Anxiety and depression in Jordanian patients, Presenting with chronic non-organic abdominal pain

Nabil Alhmoud
Specialist Psychiatrist /Royal Medical Services.

The author's aim was to find out the prevalence of anxiety and depressive disorders among patients who were presented with chronic non-organic (functional) abdominal pain to the medical clinics. One hundred and twenty patients were studied thoroughly in the Gastroentorology department and no organic pathology could be found to incriminate the cause of abdominal pain. The author, who is a psychiatrist, conducted this study liaising with the patient's family doctor and general practitioner.
Comprehensive clinical psychiatric assessments for all participants have been done, and the standardized Arabic version of the Hospital Anxiety and Depression Scale (HAD), was applied as a confirmatory measure. The study only dealt with definite cases of anxiety & depression or both.
It was found that the prevalence of depression was 37.9%, while anxiety was prevalent at 44.6%, and having both conditions constituted 8.25% of cases, this makes a total of 74.25% psycho morbidity in general. Some differences could be detected in prevalence for both disorders regarding patients gender.
Limitation of the study will be discussed later in the text.

Pain is perhaps one of the most common complaints that patients present to doctors. Somatic complaints can be an outer expression of an inner emotional suffering; there may be different psychodynamics or mechanisms behind this form of presentation, which is beyond the scope, as well as the aim of this study. The contribution of psychological factors in creation of physical presentation is collectively called somatoform disorders (DSM- IV-TR). It embraces a group of conditions or disorders (somatization disorder, conversion disorder, hypochonderiasis, body dysmorphic disorder, pain disorder, undifferentiated somatoform disorder, and somatoform disorder NOS), these disorders share a common factor, it is that they are accompanied by depression, anxiety in variable rates and prevalence, which depends on the condition and type of study, in some conditions the prevalence may be high, and the best example is hypochonderiacal cases, where figures may reach rates as high as 80% (Kaplan).
In this study, the goal was to estimate the magnitude of depression and anxiety prevailing in patients suffering from

PAM nummer 1 16-02-2004 11:53 Pagina 41

recurrent or persistent functional abdominal pain.

Methods.

This study was conducted by enrolling 120 patients 62 of which were males (51.7%) and 58 females (48.3%). All participants were above the age of 17 years, the eldest was 57 years old. Table 1, illustrates patient's characters. Patient's mainly presenting complaint with chronic abdominal pain, (lasting more than six months); patients with multiple aches or symptoms of multiple system organs were excluded. All patients had never attended a psychiatric clinic before. They had been thoroughly assessed by gastroenterologists (GI) at King Hussein medical center, which is the largest referral hospital in Jordan. Investigations included endoscopic and histopathological procedures for all patients and other relevant tests where necessary. Given the negative results of the (GI) clinical and laboratory assessment of abdominal pain, where no organic pathology could be detected, patients were then referred to their family doctor or general practitioner (GP), hence the study subjects were received from the GP clinic. Participant's selection was based on the formerly mentioned points, and we enrolled the one hundred twenty patients in the GP clinic.
All patients agreed to participate, after suitable explanations about the nature and aim of the study.
Non-structured but comprehensive psychiatric interviews were conducted for each patient, relying on (DSM -IV-TR) as a diagnostic tool. Then the standardized Arabic version of Hospital Anxiety and Depression Scale was applied to all patients. Due to illiteracy five patients were assisted, three of which were females, and two males.

Total number = 120 Age				
(Both sexes)	Below 20 years N=20 (16.6%)	20-40 years N=65 (54.2%)	Above 40 years N=35 (29.2%)	Mean age 31.7 (Both gender)
Marital status (Males)	Single 18 (15%)	Married100 (83.33%)	Divorced 0 (0%)	Widow 2 (Both males) (1.66%)
Marital status (Females)	Single 0 (0%)	Married58 (100%)	Divorced 0 (0%)	Widow 0 (0%)

Table 1 *- Patient's characters*

	Males	Females
Anxiety	34 (54.8%)	20 (34.4%)
Total 34	44.6%	
Depression	16 (25.8%)	29 (50%)
Total	37.9%	
Both anxiety and depression	6 (9.6%)	4 (6.9%)
Total	8.25%	

Table 2 *- Illustration of results*

Results.

Despite the initial clinical psychiatric recognition of cases, the mentioned psychometric instruments were used, serving as a confirmatory measure of presence & severity of psychological condition not of course to test, the tool's validity. However the agreement rate between the clinical interview and results of these tools regarding both identifications and severity of depression and anxiety reached a high figure of 93.8% regarding the presence of anxiety, depression or both. Presence of disorder was best interpreted as a state in which patients could fulfill both criteria conditions of diagnosis adequately. Marginal cases with borderline scores were excluded.
It was found that, anxiety took the highest prevalence; it had reached a total of 44.6%, while having both illnesses had the lowest prevalence (8.25%).
Gender differences were noted, mainly in prevalence of depression where females reported prevalence reaching approximately twice as that seen in males (50% vs. 25.8%). However males showed a higher prevalence of anxiety.
A total morbidity was estimated to be 74.25%(44.6%+37.9%-8.25%). Results are illustrated in table 2.

