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Somatization Disorder: Are We Moving towards an Over-generalized and Over-inclusive Diagnosis in DSM-V?

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ABSTRACT

Introduction: The confusion around the diagnosis of 'medically unexplained symptoms' has lead to a paradigm shift in criteria for diagnosis of somatization disorder. **Aims:** 1. To compare the socio-demographic variables in patients of somatization disorder 2. To compare the levels of depressive and anxiety scores of patients of somatization disorder along with the severity of disorder. **Material and Methods:** Somatization patients visiting the psychiatry outdoor of TMMC & RC, were randomly selected and diagnosed as per DSM-IVTR. After obtaining informed consent and applying exclusion criteria, demographic and clinical details were obtained on a self designed Performa. The HAM-A scale and MADRS scale were applied to calculate anxiety and depression scores. **Results:** The prevalence of somatization disorder was 2.35% in men and 6.7% in women. Females were significantly higher in number. Headache was the chief complaint. The anxiety scores and MADRS scores were highest in patients complaining of chest pain. The HAM-A and MADRS scores increased significantly as number of complaints increased. Female patients and patients belonging to rural background had significantly higher number of complaints. Illiterate patients had a significantly higher duration of illness. **Conclusion:** Somatization disorder comprises unique group of patients with high co-morbidities and longer duration of illness. It is imperative to identify and clarify severity of this subgroup as treatment decisions need to be modified accordingly.

Key words: Somatization, DSM-V.

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INTRODUCTION

Somatic presentation can be viewed as expressions of personal suffering inserted in a cultural & social context (DSM-V).[1] The confusion prevailing around the diagnosis of 'medically unexplained symptoms' has lead to the paradigm shift in changing the criteria for diagnosing somatization disorder from DSM-IV[2] to DSM- V.[1] The prevalence of this disorder ranges from 5-7% and leads to marked disability and socio-occupational functional impairment.[3]

The DSM-IV TR2 specifies the current severity of the somatic symptom disorder as mild , moderate or severe depending on the number of somatic symptoms present. Lowe et al found that 28% of 1751 primary case attenders were diagnosed by the General Practioners as having a somatoform disorder.[4]

One third of the patients diagnosed with somatoform disorder have concurrent anxiety and depressive disorder and concurrent depression increases impairment in people.[4]

The people suffering from somatization disorder show marked benefit from psychotherapy and treatment of comorbid anxiety and depression.4 There are various studies done to show that high level of stress is related with multiple somatic symptoms.[5,6,7,8]

AIMS OF STUDY

To study and compare socio demographic variables in patient of somatization disorder. To compare the level of depressive and anxiety symptoms in somatization patients with the severity of the disorder.

MATERIALS AND METHODS

SUBJECT SELECTION

Somatization patients visiting the Psychiatric outdoor of TMMC & RC were diagnosed on the basis of DSM-IVTR[2] criteria from 1st January, 2014 to 31st December, 2014. They were enrolled in the study after randomization and obtaining due written informed consent and obtaining due approval of the study protocol by research and ethics committee, TMMC &RC.

EXCLUSION CRITERIA

- Age <18 years.
- Patients suffering from any major mental illness, organic brain syndrome or mental retardation.
- Patients suffering from any major medical illness or surgical illness or taking treatment for the same.
- Patient not willing for participation.
- Patient has been consuming a drug of abuse for last 1 month before the psychiatric consultation.

INCLUSION CRITERIA

- Age > 18 years.
- Diagnosed as Somatization disorder as per DSM-IV TR2 criteria.
- All medical and surgical causes ruled out after appropriate investigations.

ASSESSMENTS

The diagnosis of Somatization disorder confirmed after applying DSM-IV TR2 criteria. Demographic and clinical valuables of the illness were recorded on the first visit. The HAM-A scale[9] and MADRS scale[10] were applied to calculate the anxiety and depressive score.

RESULTS

Out of total 65 patients, 9 were male and 56 were female. 84% of patients were of age 20 -40 years. 87.6% of the sample were married.69.23% had more than 3 children. 72.3 % of them lived in rural background. 41.5 % were illiterate and 41.5% studied up to primary.

63% lived in a joint family. 87.6% belonged to lower middle socioeconomic status.

