

Objective Psychiatric Assessment of a Sample of Patients with Irritable Bowel Syndrome (IBS)

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Abstract:

The IBS is very common in the community. Psychosocial factors other than the gut symptoms may contribute to the decision of some to seek medical care. We therefore objectively studied a sample of IBS patients (no = 30) attending a gastroenterology outpatient clinic. Twenty-five, (25) healthy volunteers matched for sociodemographic data and free from any GIS at the time of assessment were used as controls. Both groups completed Zung Self Rating Scale for Depression and Social Readjustment Rating Scale (SRRS).

Cases were subjected to objective psychiatric assessment using ICD-10 symptom checklist and diagnoses were based on ICD-10 criteria for Research. IBS patients showed evidence of pathological depression and more life events (total units) in comparison to controls. All IBS patients had an associated psychiatric disorder (no 30) 100%, the most common were other anxiety disorders (no= 15) 50% and depressive episode (no= 9) 30%, where other psychiatric diagnoses formed 20% only of the total sample. The psychiatric profile of this sample of patients with IBS was formed of symptoms of anxiety, depression, Somatization with tendency to overuse medical services. In conclusion, the study highlights the importance of the interdisciplinary approach for the medical care of patients.

Introduction:

Irritable bowel syndrome (IBS) is one of the most common of the gastrointestinal disease, but it can be a diagnostic challenge because of the many symptoms that overlap with other such diseases. Most common among the symptoms are abdominal pain, a feeling of intestinal distention or bloating, and either diarrhea or constipation (*Verne and Cerda, 1997*). *Walker et al. (1996)* reported that IBS is the most common gastrointestinal disorder encountered by primary care physicians and gastroenterologists: prevalence figures range from 13% to 52% of new referrals to gastrointestinal clinics. International population studies indicate that 15-20% of persons suffer from IBS. At the same time IBS is one of the eight most common somatic symptom complexes that account for 23% of visits to primary care physicians

(*Meadows et al., 1997*). Despite the high prevalence of this disorder, however there is incomplete agreement of its definition and its status as a valid diagnostic entity (*Walker et al, 1990*). *Goldberg and Davidson (1997)* reviewed and examined the clinical and research literature on IBS with a view to establishing the role that psychiatric factors play in the pathogenesis and treatment of this syndrome. They found that co-morbid psychiatric illness is common with IBS, yet only a small proportion of these patients seeks medical attention. Psychosomatic medicine is an area of scientific investigation concerned with the relation between psychological factors and physiological phenomena. *Stoudemire and McDaniel (1995)* declared that the general trend in recent psychosomatic theories has focused on

multi-factorial contributions to disease vulnerability, which was a basic tenet of Alexanders' specificity theory. *Meyer (1958)* attempted to integrate mind and body into a psychobiological unit. He proposed that psychological and biological processes be studied as dynamic interacting systems. His psychobiological theory forms the basis for the biopsychosocial approach.

The concept of stress has been central in the development of psychosomatic theory. *Stoudemire and McDaniel (1995)* summarized Cannon's Concept of stress that was essentially derived from physics: under certain circumstances, physical or emotional stimuli can strain an animal beyond its ability to adapt successfully. They also stressed Wolff's fundamental premises that disease is a failure or inability to adapt to life stress. Wolff's theory heralded the concept that the way in which a person is able to cope with a stressful event is a critical factor in determining the magnitude of subsequent physiological effects. *Walker et al., (1990)* reviewed studies of emotional modulation of gut motility. The studies have suggested that the locus ceruleus is one possible CNS area having both afferent and efferent connections to the gut that might constitute the "missing link". *Katon et al., (1989)* suggested that internal bowel events may cause discharge of the locus ceruleus, greater anxiety and psycho-physiological gastrointestinal symptoms. The gastrointestinal symptoms may then cause peripheral activation of the locus ceruleus, resulting in greater anxiety, adding to the mental stress of the individual and further overwhelming coping mechanisms.

Subjects and Method:

Thirty consecutive patients attending gastroenterology outpatient clinic of Suez Canal University Hospital with the diagnosis of irritable bowel syndrome were referred to psychiatric outpatient clinic for objective psychiatric assessment. Objective diagnosis of IBS was according to *Manning et al.'s criteria (1978)*, after patients were submitted to repeated stool analysis, abdominal ultrasound, barium studies and endoscopic examinations when indicated. Other causes of gastrointestinal symptoms have been excluded as patients with chronic liver disease and end stage renal diseases. Objective psychiatric evaluation was done using:

- Zung Self Rating Scale for depression (1965).
- Psychiatric interview using ICD-10 symptom checklist (WHO-1994) for mental disorders.
- Psychiatric diagnoses were based on ICD-10 diagnostic criteria for research (WHO-1994).
- Changes in lives of patients in the last year before assessment was done using *Holmes and Rahe (1978)* Social Readjustment Rating Scale (SRRS),

Twenty-five healthy volunteers matched for the socio-demographic characteristics of the study sample, and recruited from employees and visitors in Suez Canal University Hospital, were used as a control group. All subjects of the control group were free from any gastrointestinal symptoms at the time of assessment. They completed Zung self-Rating Scale for depression and (SRRS).