Discussion, Conclusions & recommendations

Functional GI disorders and pain is common. (Koloski.2002) found that the prevalence of one or more functional GI disorder in the general population is 34.6%.
Medical literature points out to different prevalence regarding presence of depression or anxiety in functional abdominal pain. (Young 1976) reported that 72% of patients suffering with irritable bowels have had psychiatric illnesses, mainly depression and "hysteria". According to (Lydiard 2001) 50%

PAM nummer 1 16-02-2004 11:53 Pagina 42

to 90% of patients seeking psychiatric help due to pain, that characterize irritable bowel syndrome, have psychiatric illness.

Present study shows a total morbidity figure of (74.25%), nevertheless (Rose1986) reported that, 64% of depressives have no organic causes to their abdominal pain, and 50% of patients referred to medical clinics with functional abdominal pain have some form of depression. He also stressed the importance of appreciating the presence of depression in functional abdominal pain and GI dysfunctions in general.

One important point to be discussed is to dig into chronology and the temporal relationship between the presenting complaint and the psychiatric findings for each patient, that is to say, which is secondary to the other? The same question will probably arise when we deal with other psychosomatic conditions. According to (Gruber1996) using psychotropic was found to be helpful to alleviate both the physical and psychological complaints, but the relationship between depression and this condition is still debatable.

In our study females tended to show higher figures regarding depression. (Approximately twice as many as males prevalence), but significantly had lower rates in anxiety. A matter that could be explained on a cultural basis, as it may be more sympathy attracting to deliver somatic complaints than psychological ones (Michael), or do females tend to somatize their depression more than they do in anxiety? A matter that warrants further studies, or it could be due to a genuine higher incidence in that psychiatric disorder, given that the ratio is 1 to 2 between males and females regarding pain disorders (Kaplan 1994).

Some previous studies showed poorer prognosis of functional abdominal pain in the case of female sex and depressive illness (Muris 1996).

Such significant findings are extremely important, which is to draw attention to the magnitude of concurrent psychological conditions. (Bass 2001) argued that, such conditions are under considered by psychiatrists and have not been given the appropriate priority, as it should. Early recognition of the psychiatric element of the condition will help as well, in order to cut down unnecessary medical costs.

This study has some limitations, as it lacks a comparative control group for variable somatic complaints. However, reviewing similar studies that have been done on other complaints, one can find a high incidence of psychopathology in GI group patients (Brenda 2001).

This study has some limitations, as it lacks a comparative control group for variable somatic complaints

In keeping a conscious mind psychiatrists, on the size of the accompanied emotional element with such functional conditions, training GPs, better liaison work, and further detailed research will help us to understand and manage patients with unexplained abdominal pain who are suffering from depression as well as anxiety.

REFERENCES

1. *Bass, C., Pevler, R. & House, A. (2001). Somatoform disorders: Sever Psychiatric illness neglected by psychiatrists. British J of Psychiatry, Jul 2002; 179:11-14.*
2. *Brenda J. Horwitz, M.D., and Robert S. Fisher, M.D. The Irritable Bowel Syndrome. The New England Journal of Medicine June2001; Number 24Volume 344:1846-1850.*
3. *DSM-IV-TR. Diagnostic and statistical manual of mental disorders. 4th Edition Revised. Washington DC: American Psychiatric Association; 2000.*
4. *Harold I. Kaplan, Benjamin S, Jack G & Robert C (eds) (1994).*
5. *Gruber AJ, Hudson JI, Pope HG Jr. The management of treatment- resistant depression in disorders on the interface of psychiatry and medicine. Fibromyalgia, chronic fatigue syndrome, migraine, irritable bowel syndrome, atypical facial pain, and premenstrual dysphoric disorder. Psychiatry Clin North Am. 1996 Jun; 19(2): 351*
6. *Koloski NA, Talley, Boyce PM. Epidemiology and health care seeking in the functional disorders: a population-based study. Am J Gastroenterology.2002 Sep; 97(9): 2290-9.*
7. *Lydiard RB.Irritable bowel syndrome, anxiety, and depression: what are the links? J Clinical Psychiatry.2001; 62 Supp 8:38-45; discuss 46-7.*
8. *Lydiard RB.Irritable bowel syndrome, anxiety, and depression: what are the links. Clinical Psychiatry2001; 62:38-45;discussion 46-47.*
9. *Michael G, Dennis G, Richard M & Philip C (1996). Oxford Textbook of Psychiatry. Oxford University press: Oxford.*
10. *Muris JW, Starmans R, Fijten GH, Knotterus JA.One-year prognosis of abdominal complaints in general practice: a prospective study of patients in whom no organic cause is found. Br J Pract.1996Dec; 46(413): 715-9.*
11. *Panayotis Trikas, MD, I. Vlachonikolis, MA, DPhil, N. Fragkiadakis, BSc, S. Vasilakis, MD, O.Manousos, MD and N. Paritsis, MD, PhD. Core Mental State in Irritable Bowel Syndrome. Psychosomatic Medicine 1999; 61:781-788*
12. *Rose JD, Troughton AH, Harvey JS, Smith PM. Depression and functional bowel disorders in gastrointestinal outpatients. Gut 1986; 27: 1025–8*
13. *Young SJ, AlpersDH, NorlandCC, Woodruff RA Jr.Psychiatric illness & the irritable bowel syndrome. Practical implications for the primary physician. Gastroenterology1976 Feb; 70(2): 162-6*