INTRODUCTION
CHAPTER - I
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Somatoform disorders are disorders in which patients have physical symptoms (e.g. pain, light-headedness, diarrhea) that suggest a general medical condition, but are not fully explained by any general medical condition. These symptoms are not under the patient's voluntary control.

Patients, who experience somatic symptoms without demonstrable organic disease or in excess of what one would expect on the grounds of objective medical findings, are a common and difficult problem in both primary care and general psychiatric practice. Such patients are often misunderstood and are thus over investigated, resulting in mental and financial strain.

With the number one complaint being of some type of physical symptoms, these disorders are often discovered in a general medical setting. Where even after other psychiatric disorders are excluded, 20-40% of patients seen have symptoms that cannot be explained medically or neurologically.

However in reality their psychological conflict may be getting translated into physical problems or complaints.

Patients with somatoform disorders probably constitute the largest diagnostic groups in daily medical practice. A major communication problem form the core of somatoform disorders. Patients report about complaints which their physicians do not understand; there is no sufficient biological reason for the patient’s symptoms. There is multifactorial origin of somatoform disorders consisting of minimal physiological changes, the perception of bodily
sensations, and their interpretation as symptoms (non normal perceptions), as well as ensuing emotional and behavioral consequences. Concerning the communication problem, it is important to realize that patients normally present symptoms, whereas the underlying bodily perceptions and the explanatory models are rarely communicated to the physician. On the physician’s side, symptoms presented by patients are subjected to his or her explanatory concepts translating symptoms into indicators of certain diseases. Thus, the information introduced into physician-patient communication by the patient has usually passed several cognitive circuits within the patient or between the patient and other significant conversation partners, thus, shaping its specific components.

Somatization and conversion disorder are sometimes equated. Somatization disorders are life-long illness with episodic exacerbation. Whereas conversion disorder can be episodic. The term Somatization is used when multiple unexplained physical symptoms are present. It has replaced the older term hysteria. Hysteria was used to describe multiple medically unexplained symptoms in emotionally impressionable women (the term ‘hysteria’ literally means ‘wandering uterus’). Somatization disorders however occur in both men and women.

Barsky and Klerman (1983) have proposed a term free of multiple meanings, clinical assumptions, devoid of social values and labels, and implicit etiological beliefs to describe these patients. These are individuals with “amplifying somatic style”. They scrupulously monitor their normal bodily sensations and functions; they scrutinize trivial and transitory symptoms that others might but dismiss as insignificant; they react to these perceptions with apprehensions and alarm; they readily attribute them to physical disease rather than to overexertion, emotions, dietary indiscretion, or stress; and they persistently, express these concerns in words and actions. They verbalize their bodily complaints to family acquaintances, and health care professionals or lay experts. They also take elaborate steps to maintain their health, cure themselves of disease, and alleviate their discomfort. The
individuals with an amplifying somatic style may or may not have serious concomitant medical condition but may have intrapsychic conflict, or high levels of general emotional dysphoria.

In an attempt to explain the tendency to develop so-called 'functional' somatic symptoms, clinicians and researchers have postulated roles of genetic and socio-cultural factors, as well as of various psychological variables. While there is some evidence that somatization is more prevalent among people of less education and lower socioeconomic position, and among ethnic groups whose cultural milieu discourages emotional expression (Barsky and Klerman, 1983), investigations have focused mostly on exploring the relationship of somatization with personality traits and concurrent emotional distress.

The mechanisms underlying somatization are not well understood. However, the following factors contribute:

a) Physiological arousal: Stressed or anxious patients experience heightened arousal and sensations.

b) Societal attitudes: "Physical" symptoms are more acceptable than psychological symptoms in the society. And are thus more commonly expressed.

c) Alexithymia: Some patients are unable to distinguish between emotional (cognitive anxiety) and physical pain. Persons who do not express emotions in words are described as alexithymic.

Contrary to the traditional psycho-analytic view that somatization is an attempt at conflict resolution and a defense against distressing affects, 'functional' somatic symptoms appear often to be consequences of emotions and even to reinforce emotions. The physical complaints are somatic idioms for emotional distress (Lipowski, 1988; Kellner, 1990). For example, somatic symptoms that induce anxiety, may lead to more somatic symptoms as a
consequence of autonomic arousal. It remains uncertain, however, why some patients minimize the affective component of emotions and selectively complain about the somatic accompaniments of emotional states (Kellner, 1990, Katon, Kleinman and Rosen, 1982), while others do not.

