

# What can we learn from a cross-national study of somatic distress?

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## Abstract

**Objective:** To examine the extent of cross-national variations in the rates and correlates of somatic distress and determine whether this can be ascribed to cultural differences. **Methods:** A two-stage survey in primary care across 15 sites in 14 countries. Screening with the 12-item General Health Questionnaire (GHQ-12) was followed with detailed diagnostic assessment with the Composite International Diagnostic Interview. Self-rating of overall health and evaluation of disability days were also conducted ( $N=5438$ ). Twelve months later, 3204 of the patients completed follow-up interviews. **Results:** Somatic distress

*Keywords:* Somatic distress; Cross-national; Frequency; Health perception

(different definitions of somatization and of hypochondriasis as well as persistent pain disorder) varied in its occurrence across sites. However, other than elevated rates in Latin America, variation tends to be complex and does not lend itself to a neat cultural explanation. The nature of patient–doctor relationship is related to this variation. **Conclusion:** Cross-national differences occur in somatic distress. The pattern of these differences does not follow clear cultural lines even though the role of culture cannot be excluded.

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## Introduction

Even though the literature is replete with reports describing association of culture with various aspects of somatization [1–4], there is little empirical evidence that observed variations in, for example, the occurrence of the disorders across countries lend themselves to obvious cultural explanations [5,6].

To draw reliable inferences in regard to cross-national variations in somatoform disorders, studies need to meet a set of conditions. One, it is important that cross-national comparisons be drawn from data that utilize identical ascertainment procedure in the countries of interest. Two, the assessment tools should be developed in such a way that they allow for the inclusion of symptoms that may be peculiar to study sites. Third, the assessment should be comprehensive, allowing not just for examination of the frequency of somatic distress but also its correlates in regard to demographic attributes and impact. When differences are obtained in these areas, attempts could thereafter be made to examine whether such differ-

ences bear associations with study sites in a manner that may suggest plausible cultural explanation.

The study Psychological Problems in General Health Care (PPGHC), a World Health Organization collaborative project that was conducted in 15 centers in 14 countries located in four continents [7], provides an opportunity to address the following questions: To what extent do differences in the experience of somatic distress across countries lend themselves to cultural interpretations? Are there factors related to the nature of patient–doctor interaction that may be associated with the reporting of somatization symptoms?

## Aims and methods

The aims of the PPGHC were to investigate the nature, impact, and course of common psychological problems presenting in primary care settings. Designed as a two-stage cross-cultural epidemiological survey of people contacting general health settings, the study was conducted in Ankara (Turkey), Athens (Greece), Berlin and Mainz (Germany), Bangalore (India), Ibadan (Nigeria), Groningen (the Netherlands), Manchester (United Kingdom), Nagasaki (Japan), Paris (France), Rio de Janeiro (Brazil), Santiago

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(Chile), Seattle (United States), Shanghai (China), and Verona (Italy).

A full description of the methodology and rationale for the study is given elsewhere [7,8] and only a brief overview is provided here. Each center screened a consecutive or random sample of adult primary care outpatients aged 18 to 65 years. Patients who consented to participate ( $N=25,916$ ) completed the 12-item General Health Questionnaire (GHQ-12) [9] before seeing their physician. Response rate for the screening stage was 96% (range: 91–100%). Selection for the second-stage diagnostic assessment was based on the screen-score performance (100% of those with GHQ score >80th percentile, 35% of those scoring between 60th and 80th percentile, and 10% of those scoring <60th percentile). For each consenting patient, the primary care physician made a rating of physical health status (completely healthy, some symptoms but subclinical, mildly ill, moderately ill, or severely ill). The second-stage assessment included self-rating of overall health (excellent, very good, good, fair, or poor), a rating of number of disability days in the prior month, and psychopathological evaluations. Trained interviewers using the primary care version of the Composite International Diagnostic Interview (CIDI) [10,11] conducted the latter. Sixty-two percent of those selected ( $N=5447$ ) completed the diagnostic assessment. All patients with current psychological disorder as well as a random 40% sample of those without were eligible for a 12-month follow-up assessment, which consisted of identical instruments as those used in the baseline. These interviews were conducted in patients' homes and, across all sites, the weighted follow-up rate was 68.5% ( $N=3197$ ). Even though follow-up participation varied significantly across study sites, it was not significantly related to age, sex, psychological disorder, and presence of somatoform disorders at baseline.

In this article, the indices of somatic distress examined include the ICD-10 defined somatization disorder and hypochondriasis, an abridged form of somatization (the Somatic Symptom Index) [12], an abridged form of hypochondriasis that has been previously shown to be valid and prevalent in primary care [6,] and persistent pain disorder, defined as a clinically significant and current pain condi-

tion that was present on most days over a period of 6 months or more.

## Results

Across the sites, the samples were composed of predominantly young to middle-aged people with a mean age of  $40 \pm 14$  years. Patients in Ankara, Bangalore, and Ibadan, with respective mean ages of  $32 \pm 13$ ,  $31 \pm 13$ , and  $33 \pm 11$  years, tended to be younger in keeping with the age structures of these countries. Patients from developing countries (Ankara, Bangalore, Rio de Janeiro, Santiago, and Ibadan) also had lower means of education than those from more developed ones (Athens, Paris, and Seattle): 5–7 years compared with 12 years or more.

### *Frequency and natural history of somatoform disorders*

Table 1 presents the centers with the two lowest and two highest prevalence rates for various types of somatoform disorder. Irrespective of the specific somatoform disorder examined, the prevalence rates varied significantly across the sites. Other than a tendency for the two South American sites (Rio de Janeiro and Santiago) to have high rates, the sites with either low or with high rates lacked an obvious unifying cultural or even developmental attribute. For example, centers with the two lowest rates for ICD-10 defined somatization disorder were drawn from three continents (Africa, Asia, and Europe) and spanned the spectrum of economic development.

The pattern shown for prevalence (in Table 1) is similar to that obtained when incidence rates were examined. For example, the two lowest incidence rates of the abridged somatization disorder were obtained in Paris (0.5%) and Ibadan (0.8%), while the two highest rates were obtained in Ankara (19.3%) and Santiago (26.1%). Indeed, the natural history of these disorders, while being significantly different across sites, also showed no identifiable cultural pattern. For example, the lowest rates for nonrecovery from persistent pain disorder after 12 months were obtained in Athens (16.7%) and Shanghai (22.2%), while the two highest rates were obtained in Ankara (79.1%) and Verona (72.2%).

Table 1  
Rates of occurrence of somatoform disorders in different cultures

Rates	ICD-10 somatization	Abridged somatization disorder	ICD-10 hypochondriasis	Abridged hypochondriasis	Persistent pain
Overall prevalence	2.8	19.7	0.8	2.2	21.5
Lowest prevalence	0.1 (Nagasaki, Verona) 0.4 (Ibadan, Manchester)	7.6 (Ibadan) 8.9 (Verona)	0.0 (Athens, Paris) 0.2 (Ankara, Bangalore)	0.2 (Bangalore) 0.7 (Ankara, Manchester, Paris, Shanghai, Verona)	5.5 (Ibadan) 11.8 (Nagasaki)
Highest prevalence	8.3 (Rio de Janeiro) 17.7 (Santiago)	32.0 (Rio de Janeiro) 36.8 (Santiago)	1.9 (Ibadan) 3.8 (Santiago)	5.4 (Berlin) 9.5 (Santiago)	32.8 (Berlin) 33.0 (Santiago)

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