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PRESENTING COMPLAINTS IN SOMATOFORM DISORDERS: A HOSPITAL BASED SOUTH INDIAN STUDY

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Abstract:

Objectives: To explore presenting symptoms of patients with somatoform disorders.

Methods: Cross sectional observational study was done examining one hundred five consecutive patients who were diagnosed with somatisation disorder and undifferentiated somatoform disorders with no psychiatric co-morbidities other than tobacco dependence seeking outpatient and inpatient service at Yenepoya Medical College Hospital and associated hospitals at Mangalore, India, over a period of one year from April 2015 to March 2016. 2 scales were applied: MINI-PLUS to rule out psychiatric co-morbidities, Physical Health Questionnaire-15 to assess and grade presenting symptoms.

Results: 37.1% had mild somatisation, 39.0% had moderate somatisation and 23.8% had severe somatisation. Most common presenting complaints (in more than 80%) were pain in arms, legs, or joints (91.4%), back pain (84.8%), feeling tired or having low energy (83.8%), nausea gas or indigestion (81.0%). Least common symptoms (in less than 40%) were pain or problems during sexual intercourse (40.0%), dizziness (40.0%), menstrual cramps or other problems with periods (37.30%), fainting spells (9.5%).

Conclusion: It's important to know the most common and least common complaints in somatoform disorders in every culture which helps in understanding and evaluating the patients better.

Key words: Somatoform disorder, presenting complaints, PHQ-15

Introduction:

Somatoform disorders have evolved from Hysteria which in Greek meant a womb which wandered throughout the body causing bodily symptom.[1] Today hysteria is known as somatisation disorder, the word was coined by Wilhelm Stekel in 1925 due to mistranslation of German word.[2] Alan Stoudemire in his article used the word somatothymia, a phenomenon which was derived from alexithymia to describe the use of somatisation for communicating psychological distress.[3] Barsky et al said "somatic symptoms are a final common pathway through which emotional disturbances, psychiatric disorder, and organic pathology all express themselves and which prompt patients to visit doctors".[4] When patients present with vague symptoms that cannot be explained on the basis of objective changes then

such symptoms are said to be functional or medically unexplained.[5] It is seen that Diagnosis of somatisation disorder is stable over time.[6] Unexplained physical symptoms can involve expensive and excessive medical work up, as they undergo unnecessary diagnostic and treatment procedures which would reduce with psychiatric consultation.[7] The prevalence of somatoform disorders among medical inpatients in a study done by Fink et al was between 18.5 – 20.2%. Prevalence as per ICD-10 research criteria of somatisation disorder in the study was 5.2%, undifferentiated somatoform disorder was 0.7%, hypochondriacal disorder was 3.5%, somatoform autonomic dysfunction was 3.2%, persistent somatoform disorder was 1.5%, neurasthenia was 1.5%, dissociative disorder was 2.6%, somatoform disorder unspecified was 5.0%. Whereas as per DSM-IV research criteria somatisation disorder was 1.5%, undifferentiated somatoform disorder was 10.1%, conversion disorder was 1.5%, pain disorder was 2.2%, hypochondriasis was 4.7%, and somatoform disorder not otherwise specified was 1.0%.

It is seen that psycho-physiological and socio-physiological processes contribute to somatic distress.[8] Studies on symptomatology of somatoform disorders are scarce, such studies are important to reflect cultural differences in presentation and symptom reporting. Our study aimed to look at symptom profile in patients with somatoform disorders.

Materials and Methods:

A Cross sectional, observational study was done for a period of one year from April 2015 to March 2016, in the Department of Psychiatry, Yenepoya Medical College Hospital and associated hospitals at Out Patient and In Patient services. Yenepoya Medical College Hospital is a tertiary care teaching Hospital in Mangalore, South India. Study was conducted after obtaining ethical clearance. Study was conducted as per ethical norms. Written informed consent was taken from participants. Patients meeting the criteria for somatisation disorder (ICD-10: F45.0, DSM-IV-TR: 300.81), and undifferentiated somatoform disorder (ICD-10: F45.1, DSM-IV-TR: 300.82) with no other co-morbidities other than tobacco dependence were taken for the study. Patients above the age of eighteen years, both males and females patients who were willing to give consent were included in the study. Patients with definite organic cause to explain the symptoms, mental retardation, patients aged less than eighteen years, patients refusing to give consent, who were unable to complete the scales were excluded from the study. During the study period one hundred seventeen patients who fulfilled the inclusion criteria were approached. Twelve patients refused consent for various reasons finally leading to one hundred five participants from whom data was collected. Consecutive serial sampling technique was followed. Demographic data was collected. Mini International Neuropsychiatric Interview (MINI-PLUS) was used to rule out other psychiatric disorders, it allows for coding of more than sixty variables, which includes DSM-IV disorders and suicide risk at the time of the interview or in the past (Gunter et al., 2008). Physical Health Questionnarie-15 (PHQ-15) was used to study individual symptom, and somatic symptom severity. It inquires for fifteen somatic symptoms. It asks patients to rate how much they have been bothered by each symptom during the past month on a 0 (“not at all”) to 2 (“bothered a lot”) scale. Total scoring is made which ranges from 0 to 30, with cut points of 5, 10 and 15 representing thresholds for mild, moderate and severe somatic symptom severity, respectively (Ravesteijn et al., 2009). Collected data was entered in Microsoft excel and statistical analysis was done using SPSS version 16.0, descriptive statistics and frequency calculation were applied.