In recent years, several clinicians and researchers have suggested that the tendency to develop functional somatic symptoms might also be associated with the personality trait of alexithymia (Lesser, 1985, Wickramasekera, 1986, Taylor, Bagby, and Parker, 1991).

Alexithymia was derived from clinical observations made on patients with 'classical' psychosomatic diseases. It was introduced by Sifneos, as a part of the 11th European Conference on Psychosomatic Research, way back in 1972. Deriving from the Greek 'a' for lack, 'lexis' for word and 'thymos' for emotion, it literally means 'no words for mooa', referring to the individuals' difficulty in describing their emotional state. The Alexithymic trait encompasses cognitive and affective characteristics, in particular,

(a) difficulty in identifying and communicating subjective feelings
(b) a constricted imaginative life
(c) and a tendency to focus on the concrete details of external events (Taylor, Bagby, and Parker, 1991).

These characteristics are thought to reflect a deficit in the capacity to construct mental representation of emotions which are essential for modulating states of emotional arousal through such cognitive processes as reflection, fantasy, activity, and the verbal communication of feelings to other people (Lane and Schwartz, 1987).

Higher levels of alexithymia have been found to be associated with the diminished ability to experience pleasure in social situations (Prince and Berenbaum, 1993) and with growing up in homes in which there was little open communication (Berenbaum and James,
1994). It is not that alexithymics do not have emotions; rather they have difficulty identifying and communicating their emotions. There is a lack of coherence in their communication (Berenbaum and Stacey, 1996).

Thus, unable to use affects as signals of inner psychic events (including responses to external situations), many alexiythmic individuals are thought to focus on, and to amplify the somatic sensations while minimizing the affective components of emotions and emotional arousal, which are then experienced as overwhelming somatic distress, and/or misinterpreted as signs of disease. Some alexithymic individuals are thought also to attempt to 'discharge' unpleasant states of emotional arousal through compulsive behaviors, such as substance abuse, binge-eating, or self-starvation or anorexia nervosa (Taylor, Bagby, and Parker, 1991, Bourke et al., 1992).

The reported prevalence rates in the general population have a wide range, from 1.8 to 8.2% (Blanchard 1981) to 12.5% in men and 8.2% in women (Honkalampi et al., 2000). In psychiatric consultation services, it is reported to be 30-40% (Taylor et al., 1992; Fukunishi et al., 1996). In the psychosomatic diseases, it may be prevalent in up to 50% of patients. In some studies it has been associated with lower socio-economic status, increasing age and in the male gender; while other studies have reported no relation with age, gender or education. No Indian studies are available on its prevalence in the general population.

Empirical evidence supporting an association between somatic complaints and the concept of somatosensory amplifications is present (Barsky and Wyshak, 1990). The awareness of affects as potential signals of inner events as well as the identification of somatic sensations as bodily concomitants of emotions relies, to a large degree, on the way information is processed in the brain. Based on earlier psychoanalytic contributions on affect development several psychological theorists have conceptualized a fundamental autogenetic sequence of affect development, involving a progressive desomatization, differentiation and...
different levels of verbalization of emotions as cognitive representations (Schur, 1955, Lang, 1979, Lane and Schwartz, 1987). According to these, the person's development ranges from earlier stages of simple awareness of undifferentiated bodily sensations to an appropriate awareness of complex feelings and the capacity to appreciate the emotional experience of others. In this context, the alexithymia concept refers to a deficit in the cognitive processing of emotions that may result in an impaired desomatisations (Krystal, 1988). This cognitive emotional deficit might be caused by variations in brain organization (Sifneos, 1988) or may be due to a disturbance of emotional development during early childhood (Krystal 1974). Furthermore, this deficit can also be thought of as a kind of partial resomatization along the cognitive - developmental sequence following severe psychic trauma, (Bach, Bach and Zwaan, 1996) which might be one of the reasons for the observation of high levels of alexithymia in patients with post traumatic stress disorder (Taylor, Bagby and Parker, 1991).

