

Year : 2016
Volume : 3
Issue Number : 1
Doi Number : 10.5455/JNBS.1443509530

Article history:

Received 29 September 2015
Received in revised form 11 November 2015
Accepted 18 January 2016

ASSESSMENT OF PAIN SYMPTOMS IN TERMS OF CULTURE

KÜLTÜREL AÇIDAN AĞRI SEMPTOMLARININ ELE ALINIŞI

Sinem Gönenli Toker^{*1}, Burcu Göksan Yavuz², Oğuz K. Karamustafaloğlu³

Abstract

The common feature of somatoform disorders is the presence of somatic symptoms that cannot be explained by a general medical condition. Pain disorder is also among the somatoform disorders. Pain is defined as an unpleasant sensation occurring as a consequence of a disease, injury or an organic pathology. Breuer and Freud, in their studies on hysteria, suggested that pain could be a manifestation of a psychological problem. The lifetime prevalence is not precisely known. In the Turkish mental health study 12 month incidence of pain disorder is found to be % 11.3 among women, % 4.8 among men and % 8.4 in the general population. The cultural diversity of the mental illnesses particularly somatic symptoms is noticed. Traditions and belief systems influence the formation, presentation and the management of dissociative and somatoform symptoms. Types of somatic symptoms differ across the cultures. Higher rates of somatic complaints are found in South America, Asia, particularly in developing countries. The separation between physical and emotional experience occurs precisely in Western countries. Thus somatic symptoms are rarely seen in Western culture.

Keywords: pain, culture

Özet

Amaç: Ağrı, hastalık, bedensel yaralanma veya organik bozukluğa bağlı rahatsızlık verici bir duygu olarak tanımlanır. Bu gözden geçirmede ağrı semptomlarının ortaya çıkışı ve seyrinde kültürel faktörlerin etkileri incelenmiştir. **Yöntem:** Ağrı ve diğer somatik semptomların farklı kültürlerdeki görünüşleri irdelenmiştir. **Bulgular ve sonuç:** Psikiyatrik hastalıklarda özellikle somatik semptomların kültüre özgü çeşitliliği dikkat çekmektedir. Gelenekler ve inanç sistemleri, disosiatif ve somatoform semptomların oluşması, ortaya konması ve bunlarla başa çıkılmasını büyük oranda etkiler. Somatik hastalardaki semptom tipi kültüre göre değişmektedir. Güney Amerika ve Asya'da, özellikle gelişmekte olan ülkelerde somatik yakınmaların sıklığı daha yüksek oranda bulunmuştur. Batı kültüründe fiziksel ve duygusal deneyimler daha kesin olarak birbirinden ayrılır. Bu sebeple somatik şikayetler batı toplumlarında daha az görülüyor olabilir.

Anahtar Kelimeler: Acı, Kültür

^{*}1Corresponding author: Psychiatry Department, Medipol University school of medicine, Istanbul. E-mail: sgonenli@hotmail.com
Mobile: +90 05325072520

²Psychiatry Department, Acıbadem University school of medicine, Istanbul. E-mail: bgoksan@yahoo.com

³Psychology Department, Uskudar University, Istanbul. E-mail: oguzkaramustafa@gmail.com

Common features of somatoform disorders are the existence of physical symptoms that act like general medical situations that cannot be explained by another mental disorder or direct effects of a substance. These symptoms cause a clinically significant distress or impairment in social, occupational, or other important areas of functioning¹ (American Psychiatric Association, 1994; 2013). Somatoform disorders have 7 subgroups in DSM IV; Somatisation disorder, Undifferentiated somatoform disorder, Conversion disorder, Pain disorder (table 1), Hypochondriasis, Body dysmorphic disorder and somatoform disorder not otherwise specified. In DSM-V, somatoform disorders and pain disorders are classified as "Somatic Symptom Disorders and Related Disorders". (table 2)

Pain, which is related to the Latin word poena (punishment, revenge, torture), is described as "a disturbing feeling due to illness, physical injury or an organic disorder"² (Evlice & Uğuz, 1999). In their research about hysteria, Breuer and Freud predicted that pain might be a sign of a psychological problem. On the other hand, International Association for the Study of Pain (IASP) describes pain as an unpleasant emotional situation that originates from a specific area that might be caused by a tissue damage and related to individuals past experiences. In DSM-IV, pain requires to be the predominant focus of the clinical presentation for pain disorder.

