature contains little information on the prevalence of somatization disorders (Nimiah, 1980). They are reported more frequently in women (approximately 1-2 per cent of female populations) and there is a familial tendency (Woodruffe et al., 1984). In persons with higher education, it is less prevalent than other psychiatric disorders (Guze et al., 1971).

In Saudi Arabia and neighboring Arab countries, somatization has been a common presentation of psychiatric disorders. Racy (1980), said that the social and cultural deprivation experienced by some Saudi women can lead to somatic symptoms. El-Eslam (1975), reported a bizarre type of somatization where the patient described himself as a "total wreck" with disturbance of many bodily functions. This type of severe disruption occurred more frequently in women than in men.

Although no data have been published, observations indicate that among Saudi Arabians the somatic presentation of psychiatric disorders is extremely common. Statistics have shown the 9.8 per cent of our psychiatric outpatients have a DSM III diagnosis of somatoform disorder (unpublished report, S. Qaragholi). Eighteen per cent of all psychiatric inpatient consultations were for patients who had been admitted with somatic symptoms but in whom no physical disorders were confirmed (Chaleby K., 1984).

This paper is a systematic, objective study of somatization of symptoms in Saudi Arabians. The sample

population cannot, however, represent all the cultural variants in this country.

METHODS

Two hundred and seventy cases were reviewed; this was the total number of patients seen by the author in approximately four months. Their presenting symptoms were categorized as: psychiatric symptoms only (A); psychiatric and somatic symptoms (B); or somatic symptoms only (C). The somatic symptoms were classified according to the system involved. For example, headache, dizziness, limb weakness or paralysis: neurological symptoms; palpitations, chest pain, shortness of breath: cardio respiratory symptoms, and so on. Demographic data, type of somatic symptoms, psychiatric diagnosis, the presence of a chronic physical disorder, and associated psychosocial stresses were recorded and correlated with each category of presenting symptoms for all patients.

	A	B	C	TOTAL
AGE IN YEARS				
less than 20	21(57)	3(8)	13(35)	37(100)
20-29	40(38)	32(31)	32(31)	104(100)
30-39	27(41)	21(32)	18(27)	66(100)
40-49	22(51)	13(30)	8(19)	43(100)
50 and over	8(40)	6(30)	6(30)	20(100)
TOTAL	118(44)	75(28)	77(28)	270(100)
SEX				
Male	58(48)	33(27)	29(24)	120(100)
Female	60(40)	42(28)	48(32)	150(100)
TOTAL	118(44)	75(28)	77(28)	270(100)

TABLE I. Presentation of patients by age and sex

(percentages in brackets)

A (n=118(44) = patients with psychiatric symptoms only

B (n= 75(28) = patients with somatic and psychiatric symptoms

C (n= 77(28) = patients with somatic symptoms only

	A	B	C	TOTAL
MARITAL STATUS				
Married	59(40)	52(35)	37(25)	148(100)
Single	49(52)	15(16)	28(32)	92(100)
Divorced/widowed	10(33)	8(27)	12(40)	30(100)
TOTAL	118	75	77	270

A vs B: X = 9.624 DF=2 p=0.0081 B vs C: X = 7.233 DF=2 p=0.0268

OCCUPATION				
Housewife	30(38)	28(35)	21(26)	79(100)
Unskilled worker	35(39)	25(28)	29(33)	89(100)
Clerk	12(38)	10(28)	9(33)	31(100)
Student	23(65)	1(3)	11(31)	35(100)
Professional	18(50)	11(30)	7(20)	36(100)
TOTAL	118	75	77	270

A vs B: X = 14.935 DF=4 p=0.0048 B vs C: X^2= 10.547 DF=4 p=0.0322

TABLE II. Mode of presentation with marital status and occupation (percentages in brackets)

A (n=118) = patients with psychiatric symptoms only

B (n= 75) = patients with somatic and psychiatric symptoms

B (n =77) = patients with somatic symptoms only

	A	B	C	TOTAL
PSYCHOTIC DISORDER	50(79)	9(14)	4(6)	63(100)
DEPRESSIVE DISORDER	54(40)	46(35)	34(25)	134(100)
ANXIETY DISORDER	14(22)	21(32)	30(46)	65(100)
SOMATIZATION DISORDER	0(0)	16(36)	28(64)	44(100)
OTHERS	16(43)	10(27)	11(30)	37(100)
TOTAL	134	102	107	343

TABLE III. Mode of presentation with associated psychiatric disorder (percentages in brackets). Some patients had more than one diagnosis.