These assessments were separate from their regular management. Persons fulfilling the study criteria were diagnosed by their regular treating consultants in the department.

Results:

Total of 105 patients were included in the study. Mean age the patients were 41.55 years (SD: 11.057). Majority of the participants were females (63.8%), educated up to primary school (50.50%). Among them married were 89.5%, people belonging to Islam religion were 67.6%, and many were home maker (61.9%) [Table-1].

Table-1- Socio-demographic details

Variable	Data
Mean age (years)	41.55 years, (SD: 11.057)
Sex	
Female	63.8% (n=67)
Male	36.2% (n=38)
Marital status	
Married	89.5% (n=94)
Unmarried	4.8% (n=5)
Widow	3.8% (n=4)
Divorced	1.9% (n=2)
Religion	
Muslim	67.6% (n=71)
Hindu	29.5% (n=31)
Christian	2.9% (n=3)
Occupation	
Home maker	61.9% (n=65)
Skilled	9.5% (n=10)
Semi-skilled	12.4% (n=13)
Unskilled	11.4% (n=12)
Unemployed	4.8% (n=5)
Education	
Illiterate	28.6% (n=30)
Primary school education	50.5% (n=53)
High school education	20.0% (n=21)
Pre university education	1.0% (n=1)

Among the participants 39 (37.1%) had mild somatisation, 41 (39.0%) had moderate somatisation, 25(23.8%) severe somatisation [Table-2].

Table-2. PHQ-15 symptoms score categorization (n=105)

Severity	Frequency	Percentage
Mild somatisation	39	37.1
Moderate somatisation	41	39.0
Severe somatisation	25	23.8

Symptoms that have been reported by more than 80% of participants were pain in arms, legs or joints (91.4%), back pain (84.8%), feeling tired or having low energy (83.8%), Nausea gas or indigestion (81.0%). Symptoms that have been reported by 40% or less number of participants were pain or problems during sexual intercourse (40.0%) and dizziness (40.0%), menstrual cramps or other problems with periods (37.30%), fainting spells (9.5%) [Figure-1].

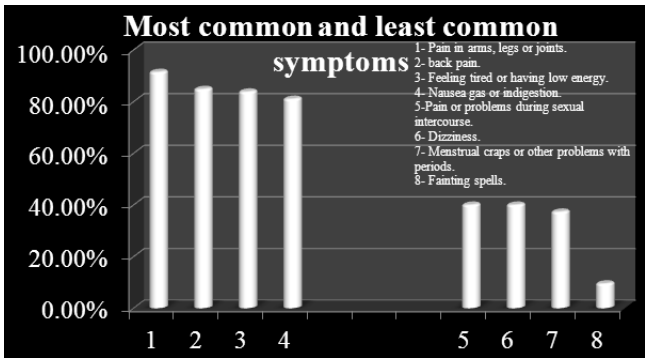

Figure- 1. Most common and least common symptoms reported by patients.

Among 38 males most common symptoms reported in our study are Pain in your arms, legs, or joints (knees, hips, etc.) (92.10%), nausea, gas, or indigestion (78.94%), feeling tired or having low energy (73.68%) of patients. Least common symptoms reported were fainting spells (7.89%), dizziness (42.10%), chest pain and pain or problems during sexual intercourse (47.36%) [Table-3].

Table- 3. Most common and least common symptoms in males (n=38).

Symptoms	Frequency	Percentage
Most common		
Pain in your arms, legs, or joints (knees, hips, etc.)	35	92.10
Nausea, gas, or indigestion	30	78.94
Feeling tired or having low energy	28	73.68
Least common		
Fainting spells	3	7.89
Dizziness	16	42.10
Chest pain	18	47.36
Pain or problems during sexual intercourse	18	47.36

Among 67 females most common symptoms reported by were back pain (92.53%), pain in your arms, legs, or joints (knees, hips, etc) and feeling tired or having low energy (91.04 %). Least common symptoms reported by female patients were fainting spells (10.44%), dizziness (38.80%) and shortness of breath (44.77%) [Table-4].