Table 1: DSM-IV Diagnostic Criteria of Pain Disorder

- A. Pain in one or more anatomical sites is the predominant focus of the clinical presentation and is of sufficient severity to warrant clinical attention.
- B. The pain causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- C. Psychological factors are judged to have an important role in the onset, severity, exacerbation, or maintenance of the pain.
- D. The symptom or deficit is not intentionally produced or feigned.
- E. The pain is not better accounted for by a mood, anxiety, or psychotic disorder and does not meet criteria for Dyspareunia.

Table 2: DSM-V Somatic Symptom and Related Disorders

- a. Including: requires at least one disturbing somatic sign
- b. Including: requires at least one of the thoughts, feelings or behaviours below for 6 months:
 - i. Non-proportional thoughts
 - ii. Continuous high level of anxiety
 - iii. Overinvestment
- c. Qualifiers
 - i. Determinants
 - The pain as predominant
 - Continuous
 - ii. Severity
 - Mild: 1 of B diagnosis criteria
 - Moderate: 2 or more of B diagnosis criteria
 - Severe: 2 or more of B diagnosis criteria with multiple somatic signs

The prevalence of the pain disorder is not well known. However, it is considered frequent in general medical practice. It is two times more frequent in women than men. There is no familial predisposition reported. It is frequent between the ages of 30-50. Recent researches report its 6 months and life time prevalence between

5-12%. Psychiatric disorders, especially affective signs are frequent almost in 1/3 of the cases. 12 months pain disorder frequency is reported as 11.3% in women, 4.8% in men and 8.4% in all population in Turkey mental health profile study³ (Kılıç, 1988). In a study of Sağduyu et. al. with 262 patients, the most frequent symptom was head ache (68.5%) and it was reported that lumbar/back pain was more frequent in women than men (45.7% and 18.8%, respectively)⁴ (Sağduyu et al.,1999).

It is common in whole world to physically express the general distress. Several physical systems are used to find the source of the distress and to form the required answer. Psychiatric disorders are linked with the increase of bodily perception, successful treatment of illnesses like anxiety and mood disorders mostly results with disappearance of somatic complaints as well. It is known that adverse experiences in early periods of life might cause psychobiological changes and objectively and perceptively poor health features might be observed on these people. It is observed that learning mechanisms have a significant role on bodily expression of mental distress and children might apply with pain symptoms that are similar to their parents' way of expressing their distress.

While emotional factors and psychic needs of the individual play a role in perceiving pain, in some patients, especially in patients with chronic pain, suffering extent is also added. Suffering is an adverse emotional response to pain and depression and anxiety might be considered in this regard² (Evlice & Uğuz, 1999). Occasionally, people express their tension (stresses like loss of somebody, not being able to reach a goal) and guilt with pain, unintentionally ease the weight of their problems that bother them and move them away from their own thoughts. The significance given to pain might be intended to avoid a subliminal difficulty and conflict and this situation is described as primary gain. Thus, the intolerable inner conflict is transformed into more acceptable pain complaints that might have support, help, attention and understanding of people. This way, individuals might have their social environment in their hands, get away from responsibilities. This is described as secondary gain. Chronic pain is a process including stationary and maladaptive behaviour processes that cannot be explained with existing physical pathology in which the main issue is the reaction patient gives to pain, not the damage or pain themselves. In chronic pain, which the pain cannot be explained with somatic and physiopathologic disorders; maintaining the patient role might be observed due to frequent treatment applications, overresponsibility adscription towards the physicians, impairments and avoidings in social and vocational functionality due to health concerns, oversensitiveness against being abandoned, fear of losing the secondary gains that provided by the patient role.