Statistical Procedure:

Data were statistically analyzed using an IBM computer with Microsoft statistical

package (*IPI Info, WHO, 1996*). Chi-square test was used for comparison of the qualitative data, however, if an expected value of any cell was less than 5, Fisher exact test was used. On the other hand, student t-test was used for comparison between quantitative data, however, if quantitative data were not normally distributed, Kruskal-Wallis test for two groups was used. A descriptive profile of psychiatric symptoms of the IBS patients using ICD-I 0 symptom checklist (Modules F2/3 and F3/4), as base data, was constructed from symptoms with frequency more than 50% of the total group (*Kirkwood, 1991*).

Results:

The socio-demographic characteristics of both cases (N = 30) and controls (N = 25) are summarized in table (1). The mean age of the patients' group was 36.33 (SD $\pm$ 9.1) and the mean age of the control group was 35.76 (SD $\pm$ 10.6) with no significant statistical difference between the two groups. There was no significant statistical difference between the two groups regarding the other socio-demographic characteristics except for the place of residence where urban residence was more represented in the control group-

Clinical presentations defined by sex of the studied sample of patients, table (2) shows that the only significant difference; was that all females no=13 (100%) reported psychological complaints when referred to psychiatric out-patient clinic in comparison to 12 out of the 17 males (70.6%). On the other hand there was no significant statistical difference between females and males as regards the presence of history of previous psychiatric assessment or family history of psychiatric disorder.

Results of screening for depression using Zung Self Rating Scale of the two studied groups are summarized in tables (3) and (4). Table (3) shows that 21 out of the 30 cases and only 5 out of the 25 controls had pathological depression with highly significant statistical difference between the two groups (P = 0.002). As regards severity of depression II (3 6.7%) of the patients' group and 4 (16%) of controls ranked in the category of minimal to mild depression. On the other hand, 9 (30%) of patients' group and only 1 (4%) of controls ranked in the category of moderate to marked depression

One subject only in the patients' group ranked in the category of severe depression. Table (4) shows means, SD and range of scores of the two groups on Zung Self Rating Scale of depression with evidence of highly significant statistical difference (P = 0.00083).

Table (5) shows the profile of psychiatric symptoms of our sample of patients with IBS. This profile suggests that patients with IBS experience a symptom complex (syndrome) of mixed anxiety, depression, somatization with tendency for repeated consultations with medical professionals that suggests great utilization of medical services. It is worth to note here that symptoms of autonomic anxiety were the most frequently reported symptoms and occupied the top position of that profile. At the same time the most common psychiatric diagnosis of that sample of IBS were: other anxiety disorders 50% and depressive episode 30% while other psychiatric diagnoses formed 20% only of the whole sample.

Comparison between IBS patients and controls on life events (units), Table (7) shows highly significant statistical

differences regarding means, SD and Range. Patients group mean score was 265.03 that exceeds the 200 points suggested by *Holmes and Rahe (1978)* to predispose to psychosomatic disease.

Table (8) summarized the frequently reported life events of IBD patients in comparison to controls that reach statistical significance.

