Psychiatric Morbidity Among a Sample of Egyptian Patients Attending Back Pain Clinic

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Abstract

This study attempts to investigate the morbidity of psychiatric disorders in back pain clinic. The clinic of El-Sahel Teaching Hospital, it has carried out by consultants in neurosurgery, orthopedics, rheumatology, physiotherapy and psychiatry. The sample consisted of 463 patients complaining of back pain attending the unit. Thorough history, examination and investigations were done by all consultants. Psychiatric diagnosis were done according to ICD-10. The findings showed that 22.7% of the sample were only psychiatric disorders manifested by back pain without any physical disorder. 15.8% were suffering of psychiatric disorders associated with physical disorders. 16.6% were suffering of physical disorders without morbidity. These findings have clearly demonstrated the importance of psychiatric departments in general hospitals, the understanding of psychiatric disorders as an etiologic factor of several physical disorders and of proper diagnosis and management.

Introduction: Consultation liaison psychiatry functions at the interface between psychiatry and medicine. It covers a board spectrum of activities, performing a traditional consultation in one individual patient, becoming an integral member of a medical, surgical team and undertaking research in clinical issues.

Psychiatric attempts to address psychiatric morbidity in the medical setting has accelerated during the last 50 years due to the establishment of psychiatric departments in medical schools and general hospitals.

Studies demonstrated that behavioral factors influence the development, onset, course and outcome of physical disorders. Back pain is a syndrome in which the psychological factors may contribute to or underlie the presenting clinical picture. These factors are characterized by their high prevalence in community. It is an extremely common condition. There are few adults who have not experienced episodes of back pain. It is a major cause of consultation with general practitioner. (Ward et al., 1968).

Psychological factors have for long been considered important in back pain patients (Paul, 1950; Felterman, 1940).

Bacon N.M. et al., (1994) found that 25.8% of low back pain patients reported a lifetime history of one or more somatic symptoms other than pain (Walkind and Forrest, 1972). Clinical studies of patients whose back pain appeared unamenable to treatment have shown high proportion of overt psychiatric disorders, (Marta et al., 1979; Lioyd et al., 1979).

Bongers, P.M. et al., (1993) concluded that monotonous work, high perceived work load and pressure are related to muscloskeletal symptoms. In addition, stress symptoms are often associated with muscloskeletal diseases and some studies indicate that stress symptoms contribute to the development of the disease.

Individuals with persisting pain often present a consultation of symptoms that include pain, health related impairment and dysphoric mood. It is now widely accepted that comprehensive assessment

must address each of these dimensions, (Klapow J.C., 1993).

Aim of study

This study attempted to investigate the psychiatric morbidity among a sample of Egyptian patients attending back pain clinic in educational general hospital, El-Sahel Teaching Hospital.

Subjects and Methods: Low back pain clinic is a consultation unit formed in El-Sahel Teaching Hospital consisted of a team of consultants in neurosurgery, orthopedic, rheumatology, physiotherapy and neuropsychiatry. It aimed to give the patient of low back pain the chance to be examined by several consultants to cover all etiologic factors and so, leading to proper diagnosis and management. We chose three months duration April to June, 1995 and all patients during this period were included in the research. We used a semistructured psychiatric interview. No exclusion criteria except the refusal of patient to conduct psychiatric interview which did not happen.

Results: Table (1) shows the distribution of patients according to sex, psychiatric and physical disorders. It shows that 22.7% of the examined patients were absolutely primary psychiatric patients. They were not suffering of any physical disorder, although they were attending the unit for their complaints of back pain.

15.8% of the examined patients had both psychiatric and physical disorders at the same time. 16.6% of the examined patients were only suffering of physical disorders without any associated psychiatric disorders. It is evident from the table that both males and females were equally affected by psychiatric disorders only (23.9%, 22.3 % respectively).

Table II shows the distribution of psychiatric disorders amoung examined

Table I: Distribution of patients according to sex, psychatric and physical disorders

	Sex				Total	
	Female		Male			
	No.	%	No.	%	No.	%
Psychiatric disorder	77	22.3%	28	23.9%	105	22.7%
Physical disorder	210	60.7%	75	64.1%	285	61.6&%
Both Psychiatric and Physical	59	43.4%	14	12.0%	72	5.8%
Total	346	100.0%	117	100.0%	463	100.0%

patients. It shows that depressive disorder was the diagnosis of 60.11% of the examined patients who had psychiatric disorders. 22.5% of the examined patients had psychosomatic disorder. 9% of the examined patients were suffering of anxiety disorders. Other major psychiatric disorder were shown in the table.

Table (III) shows the distribution of psychiatric disorders according to age. Age group 35-44 had the higher prevalence of psychiatric disorders followed by the age group 25-34 then the group age 45-54 old. i.e. it is greatest among the middle age group.

Table (IV) shows social state as a predisposing factor where the married males claimed psychiatric morbidity in 83.3% and 90.4% in married females.

Table (V) shows that rofessional and technical workers in males were the prevalent psychiatric patients. Among females, the housewives were the prevalent psychiatric patients.