Pain behaviour as refuting in illness is a process that develops with the responses (consolidation) of social environment (physicians, family, society) to the pain and the perception of pain of the patient. The significance of psychosocial factors in patients with chronic pain has been remarked^{5,6} (Fields et al.,1994; Livingston, 1998).

George Engel identified the risk factors of chronic pain as existence of defeat, guilt, aggressive impulses and fear of loss⁷ (Engel, 1959).

The importance given to pain by patients, patients' way of explicating the pain and their behaviour against the pain is closely related to their former experiences and personalities. Depression incidence is significantly higher in patients with chronic pain compared to normal population. In the study of Sağduyu et al. (1999), 54.8% of the patients stated that they feel depressed, 58.1% of them stated that they feel anxious. The main signs of chronic pain syndrome are; pain, anxiety, depression and insomnia. Neurovegetative signs of depression are also observed in these patients. Besides, (functional) pain complaint is rather frequent in depressive patients. Some clinicians tend to evaluate chronic pain as an equivalent of depression (masked depression)² (Evlice & Uğuz, 1999).

Features like dramatic demonstration of complaints, occurrence of pain being related to life events, exposure of multiple systems, history of chronic illnesses or violence in family, using of denegation, consolidation of pain behaviour by social environment are considered as leads towards signs being psychogenic² (Evlice & Uğuz, 1999).

In psychiatric diseases, diversity of particularly somatic symptoms due to culture is remarkable. Traditions, belief systems and expectations substantially effect the occurrence, demonstration and handling of dissociative and somatoform symptoms. Most patients develop medical symptoms that clinicians can understand because these symptoms are less stigmatizing than psychological symptoms⁸ (Escobar, 2004). Patients with painful symptoms apply to psychiatrists after frequently going through general medical examinations and using several medications. As Kleinman indicated, not only culture forms the disease, it also determines the way individuals perceive the disease. Transformation of personal or social stress to somatic complaints is accepted as "norm" in most cultures. Symptom type of somatic patients vary according to culture. For example, while heat, hot flash, tingling, burning in hands and feet, insensibility, burning sensation in head symptoms are frequent in Nigeria and India, these symptoms are rare in western countries⁸ (Escobar, 2004). Cross-cultural studies with depressive patients show that depressive patients in Asia and Latin America have more somatic complaints compared to United States of America (USA)^{10,11} (Escobar et al., 1983; Kleinman, 1982). Epidemiological field surveys have shown that the most frequent medically unexplained symptoms in USA are gynaecological symptoms, followed by gastrointestinal and cardiovascular symptoms. Several studies in USA have reported that somatisation is very frequent in Latin race, particularly in Puerto Rican patients^{12,13,14} (Canino et al., 1992; Escobar, 1995; Escobar et al., 1992). In a 15 centered study of Gureje that consists of 14 countries including Turkey, prevalence of somatoform disorders was determined high in two centers in South America (Rio de Janeiro and Santiago). In the same study, incidence of chronic pain was the highest in Ankara (79.1%) and Verona (72.2%) and the lowest in Athens (16.7%) and Shanghai (22.2%). Another remarkable result is that

somatisation symptoms are related to female gender but independent from poor education level¹⁵ (Gureje, 2004). In a study of Faroog et al that consist of 195 patients between the ages of 16-65 in 1994, it was reported that somatic and depressive symptoms were significantly more frequent in Asians compared to white race. Turkey is also a country that maintains cultural specialties. Somatic complaints that vary according to geographical regions are mentioned. Hafirgan, which is reported particularly around Şanlıurfa is one of them. This issue is described as palpitation in stomach and distress, it is frequently reported among local people and considered as a syndrome specific to culture¹⁶ (Hafirgan, 2003). High frequency of similar complaints show that demonstration of distress with body is also very common in our country. Thus, Turkey Mental Health Profile study suggested that psychogenic pain is the most common psychiatric diagnosis³ (Kılıç, 1988).