76.9% were working as housewives.81.5% had no family history of any mental illness. (Table 1, Figure 1)

66% had the chief presenting complaint of headache. 6.1% presented with throat pain. 7.6% had vertigo as the chief presenting complaint. 7.6% presented with chest pain. Rest 10.7% patients had chief presenting complaints of numbness in body, burning and itching sensation in body and body ache.

The mean HAM-A9 score of patients presenting with headache was 27.30 with a SD of 4.81. The mean HAM-A9 score of patients presenting with vertigo was 23.60 with a SD of 2.96. The mean HAM-A9 score of patient presenting with chest pain was 28.60 with SD of 2.96. The mean HAM-A9 score of those with throat pain was 24.40 with SD of 5.7.Mean HAM-A9 score of patients presenting with numbness of body was 25 with SD of 7.07.And others were 26.4+/- 4.39. The highest anxiety scores were seen with patient with chest pain.

The highest MADRS10 score of 27.0 with SD 5.47 was seen in patients with chest pain. The lowest MADRS10 score of 21 +/- 4.24 was seen in patients presenting with numbness. Patient coming with chief complaint of headache had MADRS10 score of 24.81 with SD of 5.25. The MADRS10 score of patients with throat pain was 24.0 +/- 7.34. Others had a MADRS10 score of 23+/- 6.85.

- The correlation of HAM-A score in patients having less than 10 complaints and those having more than 10 complaints was significantly positive (r=0.3573, p value=0.034,<0.05). As the number of complaints reported by the patients increase, the anxiety score of the patients also increased. (Table 2, Figure 2)
- Female patients exhibited significantly higher number of complaints in comparison to male patients. (Table 3, Figure 3)
- Total number of complaints does not vary significantly with the marital status of the patients. (Table 4, Figure 4)
- Total number of complaints does not vary with the age of the patients. (Table 5, Figure 5)
- Patients with a rural background had significantly higher number of complaints. (Table 6, Figure 6)
- The levels of MADRS scores increase proportionally with the number of complaints. (Table 7)
- Unemployed patients had higher number of complaints. (Table 8, Figure 7)
- Patient with more complaints had significantly negative history of any kind of mental illness. (Table 9, Figure 8)
- Religion has no role in the total number of complaints given by the patients. (Table 10, Figure 9)
- Literacy status has no effect in the total number of presenting complaints. (Table 11, Figure 10)
- When comparing duration of illness with HAM-A score, a weak positive correlation was found which is not significant. (Table 12)
- Male and female patients had no significant differences as far as duration of illness is considered. (Table 14, Figure 11)
- As the age of patient increased, his duration of remaining illness increased significantly. (Table 15, Figure 12)
- Marital Status had no effect on the duration of illness. (Table 16, Figure 13)
- Urban or rural background had no effect on the duration of illness. (Table 17, Figure 14)
- Employment status had no effect on the duration of illness. (Table 18, Figure 15)
- Illiterate people had a significantly higher duration of illness. (Table 19, Figure 16)

Table 1: Socio demographic variables of the sample

SOCIO DEMOGRAPHIC CHARACTERISTICS			
Characteristic		**N**	**Percentage**
Gender			
	Male	9	13.85
	Female	56	86.15
Age (yr)			
	< 20	3	4.62
	21 – 30	28	43.08
	31 – 40	27	41.53
	> 40	7	10.77
Religion			
	Hindu	16	24.62
	Muslim	49	75.38
Residence			
	Urban	18	27.70
	Rural	47	72.30
Relationship Status			
	Single/widowed	8	12.30
	Married	57	87.70
Family Type			
	Nuclear	24	36.92
	Joint	41	63.08
No. of Children			
	0	8	12.30
	≤ 3	12	18.46
	> 3	45	69.24
Literacy Status			
	Illiterate	27	41.54
	Primary education	27	41.54
	High School	10	15.38
	Graduation	1	1.54
Occupation Status			
	Unemployed	6	9.23
	Housewife	50	76.92
	Self employed	9	13.85
Total Monthly Income			
	< 1500	1	1.54
	1500 – 3000	6	9.23
	3000 – 5000	31	47.69
	5000 – 10000	26	40.00
	> 10000	1	1.54

