Original Article

Psychological status and coping strategy of somatization disorders

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Abstract: Objective: To evaluate the psychological status of patients with somatization disorders by using questionnaire survey and professional mental scale, aiming to provide effective coping strategies for psychological and physical recovery. Methods: Fifty patients diagnosed with somatization disorder and 50 corresponding family members were assigned into the study group. Fifty healthy subjects and 50 their family members were allocated into the control group. All participants received comprehensive evaluation by using SCL-90, SSRS and CSQ. Results: In the study group, the average scores of a majority of items in the SAS and SDS were significantly higher than those in the control group (all P<0.05). The mean scores of overall social and subjective support in patients with somatization disorder were considerably lower than those in their counterparts (all P<0.05). In the study group, the average score of negative factor was significantly higher whereas that of the positive factor was apparently lower compared with the values obtained in the control group (all P<0.05). Conclusion: Patients diagnosed with somatization disorder and their family members present with evident psychological symptoms, lack of social support and effective strategy against the symptoms of somatization disorder.

Keywords: Somatization disorder, psychological health, strategy

Introduction

Somatization disorder, also known as Briquet’s syndrome, is defined as a mental disorder clinically characterized by recurring, multiple and clinically significant complaints about somatic symptoms [1-3]. It has been recognized in the DSM-IV-TR classification scale, which is combined with undifferentiated somatoform disorder to become somatic symptom disorder in the latest version DSM-5, in which the diagnostic criteria does not require a specific number of somatic symptoms [4-7]. Multiple novel developments and advancements have been accomplished in terms of somatization disorder, which is among the most challenging of psychiatric disorders encountered in clinical experiences. Multiple diagnostic criteria have been revised to facilitate the clinical diagnosis and corresponding strategy. At present, differential diagnostic tools mainly include neurologic disorders, systemic medical disorders, and alternative psychiatric disorders, such as mental anxiety disorders, conversion disorder, malinger, and factitious disorder, etc. Previous studies have reported that a large proportion of patients present with more than one of such illnesses complicated with somatization disorder [8-11]. In clinical practice, somatization disorder requires comprehensive and novel psychosocial treatment designed by the professional neurologists and psychiatrists and alternative mental experts.

However, most previous investigations mainly focus upon evaluating the mental status of patients diagnosed with somatization disorder. Few studies have been reported to assess the discrepancy between the patients and their family members in terms of mental and psychological issues. In this study, multiple evaluation scales have been utilized to assess the mental and psychological status, explore the major problems and identify effective interventional strategies to radically resolve these issues from both social and family perspectives, which probably elevate the mental recovery and quality of life of patients suffering from somatization disorder.
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Materials and methods

Study subjects

In total, 50 patients diagnosed with somatization disorder admitted to XXX hospital between September 2014 and October 2015 and their family members (n=50) were recruited into the study group. All patients were diagnosed according to International Statistical Classification of Diseases and Related Health Problems [xxx] (ICD-10).

Among 50 patients, there were 13 males and 37 females, aged from 16 to 73 years, with mean age 43.8 ± 10.7 years. Twelve patients had educational level of elementary school or below, 25 with junior middle school, 9 with specialized middle school or senior high school and 4 with college or university background or above. Adult family members who could understand the survey contents, normal mental state, without severe physical or psychological diseases or systemic illnesses were eligible for subsequent analysis. Seven pairs of participants were spouses, 11 were mother-and-son relationship, 12 were mother-and-daughter relationship, 6 were father-and-daughter relationship, 6 were father-and-son relationship, 5 were brother or sister relationship and 3 were mother and daughter-in-law relationship.

In the control group, 50 normal controls were all staff from XXX hospital. Meantime, 50 family members of these 50 control individuals were also enrolled in this study. Adult family members who were able to comprehend the survey contents, normal mental state, without severe physical or psychological diseases or systemic illnesses were eligible for subsequent survey.

Among 50 healthy controls, there were 14 males and 36 females, aged from 16 to 71 years, with mean age 41.4 ± 10.3 years. Nine had educational level of elementary school or below, 17 with junior middle school, 19 with specialized middle school or senior high school and 5 with college or university educational levels or above. Ten pairs of participants were spouses, 12 were mother-and-son relationship, 10 were mother-and-daughter relationship, 5 were father-and-daughter relationship, 5 were father-and-son relationship, 6 were brother or sister relationship and 2 were mother and daughter-in-law relationship.

