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Original Paper

Observations and reflections on clinical and socio-psychological aspects of psychosomatic disorders in Russia and Kazakhstan

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Abstract. *The article gives an analysis of the role of various pathogenetic (ethnic, personality, personality-biological, social-economic, organizational) factors of somatic pathology associativity in formation of clinical dynamics of psychosomatic diseases in patients of the Kazakh and Russian nationality in primary care. Comparative data are given about indicators (prevalence, medical aid appealability, staffing with mental health professionals, motivational traits of patients of the Kazakh and Russian nationality) reflecting efficiency of the existing models of mental health services in Kazakhstan and Russia.*

The reliable importance of hysterical, asthenic, sensitive personality traits in formation of psychosomatic disorders in persons of both nationalities with prevalence of cenesthopathic disorders in Russians and anxiety disorders in Kazakhs is ascertained. Influence of ethnocultural factors on clinical dynamics, efficiency of therapy, and outcome of psychosomatic disorders is emphasized. The used rehabilitation programs and algorithm of medical care for patients of general somatic network are in detail described. Use of this algorithm allows reducing unreasonable medical aid appealability of patients with mental disorders to doctors-somatologists by 3.5 times, improving the quality of social functioning, reducing terms of the rehabilitation period.

Need of use of ethnocultural features in the complex of medical activities as a possible aspect of efficiency of therapy is emphasized. The main perspective strategies of efficiency of medical care to patients with psychosomatic disorders are formulated.

Keywords: Psychosomatic disorders**,** Kazakh, Russian, primary care, mental health services.

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INTRODUCTION

It is well known that the prevalence of psychosomatic disorders is different among different cultural groups. To some extent, it can be said that the clinical manifestations of psychosomatic disorders may have some distinctive characteristics related to the region of the world or ethnic groups where they occur. There may be, as well, considerable similarities but, at the same time, striking differences between the clinical characteristics of a disease in diverse settings or countries. In the case of Russia and Kazakhstan, these differences may reflect unequal organizational aspects of mental health services in both countries. Even though, in recent decades, the sick rate of mental disorders such as depression, adjustment and psychosomatic disorders has tended to increase (Russia: 2005 - 486, 2014 - 762; Kazakhstan: 2005 – 145, 2014 - 161.7), serious chronic conditions such as schizophrenia, psychopathy and organic mental disorders do not seem to have changed during the same periods. The lower incidence figures in

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Kazakhstan may be explained by reluctance to care-seeking by patients with non-psychotic disorders due to peculiarities in the perception of mental disorders.
The study of psychosomatic disorders from a clinical and cultural perspective has reflected the researchers' focus on the following aspects:

1. *Diagnostic:* related to the development and description of precise criteria for the characterization of and differentiation between psychosomatic symptomatology and ethnocultural stereotypes of behavior.
2. *Ethnopathogenetic:* the identification and description of basic psychological traits playing a main role in the development of psychosomatic disorders; these are personality traits, thinking styles, or cultural stereotypes of behavior expressed in traditions, beliefs, customs, rituals, ceremonies, etc.
3. *Clinical:* severity, duration of the clinical manifestations, comorbidity with other diseases, appearance of atypical variations.
4. *Therapeutic:* based on implementation of a biopsychosocial approach to medical care (interdepartmental interaction, integration, ethnic, personality and socio-biological factors).