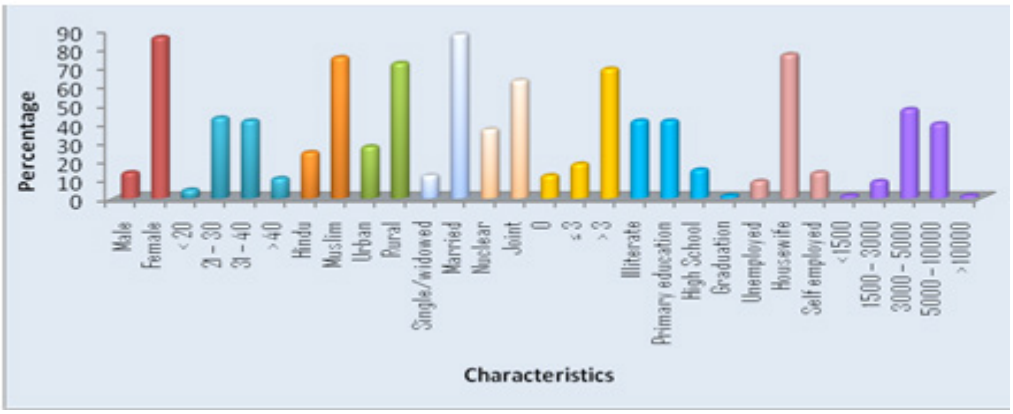

Figure 1: Socio-demographic variables of the sample

Table no 2: Total no of complaints in comparison to HAM-A score of patients

TOTAL COMPLAINTS	HAM-A SCORE	TOTAL PATIENTS
6-9	25.22	27
10-12	27.40	22
13-15	28.43	16

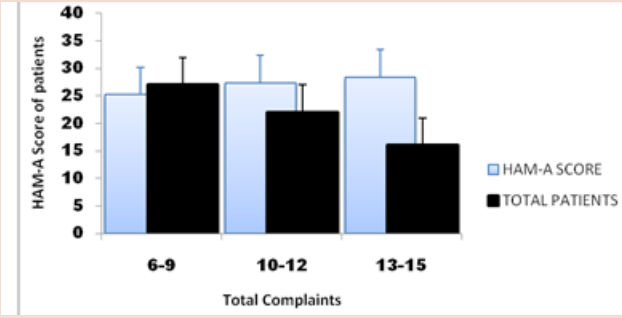

Figure 2: Total no of complaints in comparison to HAM-A score of patients

Table 3: Total no of complaints v/s sex

	Total number of complaints	
	<10	>10
MALE	9 (4.98)	0 [4.02]
FEMALE	27 (31.02)	29 [24.98]

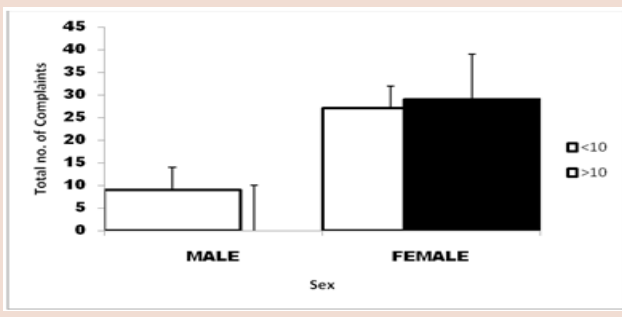

Figure 3: Total no of complaints v/s sex
X2=8.4152 ; p=0.00374 p<0.05 (significant)

Table 4: Total number of complaints v/s marital status

	<10	>10
MARRIED	30(31.57)	27(25.43)
UNMARRIED	6(4.43)	2(3.57)

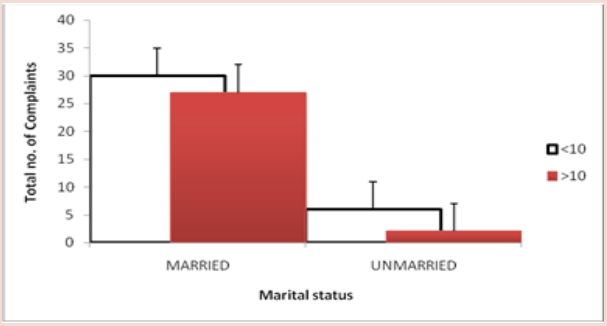

Figure 4: Total number of complaints v/s marital status
The chi square value is 1.4205

