Somatization of depression in psychiatric out-patients

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Summary

The severity of anxiety and depression in 72 patients presenting with somatic complaints to the psychiatric clinic were assessed after excluding organic illnesses. Majority of the patients were females, between 15 to 34 years of age and came from lower socio-economic background. A high percentage of patients were brought up by dominant mothers and the married patients had passive husbands or active wives controlling the family. Generally the severeity of depression was correlated with the severeity of anxiety (C.C = 0.704, $P < 0.01$). Majority of the patients were found to have both mixed anxiety depressive symptoms and the anxiety symptoms masking the underlying depressive symptomology.

Key words: Somatization of depression, masked depression, depressive symptomology, psychiatric out-patient.

Introduction

Patients seeking medical consultation for somatic complaints after thorough investigation were often found to have no identifiable organic illness. Many of these complaints were psychologically determined. These complaints may be the presenting features of various psychiatric disorders. Psychopathologic etiology of these patients ranged from psychotic illness to various neurotic disorders like atypical (masked) depression, anxiety neurosis, hypochondriasis, somatization disorder, conversion disorder and psychogenic pain disorder.

The phenomena of somatization of psychological disorder, especially depressive illness and anxiety is well known in certain communities. Some psychiatrists have advocated using the presence of somatic symptoms as one of the criteria for depression.[1] Teja et al.[2] reported that somatization of psychological distress is present to a much greater degree in non-European cultures. In America it has been reported in association with less educated persons and those of lower socio-economic status.[3] Srinivasan et. al.[4] in their study of out-patients attending psychiatric clinics in Bangalore, India found that the majority of the patients presenting with multiple somatic complaints had combination of somatic, anxiety and depressive symptoms. In 22% of these cases it was not possible to arrive at a single ICD-9 diagnosis.

Masked depression is best defined as a depression in which the physical manifestation conceals the psychopathological symptomology.[5] Keilhozl[6] stressed that the term denotes a phenomenological but not a nosological diagnosis. Masked depression occurs as often as overt depression and appears to be increasing in frequency. It was estimated that 10% of patients who consulted a physician had depression and in half of them it was masked.[7] According to Lesse,[8] urbanization and industrialization had increased the tendency of depression to be masked.

There are a number of variables for example age and sex which may confound the relationship between somatic symptoms and depression. Chandler and Gerndt stressed that depressed patients had more physical illness if the study was not properly controlled.[9] They suggested that the increase in somatic symptoms in the majority of depressed patients may not be due to depressive psychopathology, but rather to the increased number of medical problems and age. A number of researchers have found that females had greater number of somatic symptoms.[10] Kukull[11] found the older patients were more depressed than the control.

Why do some depressed patients somatize? Is it due to depressive psychopathology or associated medical problems. If it is related to the underlying depression it is important to know their characteristics and distinguish them from non-somatizers so that appropriate and effective treatment can be instituted in time, thereby avoiding unnecessary investigations and therapy which may only serve to prolong a patient's period of ill-health. The aim of the study was to find the characteristics of patients with somatized depression and investigate the underlying psychopathology. To the knowledge of the author, no such study has been done in Malaysia. It was also hoped that the characteristics of these patients could be compared with masked depression in other communities.

Subject and Methodology

The study was conducted at the Psychiatric Clinic, Hospital Universiti Sains Malaysia, Kubang Kerian from March 1987 to June 1988. All consecutive patients between 15 to 64 years of age, with somatic complaints who presented to the author in the clinic were screened. Patients diagnosed as organic brain syndrome, psychosis, drug abuse, alcoholism, psychophysiological disorder, malingering, factitious disorder and having physical disease were excluded. Doubtful organic cases were excluded from the study.

Those selected were cases of mixed anxiety – depressive states. To exclude cases of anxiety neurosis (generalised) without associated depression each subject was administered the Hamilton Depression Rating Scale (HDS).[12] Patients were excluded from the study if the score was less than 7.

The HDS criteria for depression are:–
(a) A total score of 0 to 7 – no depression
(b) A total score of 8 to 15 – minor depression
(c) A total score of 16 or more – major depression

After going through the selection procedure, 72 patients were chosen for the study. They were cases of minor or major depression with associated anxiety of different degrees.

Each subject was then assessed using the following tools:–

1. Hamilton Anxiety Rating Scale (HAS)[12] for assessment of severity of anxiety of different degrees.
   (a) A total score of 0 to 5 – no anxiety
   (b) A total score of 6 to 14 – minor anxiety
   (c) A total score of 15 or more – major anxiety

2. A proforma which included biodata, socio-economic variables, details of presenting illness,

psychological stress, interaction with parents, marital relationship and past treatment. All the diagnoses were based on ICD-9[13] -

Results

Diagnosis: The ICD-9 diagnoses of 72 cases were as follows; neurotic depression 27 (37.5%), depressive illness not classified elsewhere 22 (30.6%), anxiety neurosis 8 (11.1%), conversion disorder 7 (9.7%), psychalgia (tension headache) 5 (6.9%) and hypochondriasis 3 (4.2%). In the case of mixed state of anxiety and depression, a diagnosis of neurotic depression was made.[13] The severity of anxiety and depression based on HAS and HDS scores are shown in Table 1. It shows that majority of the patients had both minor anxiety and depression. The severeity of depression was generally correlated with severity of anxiety, (Pearson's C.C = 0.704, $P < 0.01$). However, there was no significant relationship between sex and severity of depression ($X2 = 0.01$, $P > 0.05$) and anxiety ($X2 = 0.22$, $P > 0.05$).