PSYCHOSOMATIC DISORDERS IN RUSSIA AND KAZAKHSTAN

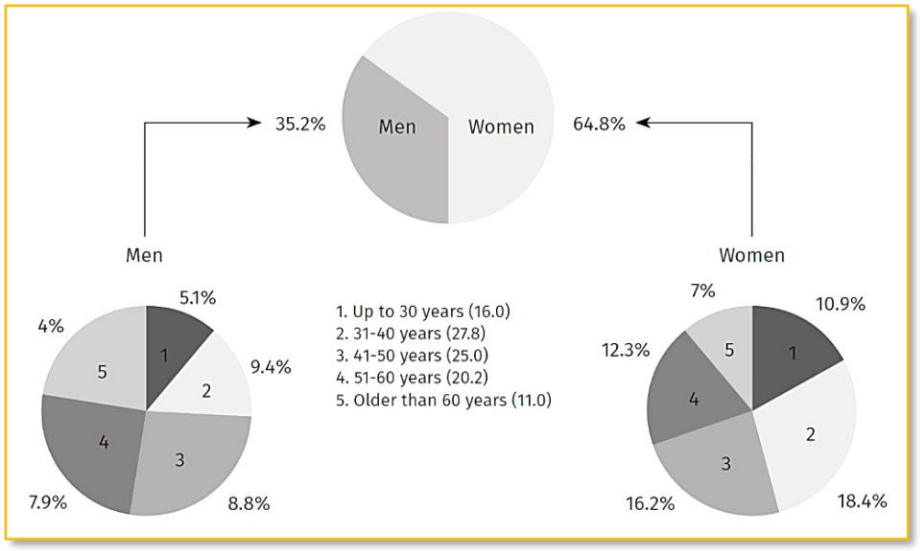
The main purpose of this collaborative, joint review/investigation effort was to conduct a complex clinical and socio-psychological study of psychosomatic disorders in patients of a general medical network in border locations of Russia and Kazakhstan, including observations about the development of therapeutic programs and an assessment of their efficiency.

The study consisted fundamentally of the review of records of 3610 patients (2010 Russians and 1600 Kazakhs; 2285 women, 1325 men) with mental disorders located in the medical (somatic) network. Comorbidity of mental disorders and somatic pathology was found in 72% of cases, out of which 45.6% (n=1186) were patients with neurotic disorders.
As a high specific weight of comorbid somatic pathology determines in a good number of cases the clinical features of psychopathological disorders, the overall sample was distributed into three groups:

1. patients with acute somatically conditioned psychotic disorders (risk group). 22.9% of all the examined patients (n= 3610) constituted the group and were referred to the psychiatrist with significantly acute psychosensorial and affective manifestations, bizarre behaviors and transient pseudo-perceptual manifestations. Neoplastic brain and thyroid gland lesions, infectious diseases such as tick-borne encephalitis, post-influenza arachnoiditis, meningitis, and subacute cerebro-vascular disturbances were considered etiologic factors.
2. patients referred in need of psychiatric observation. It must be pointed out that this contingent had not shown acute manifestations of mental disorders in the outpatient dispensary services before being referred to the general medical setting. Clearly, a diagnosis of mental disorders in their initial stage allows a timely therapeutic intervention still in the primary medical setting.
3. patients needing systematic therapy and obligatory observation by the psychiatrist. Unlike the second group, this included mental disorders with a progressive course and a tendency to chronicity. These patients required an active observation and systematic treatment.

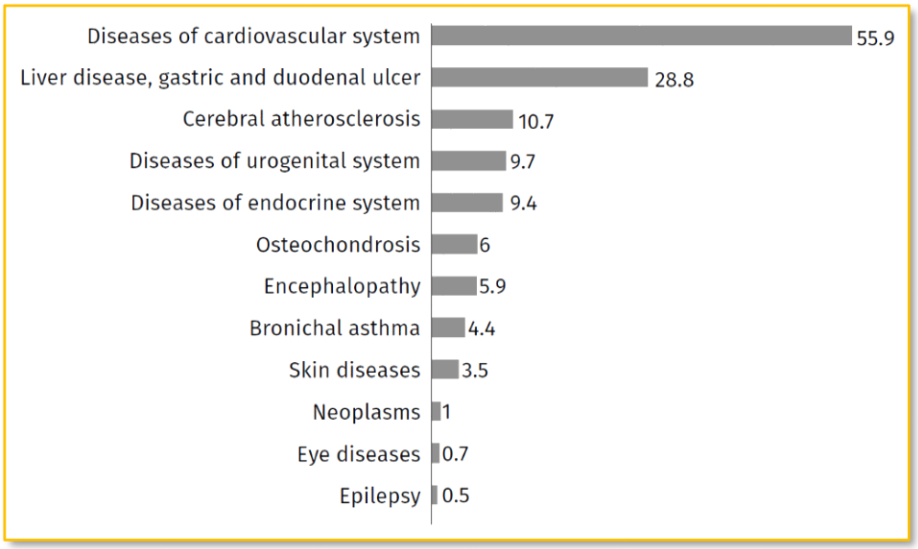
Women and patients in the 31-50 years age group, constituted a majority group in the total sample; this could be considered a pattern as these demographic characteristics in both Russians and Kazakhs, seem to determine greater susceptibility to the impact of adverse economic and family/household factors (Fig. 1).