Table 5: Total number complaints v/s Age

YEARS	<10	>10
<30	19(17.17)	12(13.83)
>30	17(18.83)	17(15.17)

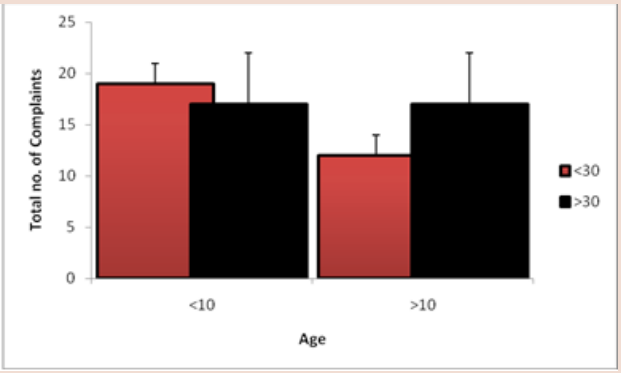

Figure 5: Total number complaints v/s Age
X2=0.836 p<0.3604 (not significant)

Table 6: Total number of complaints v/s urban & rural

	<10	>10
RURAL	20(26.03)	27(20.9)
URBAN	16(9.97)	2(8.03)

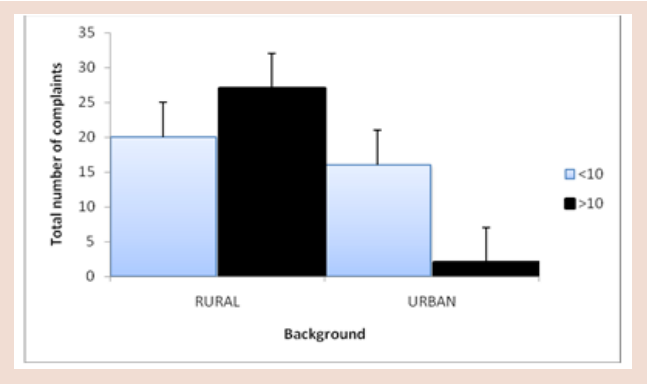

Figure 6: Total number of complaints v/s urban & rural

X2=11.3088 ; p is 0.000771 ; p<0.05(SIGNIFICANT)

TABLE 7: Total number of complaints v/s MADRS Score

Pearson coefficient. R=0.4822 ; p value of r = <0.05 (significant)

Figure 7: Employment status v/s total number of complaints

X2=9.5202 ; p=0.002032 ; p<0.05 (significant)

Table 8: Employment status v/s total number of complaints

	<10	>10
EMPLOYED	10(5.54)	0(4.46)
UNEMPLOYED	26(30.46)	29(24.54)

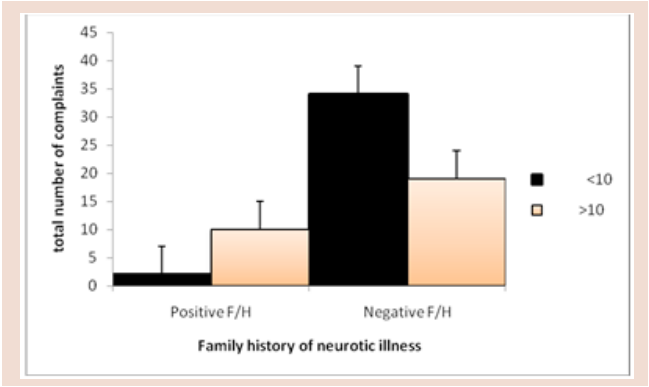

Figure 8: Family history of neurotic illness v/s total number of complaints

X2 = 8.9283 ; p = 0.002808 ; p < 0.05 (significant)

Table 9: Family history of neurotic illness v/s total number of complaints

	<10	>10
Positive F/H	2(6.65)	10(5.35)
Negative F/H	34(29.35)	19(23.65)

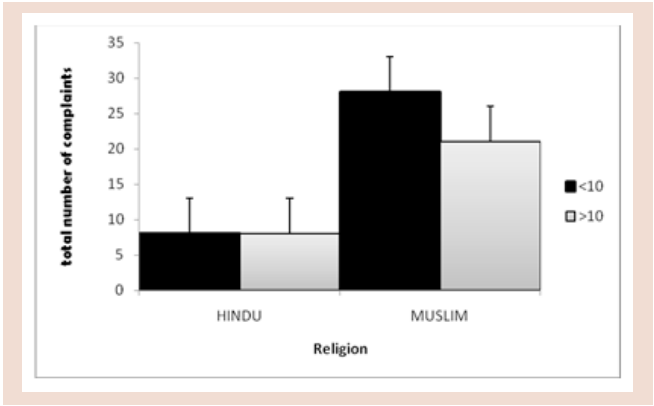

Figure 9: Religion v/s number of complaints

X2=0.249 ; p=0.617 ; p is not significant.