Table (1): Socio-demographic characteristics of IBS patients and controls

Variables	Cases 30 (100%)	Controls 25 (100%)	Total 55 (100%)	P- Value
Age / years				T = 0.50
Mean $\pm$ SD	36.33 $\pm$ 9.1	35.76 $\pm$ 10.6		P = 0.82
Range	19 – 60	20 – 60		NS
Sex				$X^2 = 0.40$
Female	13 (43.3%)	13 (52%)	26 (47.3%)	P = 0.52
Male	17 (56.7%)	12 (48%)	29 (52.7%)	NS
Education				
Illiterate	5 (16.7%)	4 (16%)	9 (16.4%)	$X^2 = 7.55$
Read and write	6 (20%)	2 (8%)	8 (14.5%)	P = 0.18
Elementary	2 (6.6%)	1 (4%)	3 (5.4%)	NS
Secondary	11 (36.7%)	5 (20%)	16 (29.1%)	
Graduate	6 (20%)	13 (52%)	19 (37.5%)	
Marital Status				
Single	2 (6.7%)	7 (28%)	9 (16.4%)	$X^2 = 4.91$
Married	23 (76.7%)	16 (64%)	39 (70.9%)	P = 0.08
Others	5 (16.7%)	2 (8%)	7 (10.7%)	NS
Occupation				
House wife	9 (30%)	4 (16%)	13 (23.6%)	$X^2 = 6.49$
Unskilled	3 (10%)	2 (8%)	5 (9.1%)	P = 0.16
Skilled	6 (20%)	1 (4%)	7 (12.7%)	NS
Semiprofession al	6 (20%)	9 (36%)	15 (27.3%)	
Professional	6 (20%)	9 (36%)	15 (27.3%)	
Residence				
Rural	11 (36.7%)	3 (12%)	14 (25.5%)	$X^2 = 4.29$
Urban	19 (63.3%)	22 (88%)	41 (74.5%)	P = 0.03 Significant

Table (2): Clinical presentations of the studied sample defined by sex

Clinical Data	Female		Male		Total		P-value of difference
	No	%	No	%	No	%	
1. Complaint							
a) Somatic							
- Present	13	100%	17	100%	30	100%	
- Absent	--	--	--	--	--	--	
b) Psychological							
- Present	13	100%	12	70.6%	25	83.3%	Fisher=0.04
- Absent	--	--	5	29.4%	5	16.7%	Sig.
2. History of previous psychiatric assessment							
- Present	--	0%	4	23.3%	4	13.3%	Fisher=0.08
- Absent	13	100%	13	76.7%	26	86.7%	N. Sig.
3. Family history of psychiatric disorders							
- Present	2		3	17.6%	5	16.7%	Fisher=0.63
- Absent	11		14	82.4%	25	83.3%	N. Sig.
Total	13		17	100%	30	100%	

Table (3): Results of assessment of depression using Zung Self Rating Scale of both cases and controls: -

Zung Categories	Cases		Controls		Total		P-value of difference
	No	%	No	%	No	%	
- No depression (less than 50)	9	30%	20	80%	29	52.8%	X ² = 14.5 P = 0.002 Highly Significant
- Minimal to mild (50 - 60)	11	36.7%	4	16%	15	27.3%	
- Moderate (60 - 70)	9	30%	1	4%	10	18.1%	
- Severe depression (Above 70)	1	3.3%	0	0%	1	1.8%	
Total	30	100%	25	100%	55	100%	

Table (4): Comparison between cases and controls as regards scores of Zung Self Rating Scale for depression:

Zung	Cases (30)	Controls (25)	P-value of difference
Mean	54.10	43.68	K = 11.16
SD	± 10.80	± 8.72	P = 0.00083
Range	31.71	28 - 62	Highly significant

K = Kruskal - Wallis test.

Table (5): Profile of Psychiatric Symptoms of IBS Patients based on ICD-10 symptom checklist (Modules F2/F3 and F4/F5)

Symptoms	No	%
Symptoms of autonomic anxiety	28	(93.3%)
Anxiety, worry, apprehension	27	(90%)
Depressed mood	22	(73.3%)
Decreased energy or increased fatigability	22	(73.3%)
Sleep disturbance	21	(70%)
Change in appetite and weight (5% of weight)	20	(66.7%)
Loss of interest or pleasure	19	(63.3%)
Symptoms of increased psychological sensitivity and arousal	19	(63.3%)
Repeated consultations with (medical) professionals and refusal to accept (medical advice)	18	(60%)
Multiple and variable complaints not explained by any physical disorder	17	(56.7%)

- Symptoms are presented in descending order of frequency. Only symptoms of frequency more than 50% are included in the profile (Kirkwood, 1991).

- N.B. % is added to more than one hundred because every patient complains of more than one symptom.

Table (6): Psychiatric Diagnoses of the Sample of IBS Patients according to ICD-10 Diagnostic Criteria for Research

Symptoms	No	%
Paranoid schizophrenia	1	(3.3%)
Schizo affective disorder	1	(3.3%)
Depressive episode:	9	(30%)
- Severe without psychotic symptoms without somatic syndrome	1	(3.3%)
- Severe without psychotic symptoms with somatic syndrome	6	(20%)
- Moderate without somatic syndrome	2	(6.7%)
Other anxiety disorders:	15	(50%)
- Panic disorder	1	(3.3%)
- Generalized anxiety disorder	5	(16.7%)
- Mixed anxiety and depressive disorder	9	(30%)
Adjustment disorder:	2	(6.7%)
- With prolonged depressive reaction	1	(3.3%)
- With mixed anxiety and depressive reaction	1	(3.3%)
Sexual dysfunction	1	(3.3%)
Failure of genital response + premature ejaculation		
Anakastic personality disorder	1	(3.3%)
Total	30	100%