The gender, age, educational background and patient-family member relationship were totally matched with no statistical significance between the study and control groups (all \( P > 0.05 \)).

Survey questionnaire

Symptom checklist-90 scale: The Symptom Checklist-90-R (SCL-90-R) is a relatively brief psychometric instrument self-reported by the patients. SCL-90 is specially designed for individuals aged 13 years and older, which consists of 90 items and takes 12-15 minutes to accomplish all questions, generating 9 scores along primary symptom dimensions and 3 scores among global distress indices. Primary symptom dimensions that are assessed include somatization, obsessive-compulsive, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, psychotism, and a category of “additional items” which assists the physicians to thoroughly evaluate alternative perspectives of the symptoms of enrolled patients.

Social support rating scale: Social support rating scale (SSRS) is composed of 10 items which are divided into objective support, subjective support and social support covering three dimensions in total. The questionnaire consists of problems and difficulties based on psychological stress of patients and multiple choices according to the sources of social support.

Coping style questionnaire: Coping style questionnaire (CSQ) includes 62 items which are classified into 6 subscales, such as problem resolving, self-complain, seeking help, fantasy, escape and rationalization. The score scale ranges from 0 or 1 system. Trait coping style questionnaire (TCSQ) and simplified coping style questionnaire (SCSQ) were adopted to assess the negative and positive coping strategies.

Results

Comparisons of SCL-90 scores between the study and control groups

As illustrated in Table 1, the mean scores of 8 items in patients diagnosed with somatization disorder and their family members were significantly higher than those values in the healthy counterparts (all \( P < 0.05 \)). However, the mean score of hostility item did not significantly differ between two groups (\( P > 0.05 \)).
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Table 1. Comparison of SCL-90 scores between the study and control groups

<table>
<thead>
<tr>
<th></th>
<th>Study group (n=50)</th>
<th>Control group (n=50)</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Patient</td>
<td>Family member</td>
<td>Healthy subject</td>
</tr>
<tr>
<td>Somatization disorder</td>
<td>2.93 ± 0.71</td>
<td>1.74 ± 0.56</td>
<td>1.36 ± 0.67</td>
</tr>
<tr>
<td>Obsessive-compulsive</td>
<td>2.91 ± 0.89</td>
<td>1.97 ± 0.43</td>
<td>1.67 ± 0.56</td>
</tr>
<tr>
<td>Interpersonal sensitivity</td>
<td>2.21 ± 0.77</td>
<td>1.97 ± 0.68</td>
<td>1.68 ± 0.80</td>
</tr>
<tr>
<td>Anxiety</td>
<td>2.49 ± 0.60</td>
<td>2.28 ± 0.43</td>
<td>1.42 ± 0.56</td>
</tr>
<tr>
<td>Depression</td>
<td>2.80 ± 0.67</td>
<td>1.83 ± 0.62</td>
<td>1.49 ± 0.77</td>
</tr>
<tr>
<td>Hostility</td>
<td>2.16 ± 0.56</td>
<td>1.52 ± 0.44</td>
<td>1.98 ± 0.69</td>
</tr>
<tr>
<td>Phobia</td>
<td>1.70 ± 0.82</td>
<td>1.64 ± 0.56</td>
<td>1.27 ± 0.68</td>
</tr>
<tr>
<td>Paranoid ideation</td>
<td>2.62 ± 0.56</td>
<td>1.80 ± 0.55</td>
<td>1.43 ± 0.67</td>
</tr>
<tr>
<td>Psychoticism</td>
<td>1.89 ± 0.49</td>
<td>1.32 ± 0.50</td>
<td>1.28 ± 0.55</td>
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</table>