Table-4. Most common and least common symptoms in females (n=67).

Symptoms	Frequency	Percentage
Most common		
Back pain	62	92.53
Pain in your arms, legs, or joints (knees, hips, etc.)	61	91.04
Feeling tired or having low energy	61	91.04
Least common		
Fainting spells	7	10.44
Dizziness	26	38.80
Shortness of breath	30	44.77

Discussion:

Age:

Demographic variables of the study reveal that around 79% of individuals were between 31 to 60 years of age. The mean age of the study group was 41.55 years, (SD: 11.057). Though somatoform disorder typically starts before the age of 30 years presentation to psychiatrist is generally late.

Sex:

Majority of participants were females which was around 63.8%, which is line with our current knowledge of somatoform disorders and is also reflected in other studies. In a study done by Fink et al to see for the prevalence of somatoform disorders among internal medical inpatients 57% of the participants were females.[9] In another study which screened for somatisation and hypochondriasis in primary care and neurological in-patients 75% of primary care patients were females and 55% of patients from neurological inpatient sample were females.[10]

Marital status:

Majority of participants i.e. around 89.5% were married and were living with family which is common in Indian Culture.

Religion:

Majority of participants were belonging to Islam religions (67.6%) who are the usual clients of the hospital.

Occupation:

Majority of participants were female home makers (61.9%).

Education:

28.6% were illiterate, 50.5% had completed primary school and only around 20.0% completed high school education.

Physical symptoms:

In the study we categorized total score of physical symptoms into mild somatisation which was reported by 37.1%, moderate somatisation 39.0%, severe somatisation by 23.8% of individuals. This shows that in our study patients who presented with severe somatisation are less when compared to mild and moderate somatisation, as it may be because by the time the patient progresses to severe somatisation, the patient would have developed other co-morbidities like depression, dysthymia, substance abuse which is the exclusion criteria for the study.

In the study common symptoms reported by the participants were pain in arms, legs or joints (91.4%), followed by back pain (84.8%), feeling tired or having low energy (83.8%), Nausea gas or indigestion (81.0%). These finding are similar with the study done in Peurto Rico where common symptoms reported were excessive gas, abdominal pain, chest pain, joint pain, palpitations.[11] Our study is also in accordance with participants of Epidemiological Catchment Area Programme where most common symptoms were joint pain, back pain, headache, chest pain, arm or leg pain, abdominal pain, fatigue, dizziness.[12] In a study on primary care patients backache was most frequent complaint.[13] A review study found that common symptoms were excess gas/ bloating, chest pain, dizziness, abdominal pain, palpitations, and back pain.[14] Among the immigrant population in Israel, immigrants had significantly more somatic symptoms. Most common symptoms were chest pain, feeling weakness in parts of the body, nausea. Distressed women acknowledged somatic symptoms significantly more often than distressed men.[15]

Above studies have revealed that abdominal pain, chest pain, palpitations, headache are also the common symptoms reported by their patients, which were less common in our study which may reflect the cultural variations and

differences among the population studied.

In fact dizziness (40%) and fainting spells (9.5%) were among least common symptoms reported by the participants of our study which again reflect the cultural difference. Pain and problems during sexual intercourse was also less frequently complained, it was reported by 40.0% of participants. Among 67 females 25 complained of Menstrual cramps (i.e. 37.30%), was another less common complaint reported in the study which can be because few participants were not having regular cycles or have reached menopause. Interviewing was done by male interviewer who is the primary author; female participants would not have felt comfortable in reporting these problems at the first interview.

When most common symptoms reported by male and female patients were seen separately, pain in arms, legs, or joints (knees, hips, etc) and feeling tired or having low energy were reported by both. Nausea gas or indigestion is commonly reported among male patients and back pain among female patients.

Least common symptoms reported by males and female participants separately were dizziness and fainting spells. Chest pain, pain or problems during sexual intercourse were less common among male patients and shortness of breath among female patients.

Strength of the study is that it consisted of homogenous somatoform group with the exclusion of other psychiatric co-morbidities; socio-demographic data are in line with the Indian culture and regional demography. Grading of somatoform disorder was done in our study; primary author interviewed all patients by himself. Individual symptoms were taken into account in the study, most common and least common symptoms were noted and standard scales were used. To our knowledge we have not come across a similar study from this region.

Limitations of the study is its cross sectional design, it was observational study done in a tertiary care hospital and results may not be generalized to community population. Female preponderance was seen in our study group. It is possible that symptoms may vary in the course of somatoform disorders, hence a cross sectional study may not reveal varying symptomatology.

Conclusion:

It's important to know the most common and least common complaints in somatoform disorders in every culture which helps in understanding and evaluating the patients better.

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