Discussion: Psychiatrists commonly encounter physical disorders among those patients attending psychiatric outpatients clinics and those in the inpatient wards, especially amongst middle-aged and elderly ones. They are likely requested to see physically ill patients in otherwards.

Many studies have confirmed that physical disorders and psychiatric disorders have a common comorbidity in clinical practice. In the nineteenth century there was wide acceptance of the idea that psychological factors may play a part in the etiology of physical illness (Tuke, 1872). In the twentieth century this idea was elaborated by Freud and his followers, who presented case studies of physical illness for which they proposed psychological causes. From these findings t

Table II Distribution of psychiatric disorders among examined patients

Psychiatric disorder	No.	%
Anxiety	16	9.0%
Dementia	2	1.2%
Depression	107	60.1%
Hysterical disorder	3	1.7%
Imptence	1	0.6%
.B. syndrome	2	1.1%
Parkinsonism	4	2.3%
Psychosmatic	40	22.5%
Schizophrenia	3	1.7%
Total	178	100.0%

Table III Distribution of psychiatric patients according to age

Age group	No.	%
15-24	12	6.7%
25-34	46	25.8%
35-44	60	33.7%
45-54	36	20.2%
55-64	20	11.2%
65-74	3	1.7%
75+	1	0.6%
Total	178	100.0%

Table IV: Distribution of psychiatric patients according to martial status

	Sex				Total	
	Female		Male			
	No.	%	No.	%	No.	%
Married	35	83.3%	123	90.4%	158	88.8%
Single	7	16.7%	13	9.6%	20	11.2%
Total	42	100.0%	136	100.0%	178	100.0%

Table V: Distribution of psychiatric patients according to occupation and sex

	Sex				Total	
	Female		Male			
	No.	%	No.	%	No.	%
Housewife	112	82.4%	0	0.0%	112	62.9%
Manual worker	2	1.5%	3	7.1%	5	2.8%
Professional	6	4.4%	16	38.1%	22	12.4%
Student	7	5.1%	3	7.1%	10	5.6%
Technical	8	5.9%	17	40.5%	25	14.0%
Unemployed	1	0.7%	3	7.1%	4	2.2%
Total	136	76.4%	42	23.6%	178	100.0%

emerged a body of theory and practice known as psychosomatic medicine. The central theme of psychosomatic medicine was that psychological factors, particularly certain conflicts could play an important part in causing the onset of certain physical diseases, once these physical diseases were established, psychological factors could contribute to maintain, aggravate them or triggering relapse.

Pain may cause psychological distress or may itself arise from psychological causes. On the other hand it may be a feature of any psychiatric condition, particularly depression (Blumer and Heilbronn, 1982).

The main sites of psychologically determined pain as referred to in many studies are the head and neck, the abdomen (Dally and Gomez, 1980), and the lower back (Wolkind, 1976, Crown, 1980).

New nosological approaches introduced the category of somatoform disorders which are characterized by physical symptoms suggesting medical disease but no demonstrable organ pathology or known pathophysiological mechanism can be found to account for them. They are considered psychiatric disorders because there is clear evidence or a strong presumption that the symptoms are linked to psychological factors..

Patients with low back pain often present a challenge to physical therapists trained in the evaluation of the physical nature of low back pain,they suggest that adequate treatment of them requires evaluation of the impairment, functional limitation and disability including patient's self report of quality of life (Dilitto A. 1994).

Halzberg et l., (1993), studied he relationship between depression and the cognitive functions of chronic pain patients. It was hypothesized that the ambiguity and desirability of self rated traits would significantly predict level of depression. These findings may have important implication for the cognitive-behavioral treatment of chronic patients.

Poltin et al., (1993), studied 200 chronic low back pain patients for current and life psychiatric syndromes using structured psychiatric interview of DSM-III-R. Diagnosis showed that 77% of patients met lifetime diagnosis criteria and 59% demonstrated current symptoms for at least one psychiatric diagnosis. The most common of these were major depression, substance abuse, and anxiety disorders.

Chronic low back pain patients often are described as "somatizers", who report multiple somatic complaints beyond back pain itself. To clarify the characteristics correlated and severity of somatization in low back pain patients, we vigorously assessed somatization symptoms in a sample of patients not selected for psychiatric or pain clinic referral. Male lower back pain patients (N=97), attending a primary care orthopedic clinic, were assessed, 25.8% of patients reported a lifetime history of one or more somatic symptoms.

Major depression and alcohol dependence were significantly associated with increased severity of somatization. Lower mood and increased impairment, but not pain intensity, were related to a greater number of somatic complaints. Recognizing this spectrum of somatization would lead to better patient- treatment matching and improved clinical outcomes (Bacon N.M. et al, 1994).