Table 10: Religion v/s number of complaints

	<10	>10
HINDU	8	8
MUSLIM	28	21

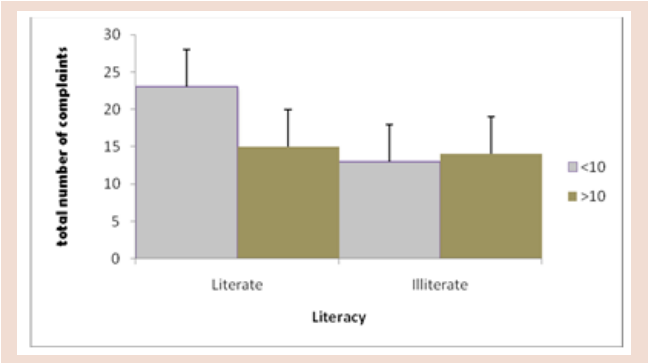

Figure 10: Literacy v/s total number of complaints

X2=0.9788 ; p=0.3275 (not significant)

Table 11: Literacy v/s total number of complaints

	<10	>10
Literate	23(21.05)	15(16.9)
Illiterate	13(14.95)	14(12.05)

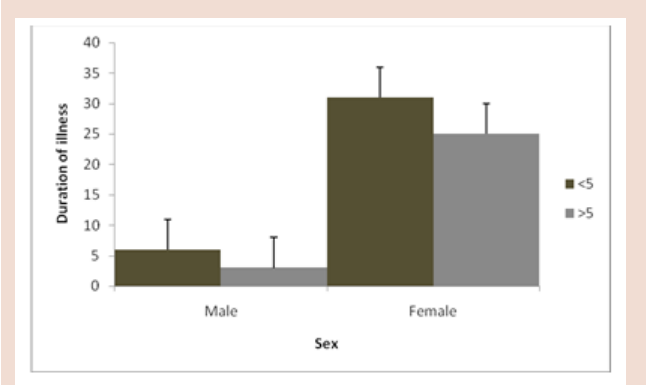

Figure 11: Duration of illness compared with sex

X2=0.4045 ; P = 0.524(not significant)

Duration of illness did not significantly vary with the sex, marital status, rural background, religion, employment status of patients. But as the age of patient increases his chances of staying in illness increased significantly and illiterate people were significantly at higher risk of having a long duration of illness.

DISCUSSION

Somatoform disorders have undergone a vast change as a diagnostic category in all the diagnostic criteria in DSM. There has been debate and disagreement on every aspect of this diagnostic entity from the exhaustive criteria put forward in DSM 4 TR,2 including 4 pain, 2 Gastrointestinal, 1 sexual and one pseudo neurological to more focus on the thoughts

TABLE 12: Duration of illness compared to HAM-A score

On applying pearsons coefficient, Value of r = 0.0326 ; Not significant (p=0.796) But weak positive correlation.

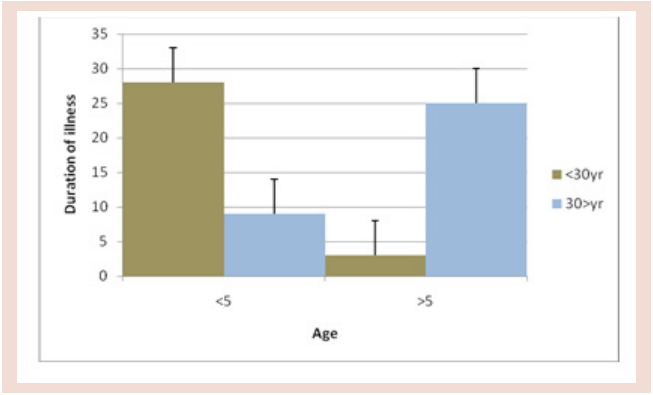

Figure 12: Duration of illness v/s age

X2=26.9614 ; p = 0.00 (significant)

Table 13: Duration of illness compared with MADRS.