Table (7): Comparison between IBS patients and controls on units of social readjustment rating scale

Life Events (units)	Cases 30	Controls 25	P-value of difference
Mean	265.03	177.56	T = 7.74
SD	± 129.14	± 98.17	P = 0.007
Range	40 – 570	12 – 397	Highly significant

Table (8): The Frequently reported life events by IBS patients in comparison to controls

Individual Life Events	Cases		Controls		Total	P-value of difference
	No	%	No	%		
Marital discord	16	(53.3%)	5	(20%)	21 (38.2%)	0.012 Sig.
Pregnancy	10	(33.3%)	2	(8%)	12 (21.8%)	0.024 Sig.
Major change of responsibilities at work	10	(33.3%)	2	(8%)	12 (21.8%)	0.024 Sig.
Major change in sleeping habits	22	(73.3%)	11	(44%)	33 (60%)	0.038 Sig.
Major change in eating habits	20	(66.7%)	10	40%	30 (59.4%)	0.050 Sig.
Major change in amount and type of reaction	12	(40%)	4	(16%)	16 (29.1%)	0.053 Sig.

Discussion:

The association between irritable bowel syndrome (IBS) and psychiatric disorders is well known to most clinicians, but the nature of the relationship is far from clear. There is an increased prevalence of psychiatric illness in IBS patients and an increase in IBS in psychiatric patients (*Lydirard, 1997*). *Walker et al., (1990)* had reviewed six studies of coexisting gastrointestinal and psychiatric symptoms in patients with IBS. These studies suggested that 54% - 100% of patients with IBS may have an associated psychiatric illness. All IBS patients of our study $n = 30$ (100%) had an associated psychiatric disorder in accordance with one of those six studies by *Walker et al. (1990)*. An Egyptian Study by *Fathy et al., (1990)* detected psychiatric morbidity in 70% of an elderly group of patients with IBS in

comparison to 60% of a group of young adults. *Gupta et al., (1997)* reported that amongst patients seeking medical attention for IBS, 70 - 90% may have psychiatric comorbidity. The discrepancy in the rates of associated psychiatric morbidity in IBS can be attributed to many factors as lack of consensus about definitions, differences in sampling, tools of assessment and the use of different diagnostic criteria.

IBS patients in the present study showed definite evidence of pathological depression according to Zuny Self Rating Scale in comparison to controls, tables (3) and (4). The psychiatric profile, table (5) and the most frequent psychiatric disorders, table (6) of the study sample were in agreement with the results of a prospective study done by *Gwee et al., (1996)* who reported that patients who subsequently developed IBS

had higher scores of anxiety, depression, somatization and neurotic trait. They interpreted their results as supporting the hypothesis that psychological factors are important in IBS. The striking high frequency of symptoms of autonomic anxiety in the patient's profile, table (5), supported the notion by *Whorwell et al., (1986)* that IBS patients show features of autonomic arousal that are common in mood and anxiety disorders. They reported symptoms such as weakness, fatigue, headache, hand tremor, back pain, sleep disturbance and symptoms of sexual dysfunction. Of worth noting here that one patient of our study sample had an associated diagnosis of sexual dysfunction.

In the same direction *Orr et al., (1997)* confirmed the presence of enhancement of REM sleep in patients with IBS that suggests an intrinsic alteration autonomic and CNS functioning. Another study that presented a model for brain-gut interaction was conducted by *Heitkeper et al., (1996)*. They compared urine catecholamines (norepinephrine, epinephrine) and cortisol in women with IBS (Patients), IBS (non-patients) and controls. Women seeking healthcare for IBS (IBS-patients) had an increase in indicators of sympathetic nervous system activation (catecholamines) and cortisol, that reflects greater symptom distress or may contribute to increased symptom distress. The tendency to report multiple somatic complaints and to overuse medical resources that formed part of IBS patient's profile, table (5) is in accordance with a study by *Whitehead (1996)*. The term *Alexithymia* developed by *Sifffioeos* and *Nemiah*, to describe persons who are unable to formulate and express affect and psychological conflict verbally, can explain those tendencies. Recently, the concept of somatothymia has been

proposed to designate the use of somatically based words to describe emotional experiences, and in some cultures, as in ours' (*Okasha, 1997*) remained the predominant mode of affective communication (*Stoudemire and McDaniel, 1995*).