This current study revealed that 2.7% of the examined patients were suffering only of psychiatric disorders without any physical disorders after being examined and investigated by all consultants. It revealed also 15.8% of the examine patients had both psychiatric and physical disorders. Current findings of the distribution of psychiatric among the examined patients agree with the findings of the work of Polatin P.B. et al., (1993) and Bacon N.M et al., (1994) that major depressive disorder was the commonest psychiatric disorder. Depressive disorder was the diagnosis among 60.11% of the examined patients, 22.5% were diagnosed as psychosomatic disorder and 9% of the examined patients were anxiety disorder. Both males and females were equally affected. Age 35-44 had the higher prevalence.

Depression has claimed the attention of psychiatrists, who have only studied and described the psychiatry symtomatology characterizing depressive modes and expression as a cause of purely subjective somatic symptoms which lack the deepness of frank depression experience. Among those somatic symptoms, psychic conflict may sail under a pain flag in the sea of depression. In these cases, pain may constitute the "mask" concealing the underlying depression (Sadek A., 1982).

The belief in the existence of a relationship between depressive illness and somatic disturbance, which may be the main complaint and a diagnostically puzzling presenting symptoms of depression, has been handed down to us since ancient times, and was described by ancient Egyptians in the books of the heart of Eber' papyrus (Okasha, 1978).

Chapman (1976), denoted that a dual relationship between pain and depression, that makes it possible to report, a chronic painful illness producing secondary depressive changes and a depressive illness that makes a primary contribution

to the pain. Depression secondary to chronic painful illness is emphasized by Stege (1965), Boyer and Guelif (1992) and Peteet (1979).

Weiser S. et al., (1992) reviewed research on psychological and social factors associated with the onset and progression of back pain. They concluded that psychological and social traits appear to be the important contributors to the course of pain and disability. Programs which include psycho social intervention appear to have superior results to these which do not.

Fazzi A. et al., (1991) pointed out that social economic and psychological factors contribute to manifestations of many lumber spine disorders and that the knowledge of psychosomatic concepts will help to a better understanding of the symptoms presented by these patients.

In one of the relatively recent studies twenty-sex adult outpatients suffering of chronic back pain were observed in a clinic study. Treatment was multifaceted. A psychiatrist served as the coordinator of all treatments used. Treatment included biofeedback, physical therapy, behavioral management program and pain measurement scales, psychotherapy with pain counseling and medications. Results of the study bore out the necessity of a coordinate multifaceted approach to treatment of chronic pain. Strong emotional expression was seen in all patients Stress, depression and secondary gain are symptoms that were addressed. Patients improved significantly. The psychiatric components serving as the anchor for treatment was viewed as a key to success (Strenger, E.M. 1992).

Lastly the problems that can arise in patients of a back pain clinic demonstrate as well as any the way in which psychological and physical factors can interact with each other. Help from a liaison psychiatrist with a special interest in this field should be available to all such units. By working together, the other specialists will become aware of the contributions a psychiatric team can make. Similarly the psychiatrist will become increasingly knowledgeable about the varieties and degrees of handicap found in low back pain patient. He will be able to take these fully into account when planning any form of psychiatrists intervention. He may also have important role in helping paramedical staff, such as psysiotherpaists, who can easily become entrapped in mutually destructive interactions with difficult patients. The psychiatric component playing an important role for the success of the treatment. The emotional component present in back pain must not be overlooked, because it plays a vital role in proper diagnosis and successful treatment. psychological intervention in general health care setting not only improve psychiatric morbidity, psychological adjustment, and the medical conditions but reduce the total health care costs as well.

Conclusion: Our results indicate that certain psychiatric symptoms appear to be presented or associated with back pain. Such findings substantially add to our understanding of the causality and predisposition in the relationship between psychiatric disorders and back pain. They also clearly reveal that clinicians should be aware of potentially high rates of emotional distress syndromes in back pain and enlist mental health professional to help maximize treatment outcomes. We call attention to the importance of an integrated multiprofessional attendance of patients with back pain.

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الاضطرابات النفسية لدى عينة من المرضى المصريين المترددين على عيادة آلام الظهر

تحاول هذه الدراسة فحص درجة وجود الاضطرابات النفسية لدى المترددين على عيادة آلام الظهر. وقد أجريت الدراسة فى مستشفى الساحل التعليمى و قام بها الاستشاريين فى جراحة الأعصاب و جراحة العظام و الروماتزم و العلاج الطبيعى والطب النفسى.و تكونت العينة من ٤٦٣ مريضا يشكون من الآم الظهر. و أجريت لهم فحوص دقيقة بواسطة الاستشاريين و استخدمت معايير ICD 10 فى الفحص النفسي. وبينت النتائج أن ٢٢,٧٪ من هؤلاء المرضى كانوا مجرد مرضى نفسيين ظهرت أعراضهم من آلام الظهر دون أى اضطراب جسمى. كما أن ١٥,٨٪ كانوا يعانون من اضطرابات نفسية مرتبطة باضطرابات جسمية. و كان ١٦,٦٪ يعانون من اضطرابات جسمية فقط دون أى اضطرابات نفسية مصاحبة. و توضح هذه النتائج أهمية وجود أقسام نفسية فى المستشفيات العامة. و ضرورة إدراك أن الاضطرابات النفسية تلعب دورا سببا فى العديد من الاضطرابات الجسمية.