According to researches, incidence of somatic complaints was found higher in South America and Asia, particularly in developing countries. Physical and emotional experiences are differentiated more rigorously in western culture. Therefore, somatic complaints might be less frequent in western societies.

Patients that have a difficulty demonstrating their memories of sexuality, aggregation and childhood verbally in the society they live in might use their body as a communication way. Consequently, bodily symptoms show repressed emotions and conflicts that patients avoid to verbalise. Patients that have painful symptoms without physical reasons might be demonstrating their inner conflicts via their bodies symbolically.

References

- A Sağduyu, M Rezaki, BG Rezaki, İ Kaplan, G Özgen. Somatoform Ağrı Bozukluğu: Tanımlayıcı Özellikler Ve Diğer Ruhsal Bozukluklarla İlişkileri. *Türk Psikiyatri Dergisi* 1999;10(1):21-33.
- American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (DSM-IV). Washington, DC, American Psychiatric Press, 1994.
- American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-V). Washington, DC, American Psychiatric Press, 2013.
- Canino IA, Rubio-Stipec M, Canino G, Escobar JI. Functional somatic symptoms: a cross-ethnic comparison. *Am J Orthopsychiatry*, 1992; 62(4):605-612.
- Engel, G. "Psychogenic" pain and the pain-prone patient. *American Journal of Medicine*, 1959, 26, 899 -918.
- Escobar JI, Canino G, Rubio-Stipec M, Bravo M. Somatic symptoms after a natural disaster: a prospective study. *Am J Psychiatry*, 1992; 149(7):965-967.
- Escobar JI, Gomez J, Tuason VB. Depressive phenomenology in North and South American patients. *Am J Psychiatry*, 1983; 140(1):47-51.
- Escobar JI. Transcultural aspects of dissociative and somatoform disorders. *Psychiatr Clin North Am*, 1995; 18(3):555-569.
- Escobar JI. Transcultural aspects of dissociative and somatoform disorders. *Psychiatric times* 2004; vol 21.5-9
- Fields, H. L. & Price, D. D. Pain: perceptual properties and neural mechanisms. In *A Companion to the Philosophy of Mind* (ed. S. Guttenplan), pp. 452 -459. Oxford: Blackwell, 1994.

Gureje O. What can we learn from a cross-national study of somatic distress? J Psychosom Res. 2004; 56(4):409-12

Kılıç C. Türkiye Ruh Sağlığı Profili: Erişkin nüfusta ruhsal hastalıkların yaygınlığı, ilişkili faktörler, yeti yitimi ve ruh sağlığı hizmeti kullanım sonuçları."Türkiye Ruh sağlığı Profili Raporu". (Haz: Erol N, Kılıç C, Ulusoy M ve ark.). 1. Baskı. Ankara, 1988.

Kleinman A. Anthropology and psychiatry. The role of culture in cross-culturel research on illness. Br J Psychiatry, 1987; 151:447-454

Kleinman A. Neurasthenia and depression: a study of somatization and culture in China. Cult Med Psychiatry, 1982; 6(2):117-190.

William K. Livingston. Pain and Suffering. Edited by Howard L. Fields. International Association for the Study of Pain. Seattle: IASP Press, 1998. xvii , 250 pp.

Yanik M. Hafırgan kültüre özgü bir sendrom mu yoksa anksiyetenin kültüre özgü bedensel bir ifadesi mi. Klinik Psikofarmakoloji Bülteni 2003;13:191-196

Yunus Emre Evlice, Uz. Dr. Şükrü Uğuz. Psikiyatrik açıdan ağrı. Galenos 1999; Ağustos; 33