A (n=118) = patients with psychiatric symptoms only

B (n= 75) = patients with somatic and psychiatric symptoms

C (n= 77) = patients with somatic symptoms only

	A	B	C	TOTAL
CHRONIC MEDICAL DISORDER				
Present	59(55)	27(25)	21(20)	107(100)
Absent	59(36)	48(29)	56(34)	163(100)
TOTAL	118	75	77	270

A vs B: X = 3.638 DF=1 p=0.0565 A vs C: X = 9.948 DF=1 p=0.0016

PSYCHOSOCIAL STRESSES				
Identifiable	54(38)	48(34)	40(28)	142(100)
None identifiable	64(50)	27(21)	37(29)	128(100)
TOTAL	118	75	77	270

A vs B: X = 6.120 DF=1 p=0.0134

TABLE IV. Mode of presentation with or without chronic medical disorder and associated psychosocial stresses (percentages in brackets).

A (n=118) = patients with psychiatric symptoms only

B (n= 75) = patients with somatic and psychiatric symptoms

C (n= 77) = patients with somatic symptoms only

RESULTS

The three categories of symptoms (A = psychiatric, B = somatic and psychiatric, C = somatic) are correlated with five different age groups and sex in Table I; with marital status and occupation in Table II (the "professional" groups include all college graduates and unemployed housewives); with psychiatric disorders in Table III; and with associated chronic medical disorders, with or without identifiable stress, in Table IV. Table V gives the incidence of the different systems involved at presentation.

DISCUSSION

A number of studies by psychiatrists in general practice or tertiary care hospitals (Jacobs et al., 1968; Lipsitt, 1970) have reported that intermittent or chronic depression may be unrecognized in patients (often labelled hypochondriacs) with recurrent medical complaints. In this study, however, somatization of symptoms was not confined to depressive disorders (Table III), but occurred in almost every diagnostic category including obsessive-compulsive disorders, adjustment disorders, schizophrenia and bi-polar disorders. Whether this is culturally related and linked with a lower level of sophistication is yet to be determined, although Racy (1980) and El-Eslam (1975) have implied that this is so. Somatization frequently occurs in the culturally deprived because of the individual's poor ability to express himself verbally, and provides a cultural model of Nimah's theory of alexithymia (Nimiah, 1977). This cannot be confirmed in this study, because although Saudi females are considerable more illiterate and culturally deprived than males, the prevalence of somatization of symptoms was found to be almost the same in both sexes. However, the hypothesis was supported by the tendency to somatize being less common among the more sophisticated and verbal Saudis, that is the young (under 20 years of age) (Table

I), students, professionals, and singles (Table II).

In this study there was a high rate of somatization (56%) and half of those patients presented with somatic symptoms only (Table I). This is largely due to the clinic practice being in a general, tertiary care hospital with many patients referred from speciality clinics, thus contributing to the selection bias of the sample. The most frequent type of somatic complaint was neurological, commonly headache or dizziness. Next in frequency, cardiorespiratory and gastrointestinal symptoms were equally represented (Table V). It is interesting that patients with associated chronic physical problems are much less likely to somatize (Table IV).

Despite the tendency to somatize, somatization disorders which met the DSM III criteria were diagnosed in only 44 patients (16%) (Table III). Psychotic disorders (schizophrenic bipolar disorders and psychiatric organic brain syndromes) showed that the least somatization; depressive disorders (major depressive disorders, unipolar depression and dysthymic disorders) showed some somatization; and the anxiety disorders (anxiety, phobia, obsessive compulsion and hysterical conversion disorders) showed the most somatization. The last was an unexpected finding, and contradicts the opinion that somatization is a variant of depressive manifestation.

The final observation of this study was that patients who could identify psychosocial stresses contributing to their symptoms were more likely to somatize that those who could not. This is hard to explain, but in a previous study (Chaleby) the author noted the significance of stresses to psychiatric symptoms in Saudi women, marital and family conflicts being the most frequently reported. The greatest impact is thus on housewives who tend to be less able to express their feelings in words.

SYSTEMIC INVOLVEMENT AT PRESENTATION	INCIDENCE
PSYCHIATRIC	194(72)
MUSCULO-SKELETAL	37(14)
GASTROINTESTINAL	52(19)
CARDIORESPIRATORY	51(19)
NEUROLOGICAL	84(31)
GENITAL	9(3)
MIGRATING MULTI-SYSTEM	11(4)

TABLE V. Systemic involvement at presentation (percentages in brackets). Some patients had multi-system involvement at presentation.

REFERENCES

1. Casper, R.C., Redmond, D.E., Katz, M.M. et al., (1985): Somatic symptoms in primary affective disorders.
Arch Gen Psychiatry 42: 1098-1104.

2. Chaleby, K. (1984): An overview of psychiatric consultation of inpatient services at King Faisal Specialist Hospital.
Annals of Saudi Medicine 4: 229-234.

3. Chaleby, K.: Psychosocial stresses and psychiatric disorders in an outpatient population in Saudi Arabia. Psychiatr Scand (in press)

4. Diagnostic and statistical Manual III (1980): The American Psychiatric Association Publication pp. 241-243.

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

6. Guze, S.B.; Woodruffe, R.A.Jr.; Clayton, P.J. (1971): A study of conversion symptoms in psychiatric outpatients.
Am J. Psychiatry 128: 643-646.