Duration of illness compared with MADRS. Value of r = 0.021 P = 0.868125 ; Not significant

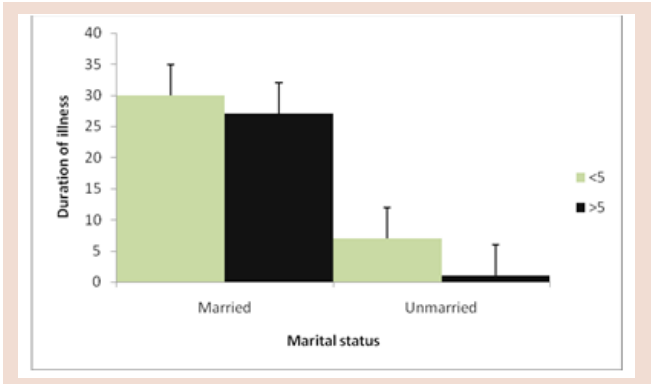

Figure 13: Duration of illness v/s marital status

and behavior related to this diagnostic category in DSM-51, there has been a vast shift in diagnosing this disorder which has a chronic indolent course. With a vast majority of comorbidities including anxiety disorders, mood disorder, substance use disorder and a number of personality disorders.[10,11,12]

Considering that this condition has such a chronic course with so much comorbidities and also that this disorder can be effectively managed by managing comorbidities and psychotherapy, this study tries to shed light on various social and demographic variables of this diagnostic condition and also the need to assess this condition in relation to comorbidities and severity of the disorder.

Table 14- Duration of illness compared with sex

	<5	>5
Male	6	3
Female	31	25

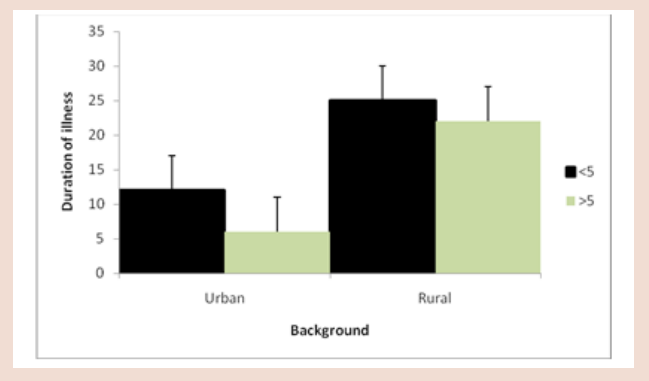

Figure 14: Duration of illness v/s urban and rural background.
X2=0.9638 ; p=0.3262 (not significant)

Table 15: Duration of illness v/s age

	<5	>5
<30yr	28	3
30>yr	9	25

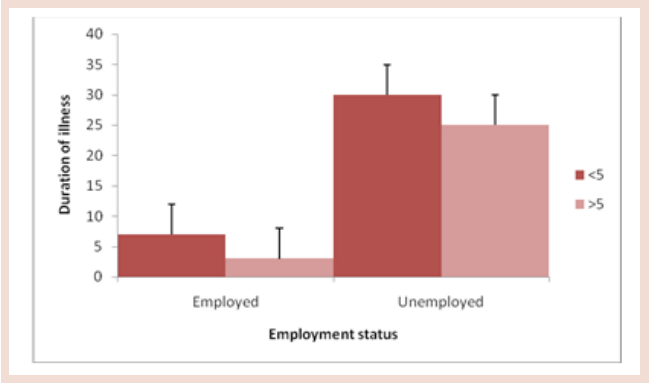

Figure 15: Duration of illness v/s employment status
X2=0.8242 ; P = 0.36395 (not significant)

Table 16: Duration of illness v/s marital status.