Table 1
Degree of Depression and Anxiety of Somatizers Based on HDS and HAS Scores.

	HDS* Score						HAS** Score					
Score	0–7		8–15		>16		0–5		6–14		>15	
Sex	F	M	F	M	F	M	F	M	F	M	F	M
No. of patients	–	–	27	20	–	–	5	4	21	15	1	1
	–	–	–	–	14	11	1	–	6	7	7	4
Total patients	–	–	27	20	14	11	6	4	27	22	8	5

*HDS – Hamilton depression scale
**HAS – Hamilton anxiety scale
F – Female
M – Male

Socio-demographic variables: The patients age, sex, marital status, level of education and total family income are summarised in Table 2. Of the total 72 patients, two were Chinese and the rest Malays. The majority of cases were females. A large number of them were between 25 to 34 years old, married with secondary level of education and total family income below $300.00 per month. The mean age for mild and severe depression group were 30.1 and 33.6 years respectively.

Duration of illness and past treatment: There is a considerable delay between the onset of the illness and psychiatric consultation. Of the patients in this study 4.2% were ill one month prior to the psychiatric consultation, while 75% were sick for more than six months. Even more impressive was the observation that 37.5% of the patients were ill for more than two years and 18.1% for more than 5 years (Table 3). None of the patients came for psychiatric consultation within one week of their illness. Table 3 also showed percentage of the patients past treatment. Majority of the patients had consulted general practitioners (72.2%) and/or bomohs (Malay traditional healers) (68.1%) prior to their present visit to the clinic.

Table 2
Socio-Demographic Variables of Somatizers

	No. of patients	
	Female (N=41)	Male (N=31)
Age (years)		
15–24	12	11
25–34	14	10
35–44	7	8
45–54	5	2
55–64	3	–
Marital Status		
Married	23	16
Single	12	13
Widowed	6	–
Divorced	–	2
Family Income		
$ < 300.00	20	11
$ 300 – < $ 500.00	6	9
$ 500 – < $1,000.00	9	5
$1,000 – < $2,000.00	4	5
$2,000 – < $3,000.00	1	0
$ < 3,000.00	1	1

Table 3
Duration of Illness and Past Treatment

i)	Duration of illness	%
	Within 1 month	4.2
	1 month to < 6 months	20.8
	6 months to < 1 year	13.9
	1 year to < 2 years	23.6
	2 years to < 5 years	19.4
	more than 5 years	18.1
ii)	Past treatment	
	General Practitioner	72.2
	Bomoh	68.1
	Government Hospital/panel doctors	41.6
	Homeopathy	4.2
	Non-psychiatric admission	11.1
	Nil	2.7

The highest referral of the cases was from the general out patient department (40.3%). Referral from other specialist clinics was the second highest (30.6%). The majority of cases was referred from the medical clinic. The rest were referred by general practitioners and government doctors, or walked in directly.

Presenting complaints: Table 4 shows the twelve commonest presenting complaints of the 72 patients. The most common complaint was headache (40%), followed by muscle ache (39%) and abdominal discomfort (28%). A total of 173 complaints were noted with a mean of 2.4 complaints per patient. The mean of somatic complaints for female and male was 2.5 and 2.3 respectively. A high percentage of the patients had 2 or 3 complaints. There were 110 complaints for mild depression (mean 2.5) and 63 complaints for major depression (mean 2.3). Nine patients with no anxiety score had a mean of 2.1 complaints each. There was no significant different in mean of somatic complaint between minor and severe depressive patients ($P > 0.05$).

Table 4
Frequency of Somatic Complaints of Somatizers

Symptoms	Number of somatic complaint	
	Female	Male
1. Headache	17	14
2. Muscle aches	14	15
3. Abdominal discomfort/fullness	12	8
4. Lethargic/tiredness	11	7
5. Palpitations	10	6
6. Chest discomfort	8	6
7. Giddiness	6	5
8. Hot or Cold Spells	7	3
9. Low backache	5	2
10. Dyspnea	4	3
11. Numbness (tingling sensation)	4	2
12. Fainting spell	3	1
Total	101	72

Psychosocial stresses: Psychosocial stresses were defined by the patient's subjective judgment of what had contributed to his illness within six months prior to its onset regardless of the objective view of the assessor. The stresses were divided to five types: marital stress; family stress; stress of work or study; financial stress and other stresses which included uncertainty about legal outcomes, conflict of interest, worry about physical illness and rejection by the local community. Types of stresses and the percentage of patients reporting such stresses are shown in Table 5.