7. Jacobs, T.J., Gogelson, S., Charles, E. (1968): Depression rating in hypochondria. Mv State J. Med. 68: 3119-3122.

8. Kielholz, P. (1973): Masked Depression. Berne, Hans Huber.

9. Lipsitt, D.R. (1970): Medical and psychological characteristics of "crocks". Psychiatric Medicine 1: 15-25.

10. Nimiah, J.G. (1977): Alexithymia, theoretical

considerations.
Psychother Psychosom 28: 199-206.

11. Nimiah, J.C. in Comprehensive Textbook of Psychiatry. Freedman, Kaplan, Saddock eds, (1980). New York, Williams & Wilkins, p. 1526.

12. Quill, T.E. (1985): Somatization disorder, one of medicine's blind spots. Jama 254: 3075-3079.

13. Racy, J. (1980): Somatization in Saudi women. A therapeutic challenge. Br. J. Psychiatry 137: 212-216.

14. Woodruffe, R.A.Jr., Goodwin, D.W. Guse, S.B. (1984): Psychiatric Diagnosis New York, Oxford University Press.

15. Zetzel, E.R., Meissner, W.W. (1973): Basic Concepts of Psychoanalytic Psychiatry. New York, Basic Books.

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موجز

الأعراض الجسمانية للأمراض النفسية فى عينه من المرض السعوديين المترددين على العيادات الخارجية

ان ظاهرة تحويل الأعراض النفسية الى أعراض جسمانية في المملكة العربية السعودية درست بمراجعة سجلات ٢٧٠ حاله ممن قدمه للعلاج في هذه المستشفى خلال ٤ شهور .

ووجد أن هناك معدل عال من هذه الظاهرة (٥٦ ٪ .) .

وأوضحت النتائج أن الرجال والنساء متساوون فى ظاهرة تحويل الأمراض النفسية إلى أعراض جسمية وأن صغار السن والغير متزوجون والطلاب والمهنيين والمرضى الذين يعانون من أمراض عضوية مزمنه أقل عرضه لتحويل الألم النفسى الى أعراض عضوية .

ووجد أيضا أن مرضى الذهان أقل عرضه لظهور أعراض جسمانية من مرضى القلق والأكتئاب كما أوضحت أن المرضى الذين تعرضوا لضغوط نفسية قبل المرض أكثر عرضه لتحويل الأعراض النفسية الى أعراض جسمانية .

ABSTRAIT

Le phenomene de somatisation est consideré dans une revue des enregistrements de 270 malades presentant à un hôpital en Arabie Seoudite durant une periode de 4 mois. Un grand pourcentage (56%) de transformation des problèmes psychiques en symptomes corporels ont été trouvé. Les hommes et les femmes presentaient une tendance égale de somatisation. Les jeunes, celibataires, étudients, professionnels ainsi que les malades associés avec une maladie physique chronique ont été moins vraisemblable de somatiser que les autres. Les malades psychotiques ont presenté des symptomes somatiques moins fréquents que les malades avec des troubles d'anxieté ou de depression. Les malades rapportant des tension psychosociales influençant leur symptomes ont eu une plus grande tendance de somatiser.

BOOK REVIEW
A B C OF BRAIN STEM DEATH

By Christopher Pallis, Articles from the British Medical Journal, Devenshire Press, 1983.

The book is one of a series of articles for the BMJ is the "ABC" format that concentrates on the more practical aspects of diagnosing brain stem death which serves to avoid the longstanding fear of premature burial or mistaken diagnosis of death on one hand, and offer an answer to the critical question elaborated with organ donation in the transplantation operation on the other hand.

This article declared three objectives: firstly, to emphasise that it is legitimate to equate brain death with death (and this is now sidely accepted in medical and legal circles throughout the world); secondly, to suggest that the necessary and sufficient component of brain deathis death of brain stem (this is less widely accepted, largely because it is a relatively new concept); and, thirdly, to realise that a dead brain stem can reliably be diagnosed at the bedside. The acceptance of these ideas would lessen human distress and lead to more rational use of our limited intensive care facilities.

The book is composed of 9 chapters in 33 pages. In its first chapter, the concept of human death is proposed. Chapter 2 explores the difference between functional death of the organism as a whole, and total cellular death of the whole organism. Chapters from 3 to 6 show systematic approaches for diagnosis of brain stem death that specify preconditions and exclusions, and confirm the absence of brain stem functions. Pitfalls and safeguards in this respect, and issues for declaration of death were described. Chapter 7 gives the prognostic value of clinical signs of brain stem death. The position in different countries and the argument about the relevance of B.E.G. in establishing the presence of a dead brain stem were discussed in chapters 8 and 9.

The book prepared the way for better insight into all these matters as well as better understanding of the social, cultural, ethical, religious, and economic implications of the subject. The presented tables and figures provided great help in clearing the theoretical