Two of IBS patients of our study table (6) had an associated diagnosis of schizophrenia paranoid and schizo-affective disorder. At the same time, *Gupta, et al. (1997)* found 19% prevalence of IBS in a sample of patients with schizophrenia in comparison to (2.5%) prevalence in controls. The results of those two studies proved the multi conditionally of the disease or disorders as a starting point of the psychosomatically founded approach in medicine as *Hoes (1997)* declared. An inclusive term for the field of psychosomatic medicine is "Behavioral Medicine" designated by the National Academy of Science in 1978 as "the interdisciplinary field concerned with the development and integration of behavioral and biomedical science knowledge and techniques relevant to health and illness and the application of this knowledge and these techniques to prevention, diagnosis and rehabilitation" (*Kaplan, et.al, 1994*).

Chronic nonspecific stress, usually with the intervening variable of anxiety has been suggested as having physiological correlates that, combined with genetic vulnerability, predispose certain persons to a psychosomatic disorder (*Kaplan, Sadock and Grebb, 1994*). This supported the findings of our study that showed that patients with IBS had experienced more stressful life events in terms of total unites (265.03) of life events in comparison to controls (177.56). This value exceeds the minimum 200 units in a single year, of life

events, proposed by **Holmes and Rahe (1978)** to increase the incidence of psychosomatic disorder. In the same direction **Dumitrascu and Granesu (1996)** found that life event scores were high in 63% of IBS patients as compared to controls. Another study by **Levy et al., (1997)**, reported a significant and positive relationship between daily stress and daily symptoms in both IBS non-patients and IBS patients in comparison to controls. The most frequently reported individual life events in our sample of patients with IBS in comparison to controls, table (8) were:

Marital discord, pregnancy, major change in responsibilities at work, major changes in sleeping and eating habits and major change in amount and type of recreation. **Wolff and Wolf (1997)** observed that the physiological states of the gastro-intestinal tract appear to correlate with specific emotional states (hyper function with hostility and hypo-function with sadness). They emphasized the role of certain stressors as familial discord, emotional deprivation, goal frustration, object loss, separation and unemployment as threatening events that determine the nature and severity of psycho-physiological response pattern of gastrointestinal tract. **Walker et al., (1990)** emphasized the role of patient's coping and adaptation pattern rather than the disease itself in determining the frequency to experience symptoms and to seek medical advice. So future study is needed to assess personality characteristics and coping style of patient with IBS.

In conclusion, psychiatric disorders are fairly common in-patients seeking treatment for IBS. The most common symptoms are anxiety, depression and somatization with the tendency to overuse medical services. They seem to experience

symptoms and distress in response to changes in their lives that are perceived by them as stressful and distressing. Psychiatric referral for those patients can provide proper diagnosis and treatment of coexisting psychiatric disorder and maladaptive illness behavior in the form of multi-modal treatment plan including psychotherapeutic and pharmacological management.

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التقييم النفسى الموضوعى لعينة من مرضى زملة تهيج الأمعاء (القولون العصبي)

إن زملة تهيج الأمعاء تعتبر شائعة بالمجتمع. بعض العوامل النفسية والاجتماعية وليس فقط الأعراض الحشوية ممكن أن تساهم فى أن يتخذ البعض القرار بطلب العلاج الطبى. ولذلك درسنا بموضوعية عينة من المرضى عددهم ٣٠ كانوا يترددوا على العيادة الخارجية للجهاز الهضمى، وتم مقارنة عينة ضابطة من المتطوعين الأصحاء (٢٥ شخصا) ولا يعانون من أى أعراض مرضية بالجهاز الهضمى. وتم تقييم المجموعتين بمقياس زنج للإكتئاب ومقياس إعادة التكيف الاجتماعى.

وتم كذلك تقييم المرضى بالفحص النفسى الإكلينيكي باستخدام المقياس الدولى العاشر لقائمة الأعراض والتشخيص النفسى. وظهر أن مرضى القولون العصبي يعانون من إكتئاب مرضى وأنهم حصلوا على درجات مرتفعة فى مقياس أحداث الحياة بالمقارنة للعينة الضابطة. كل المرضى (١٠٠%) كانوا يعانون من اضطراب نفسى: قلق نفسى، آخر (عدد=١٥) ٥٠%، ونوبة إكتئاب (عدد=٩) ٣٠%، وباقى الأمراض النفسية شكلت نسبة ٢٠%. إن الوصف النفسى لهذه العينة من مرضى القولون العصبي كانت عبارة عن أعراض قلق، إكتئاب وجسدية مع ميل الى الأفرط فى استخدام الخدمات الطبية. والخلاصة أن الدراسة ألفت الضوء على أهمية التدخل الطبى متعدد الاتجاهات للمرضى.

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