SUMMARY

Somatizing patients in Nigeria have received various psychiatric diagnoses using the yardstick (criteria/illness categories) originally developed in the western cultures. There have been concerns regarding the validity of such diagnoses because most of the somatic complaints which are common in Nigeria are not explicitly stated in the western criteria.

In this study, sixty somatic symptoms from patients seen in a General Out Patients Clinic of the University of Calabar Teaching Hospital were assessed.

The aims were to;

(i) Establish the prevalence of these sixty symptoms.

(ii) Assess the severity of these symptoms in the patients that presented with them.

(iii) Determine the International Classification of Diseases – 10th edition (ICD – 10) Psychiatric diagnoses amongst the patients presenting with these symptoms.

(iv) Determine whether or not the somatic symptoms occur in clusters that could constitute specific syndromes.

(v) Determine whether or not there is a relationship between possible clusters and the ICD – 10 diagnoses.
The study design was cross sectional; using three different instruments, two of which were designed by the investigator. These instruments were:

(a) The Somatic Symptom Checklist which sought for the presence or absence of the somatic symptoms in 4215 clinic attendees. With this instrument, the first aim of this study was established.

(b) The Somatic Symptom Severity Questionnaire (SSSQ). This second instrument was self administered on a sample of one hundred patients that were randomly recruited (from the clinic attendees that met the inclusion criteria) for further studies. This questionnaire assessed the severity of these somatic symptoms (the second aim of this study) using visual analogue scale.

The responses of these recruited patients on the sixty somatic complaints were subjected to cluster analysis. This was to determine the major (fourth) aim of this study which was whether or not somatic symptoms occur in clusters that could constitute specific clinical syndromes.

These recruited patients were also interviewed with the third instrument which was the Schedule for Clinical Assessment in Neuropsychiatry (SCAN) for possible psychiatric diagnoses based on the ICD – 10 criteria. This addressed the third aim of this study.
Results showed that 3937 (93.4%) of the clinic attendees reported one or more of the somatic symptoms and that psychiatric diagnoses were reached (using the SCAN) in over three-quarters (79%) of the one hundred patients that were randomly recruited from the clinic attendees that presented with the somatic complaints. Patients who rated their symptoms as either moderate or severe were the ones more likely to have SCAN diagnosis. The diagnoses were mainly depression and anxiety disorders. While depressive disorders were commoner and tended to occur in older patients, males and younger somatizing patients were more likely to have anxiety disorders.

Cluster analysis produced seven distinct clusters confirming that somatic symptoms occur in clusters. From these seven clusters, six clinical syndromes were identified. Attempts to relate these cluster/syndromes to the psychiatric diagnoses made with the SCAN did not yield satisfactory results because it was observed that the clusters/syndromes did not fit in neatly into the western classificatory system. This indicates that the use of the categories originally developed in western cultures is inadequate for classifying somatizing patients in Nigeria.