Psychological characteristics:

(i) **Marital relationship**: Table 6 shows details of marital relationship of 39 married couples.

Table 5
Type of Psychosocial Stresses

Type of stresses	%
Marital	16.7
Family	43.1
Study/work	29.2
Financial	15.3
Others	6.9

In nearly half of the married patients (46.2%), relationship between husband and wife was described as well cooperative where the wife was actively involved in decision making. In 12.5% of the couples, the wife was more dominant than the husband and controlling the family. This is unusual for the Malay community where the husband is expected to be the more dominant.

(ii) **Parent child interaction**: Table 6 also shows details of behaviour of the mother compared to the father in their marital relationship as reported by the patients. A high percentage of patients (30.6%) reported that the mother was more dominant than the father and controlled the family. This was followed by the mother who participated actively in decision making (26.4%). Among those who did not give comments were three patients where one of their parents had died when they were below 11 years of age and the remaining parent did not remarry.

Table 6
Psychological Characteristics of Somatizers

		No. of patient (n=72)
i)	Type of marital relationship	
	Dominant wife and passive husband	9
	Well cooperative husband and wife	18
	Dominant husband and passive wife	8
	Hostile and controlling husband	4
	Not applicable/unspecified	33
ii)	Behaviour of the mother in marital relationship	
	More dominant than the father and controlling the family	22
	Participate actively in decision making	19
	More passive than the father	15
	No idea/comment	16

Discussion

The association between anxiety and depression is well documented in psychiatric literature. Clinical states of anxiety and depressive disorders are composed of a complex interplay of

symptoms. For example a depressive state may have prominent anxiety symptoms and vice versa. Stavrakaki and Vargo[14] proposed three conceptual models to explain the relationship between anxiety and depression. Their anxious depressive model, where combined anxiety and depression syndromes differed both quantitatively and qualitatively from either pure anxiety and pure depression, seems to fit with the finding in this study. This is not surprising as 11.1% of the patients in this study were diagnosed as anxiety neurosis. The predominance of anxiety symptom was the main reason why the diagnosis of anxiety neurosis was made.

This study found no correlation between the mean of somatic complaint per patient with severity of depression ($P > 0.05$). A closer look at the 12 presenting somatic complaints shows that 11 of the symptoms are part of the symptom of anxiety and panic attack. All these symptoms, except low backache, can be explained by autonomic hyperactivity or increased motor tension. Thus, the anxiety symptoms masking the underlying depressive features in majority of the cases. O'Connor[16] claimed that somatic symptoms of anxiety were present in 85% of patients with depression. She stressed that a useful role of thumb was that if the symptoms of anxiety and hypochondriasis appear for the first time in the elderly person, the diagnosis should be of depressive illness.

The study found that the female-male ratio is 5:4, majority of the patients were between 15 to 34 years old and had monthly income of less than $500.00. Similar findings on somatization of depression were noted. For example the female is predominant,[17,18] majority of the somatizers were below 35 years of age[4,17,19] and came from lower socio-economic background.[20]

Large percentage of couples have mutually active wives and husbands in decision making. The second highest group was dominant wife and passive husband. This is also in agreement with Lesse[17] who reported female married patients as very active, controlling, meticulous and demanding, while the husband was passive in contrast to the dominant and aggressive wife. Regarding the parental interaction the study found that a high percentage of patients had dominant mothers compared with the fathers. This also supported Lesse's[17] finding that the parents were rigid and controlling, and majority of the mothers were dominant parents.

A high percentage of patients were reported to have psychosocial stress. Nearly half were found having family stress followed by stress at work or study. The combination of depressive and anxiety could be due to the patient's subjective experience of both a sense of loss and threat pertaining to stressful life events. Leon et al[19] similarly found a higher incidence of stress factor among groups of somatizers in their study.

A patient with somatic complaints is more likely to seek treatment elsewhere rather than visit a psychiatrist. This is not surprising as 30.6% of the patients were referred from other specialist clinics in the hospitals and a high percentage had gone to see general practitioners and traditional healers prior to their visit. The author is of the opinion that delayed psychiatric treatment is related to cultural beliefs, misconception, strong stigma and taboos attached to mental disorder and psychiatric institutions in the Malaysian society. Thus, majority of the psychiatric patients, would normally rather not consult a psychiatrist. Masking of depressive illness is therefore socially and culturally convenient.

Due to methodological problems in the assessment of personality, and a high default rate, type of personality was not assessed and response to treatment and follow up was not explored. This study was not a controlled study and patients were not seen on a consecutive basis in terms of total psychiatric clinic population. As a result the incidence of somatization of depressive

illness could not be calculated. A future study should focus on these issues as well as differences in characteristics of somatizers between major ethnic groups in Malaysia.

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