Table 2. Comparison of SSRS scores between the study and control groups

<table>
<thead>
<tr>
<th></th>
<th>Study group (n=50)</th>
<th>Control group (n=50)</th>
<th>P</th>
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</thead>
<tbody>
<tr>
<td>Total score</td>
<td>34.60 ± 7.89</td>
<td>38.96 ± 7.21</td>
<td>&lt;0.05</td>
</tr>
<tr>
<td>Objective support score</td>
<td>9.12 ± 4.83</td>
<td>7.63 ± 5.37</td>
<td>&gt;0.05</td>
</tr>
<tr>
<td>Subjective support score</td>
<td>18.73 ± 5.34</td>
<td>24.01 ± 6.27</td>
<td>&lt;0.05</td>
</tr>
<tr>
<td>Availability</td>
<td>9.25 ± 3.36</td>
<td>9.54 ± 3.35</td>
<td>&gt;0.05</td>
</tr>
</tbody>
</table>

Table 3. Comparison of CSQ scores between the study and control groups

<table>
<thead>
<tr>
<th></th>
<th>Study group (n=50)</th>
<th>Control group (n=50)</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive coping style</td>
<td>24.34 ± 7.85</td>
<td>36.14 ± 8.04</td>
<td>&lt;0.05</td>
</tr>
<tr>
<td>Negative coping style</td>
<td>34.45 ± 5.7</td>
<td>24.86 ± 6.13</td>
<td>&lt;0.05</td>
</tr>
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</table>

Discussion

The results in this study indicated that patients diagnosed with somatization disorder constantly suffer from psychological problems. Patients with somatization disorder suffer from severe financial challenge to the health service due to the fact that symptoms are often intractable and require long-term care. During hospitalization, the physicians and nurses place much attention to the patients, whereas neglect the education towards the family members of the patients, which may negatively affects the recovery of the quality of life of patients.

Comparisons of SSRS scores between the study and control groups

As revealed in Table 2, the total score and subjective support score in the study groups were significantly lower compared with those values in the control group (both P<0.05). However, the objective support score and the availability score did not considerably differ between the study and control groups (both P>0.05).

Comparisons of CSQ scores between the study and control groups

As illustrated in Table 3, the mean score of positive coping style in the study group was significantly lower than that in the control group (P<0.05), whereas the average score of negative coping style in the study group was considerably higher than that in the control group (P<0.05).

Through administering questionnaire, the true psychological status of patients was acknowledged by the medical staff under the prerequisite of eliminating the anxiety emotion and obtaining mutual trust between patients and physicians. If the patients were unable to complete the survey independently, relevant nurses should provide certain assistance to help them to accomplish the task.

Upon admission, the nurses were responsible for explaining the specialized knowledge regarding somatization to the patients via multiple channels, such as online chat tool, Weibo blog and alternative online platforms. Furthermore, the patients were informed about the diagnosis, treatment strategy and process. Such assistance could not only make the patients better understand somatization disorder, but also increase their confidence in the treatment and recovery.
Besides the patients themselves, their family members are likely to suffer from emotional problems due to high medical cost and long-term taking care of the patients. These economic and psychological burdens may negatively and extensively affect the occupation, study and daily life of the patients’ family members, eventually leading to anxiety, stress and even depression [12, 13]. The nursing group should take responsibility to deliver psychological assistance and guidance to the family members, help them to properly adjust mental status, reduce psychological burden, and actively and devotedly take care of the patients, which can collectively accelerate the psychological recovery of the patients. Establishing a channel of frequent and effective communication between patients, family members and physicians significantly elevates the cognitive understanding of patients towards the disease, satisfy their psychological needs and enhance their confidence upon the clinical treatment and fast recovery.

The support from family members of the patients takes great responsibility [14]. First, family member who take care of the patients should learn to deliver psychological hints to help the patients to correct their inappropriate behaviors, which make the patients better understand themselves and enhance self-confidence and eliminate negative feelings. The physicians and nurses should guide family members to attend the lectures regarding somatization disorder, which widens their viewpoint and understanding of the pathogenesis, diagnosis and treatment of somatization disorder. Besides, they can learn useful techniques in terms of physical movement, rest duration and recovery knowledge, etc.

Due to the complex pathogenesis and frequent recurrence of somatization disorder, identifying the intrapsychic conflicts of the patients and implement effective coping styles play a pivotal role in the success of corresponding therapy [15, 16]. Understanding of the complex neurobiological, psychological and social causes of somatization disorder contributes to improve diagnostic accuracy and therefore the capacity to develop a treatment plan tailored to the special needs of each patient.

**Disclosure of conflict of interest**

None.

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**References**

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