	<5	>5
Married	30	27
Unmarried	7	1

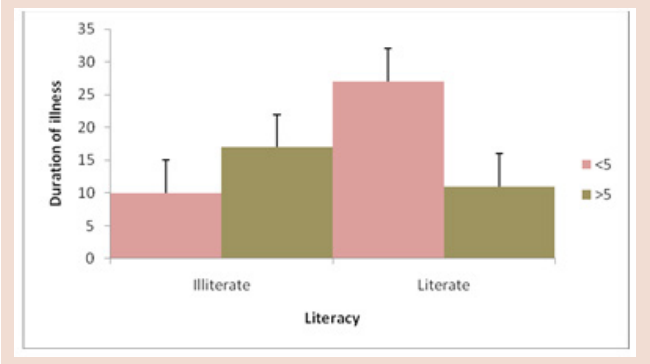

Figure 16: Duration of illness v/s literacy
x2=7.4483 ; P=0.006 (significant)

Table 17: Duration of illness v/s urban and rural background.

	<5	>5
Urban	12	6
Rural	25	22

Table 18: Duration of illness v/s employment status:

	<5	>5
Employed	7	3
Unemployed	30	25

Table 19: Duration of illness v/s literacy

	<5	>5
Illiterate	10	17
Literate	27	11

The prevalence of somatization disorder in our sample was 6.7 % in women and 2.35 in men which is in which is in conformation with other studies.[13,14]

Female were significantly higher in number than males as has been proved in various other studies.[13,14] This could be because of the difference in gender in expressing their psychological distress. Somatization could be a more acceptable form of exhibiting distress in these majorly rural, uneducated, unemployed and low socioeconomic strata of society.

Majority of the patients exhibited headache as the chief presenting complaint. However the anxiety scores did not differ significantly according to the presenting complaints. The highest score was seen with chest pain (28.6+/-2.96). This could reflect the severe anxiety associated with condition pertaining to heart and its related symptoms, which was again proved with chest pain patient receiving the highest MADRS score as well. (27+/-5.47)

As the number of symptoms/complaints increased, the HAM-A9 score of the group also increased significantly (Table1). This is an interesting finding as the DSM-V 1abolishes the

categorisation of severity on the basis of number of symptoms in comparison to DSM-IV TR2, which categorised the disorder as mild, moderate or severe depending on the number of symptoms.

Female patients exhibited significantly higher number of complaints in comparison to male patients (Table 2), as also the patients from rural background (Table 5). Unemployed patients had significantly higher number of complaints (Table 7). Interestingly, religion, education status, marital status, age and socioeconomic status had no bearing on the total number of presenting complaints.

The duration of illness, as it has a chronic debilitating course and a worse outcome, did not significantly vary with sex ,marital status, rural background, religion and employment status of the patient. It did significantly increase in patients who were illiterate (Table 13-19). This shows that literacy had a good outcome as far as the duration of illness was concerned. It could be due to more awareness regarding the disorder and hence the chronicity of this debilitating disorder was shorter in this population rather than the illiterate people.

Interestingly the anxiety and depressive scores had a very weak positive correlation with the duration of illness, which was not significant.

CONCLUSION

This study aims to identify a common group of patients with multiple somatic complaints, as a core feature. This common group mostly females, with increase in comorbidities of anxiety and depression as the number of complaints of complaints increase. This group needs to be identified as a separate group as the severity of the disease determines the nature of intervention to be applied to this subset of patients and also the outcome of the patients differ significantly.

CONFLICT OF INTEREST

We wish to confirm that there are no known conflicts of interest associated with this publication and there has been no significant financial support for this work that could have influenced its outcome. We confirm that the manuscript has been read and approved by all named authors and that there are no other persons who satisfied the criteria for authorship but are not listed.

We further confirm that the order of authors listed in the manuscript has been approved by all of us. We confirm that we have given due consideration to the protection of intellectual property associated with this work and that there are no impediments to publication, including the timing of publication, with respect to intellectual property. In so doing we confirm that we have followed the regulations of our institutions concerning intellectual property.

We further confirm that the work covered in this manuscript has been conducted with the ethical approval of all relevant bodies and that such approvals are acknowledged within the manuscript.

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ABBREVIATIONS USED

DSM IV TR: Diagnostic and Statistical Manual Of Mental Disorders– Text Revision (fourth) ; DSM V: Diagnostic and Statistical Manual Of Mental Disorders – fifth Edition ; HAM –A : Hamilton Anxiety Rating Manual – anxiety ;MADRS ; Montogomery Asberg Depression Rating Sclae

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