From the physiological mechanism perspective, it has been explained as an inability to utilize right hemispheric processes to process powerful stimuli resulting in an exaggerated perception of painful stimuli (Kaplan and Wogan, 1977). Disturbances in the neural connections between the limbic system and the neocortex have been reported in somatization patients (Taylor, 1987). This implies that the essential perceptual process in somatization may be amplification of somatic symptoms. On the other hand, alexithymia encompasses both cognitive and affective styles which may result in emphasis on physical rather than emotional experiences; and hence may foster somatization. Although, related they are separate constructs, conceptually as well as factors analytically (Bach, Bach and Zwaan, 1996).

According to Sifneos' (1973) original description alexithymics

(a) have marked difficulty finding words to describe their feelings,

(b) have a paucity of dreams and fantasy,

(c) are characterized by preoccupation with concrete details of events in the world or body sensations.
(d) Poor interpersonal relationships and poor posture have also been noted to appear with alexithymia (Sifneos et al., 1977).

As Taylor (1977) points out, alexithymics may make up a major proportion of those people who are judged as poor candidates for psychotherapy due to a lack of “psychological mindedness”.

It must be emphasized that alexithymic individuals do experience emotions; the difficulty is only in recognizing and describing them. Thus, it is distinguished from anhedonia. It has also been empirically distinguished from repression, obsession, hypochondriasis and hysteria. Alexithymia is not just a verbal phenomenon, but reports suggest nonverbal deficiencies in symbolic functioning, like self reported weeping frequency (Vingerhoets et al., 1993, 1995), and in facial communication (Parker et al., 1993, Lane et al., 1996).

Alexithymia has been found to be an independent construct in relation to neuroticism (Vingerhoets et al., 1995) but has a positive correlation with it (Luminet et al., 1999). When compared with the five factor model of personality, Luminet et al. (1999) found alexithymia to be negatively correlated with extraversion and openness, and found no relationship with agreeableness, and conscientiousness. The uniqueness of alexithymia as a personality dimension is recorded; and has been reported to be independent of any of the DSM – II-R axis-I lifetime diagnoses (Bach et al., 1994). An association between alexithymia and certain personality characteristics has been reported, such as, social introversion (Parker et al., 1989), lack of psychological mindedness, persecutory ideation, impulse expression (Bagby et al., 1986), perceived difficulties of self-disclosure (Loiselle and Dawson, 1988), emotion suppression, illness and self-consciousness (Kirmayer and Robbins, 1993).

Alexithymia is thought to be connected with somatization. Alexithymic individuals and somatization individuals frequently attend the primary health centers (Joukamaa et al, 1995).
Some alexithymic patients who are distressed are not able to speak about their emotional problems, and therefore, they depend on somatization and frequently visit various outpatient health care services. Thus, a need was felt to assess alexithymia and psychological distress of the patients attending the psychiatric outpatient department to seek help for somatic complaints. This was particularly important when somatization as well as alexithymia separately and independently have been viewed as having cross-cultural differences. A multicenter international study conducted by WHO in 14 countries in primary care settings has established the lack of variability in the frequency of unexplained somatic symptoms across geographical areas or with level of economic development, using ICD-10 defined somatization disorder. However, the nature of symptoms i.e. the presentation of the disorder has been reported to vary with cultures, for instance, somatic symptoms may present as Dhat in India or as “ataque de narios” in Latin America or as “Hot and Cold” syndromes in Puerto Ricans (Escabar, 1995).

Similarly, alexithymia with its evolution from the clinical observation of clients undergoing psychoanalytic psychotherapy in North America and western Europe, might be a highly culture specific concept. Rather than being a personality trait, it may be a reflection of psychological mindedness (Kirmayer, 1987).

In this context, the present study has been conceptualized. There is a need to explore the relationship between somatoform disorders and alexithymia in the Indian context.

For an adequate understanding of the ‘somatic complaint syndromes’, a biopsychosocial holistic approach is needed. This can be as per the DSM-IV ‘multiaxial system’ whereby the mental or psychological presentation of symptom is coded on axis-I, personality disorders on axis-II, psychosocial stressors, and level of adaptation on axis IV and V. A holistic or biopsychosocial perspective should derive from this simultaneous...
consideration of different domains of assessment (Lalas, 1989). Based on the above system, somatoform disorder patients (axis-I) would be assessed on alexithymia (axis II) on stressful life events, social support and family functioning (axis IV) and on coping (axis V). To clarify the presence of a basic cognitive ability deficits associated with, and becoming a predisposing factor for alexithymia, the verbal fluency would also be assessed (biological aspect).