Figure 1 Age-sex characteristics of patients with combined neurotic and somatic diseases detected under conditions of the catchment area polyclinic (n=1186)



In persons of Kazakh nationality, more severe neurotic disorders predominated 62.1% (group III), milder, 20.4% (group II) and psychotic somatogenic disorders, 18.5% (group I) in that order. In Russian patients, the ratios of mild (group II) and more severe disorders (group III) were equivalent. These differences may be due to an ambiguous perception of emotional experiences related to a psychotraumatic situation, traditional and cultural traits, different demographic indices and socio-economic features. The comorbid somatic pathology reflected the obviously greater prevalence of somatic conditions in the referring out-patient network. Cardiovascular diseases were a reliably more often ($p<0.05$) comorbid somatic pathology, diagnosed in 55.9% of the cases with mental disorders; it can be asserted then that patients with cardiovascular diseases were a relatively high risk group for the development of mental disorders among all of those with a psychosomatic diagnosis.

Figure 2. Structure of somatic pathology in patients with mental disorders needing psychiatric help (%)



The neurotic, stress-related and somatoform disorders (diagnosed according to ICD-10) in patients of the out-patient medical network were:

1. F40 Phobic anxiety disorders, 16%
2. F41 Panic disorders, 16%
3. F43 Reaction to severe stress and Adjustment disorders, 15%
4. F44 Dissociative disorders, 12%w
5. F45 Somatization disorders, 26% (177 persons)
6. F48 Neurasthenia, 20%

The predominance of somatization disorders seemed to be determined by the concomitant occurrence of cardiovascular diseases, skin diseases and bronchial asthma among patients of the two nationalities. Therefore, it can be said that these medical conditions constitute risk factors for the co-occurrence of neurotic disorders.

OBSERVATIONS AND DISCUSSION

One initial point resulting from the above observations is that the referral of patients with psychosomatic disorders to the psychiatrist is preceded by long periods of treatment by general practitioners with the subsequent delay in the start of specialized management, longer periods of treatment and the possibility of a less favourable clinical course (Lebedeva, 1990). General practitioners tend to consider psychosomatic disorders as clinical/ functional deviations that do not meet the classical criteria of medical diseases, hardly respond to treatment, and tend to chronicity. Later on, already with a "neurotic" type of personality temperament, some of these patients still prefer to attend medical settings and, thus, any deterioration of the psychosomatic condition is treated as a manifestation of somatic pathology.

Furthermore, there may be a hypochondriacal trend in the structure of most neurotic disorders, manifested as anxious, dysthymic or obsessive syndromes. In patients of the ethnic groups hereby studied, incomplete secondary education was reliably recorded more often as were hysterical and phobic neurotic syndromes in the debut stage of the medical picture. Similarly, hysterical, asthenic and sensitive, personality traits, in many cases reaching the level of clear personality disorders, predominated during the pre-illness stage. Personality-based types of response in such patients led to lengthening of their stay in medical hospital units, creating a group of "difficult patients" experiencing subjective emotional discomfort irrespective from their real mental and somatic state. All patients had a general somatic syndrome of different degree of severity combined with asthenic, affective, i.e., neurotic rank of mental disorders. Russians had reliably more often neurotic types of disorders, manifested more frequently by phobic, cenesthopathic syndromes, and Kazakhs showed more affective manifestations --anxious depression, reaching frequently levels of agitation.

For male patients, the mean age of referral to the internist was 47±13.4 years, and for women, 45±13.09 years. The mean age when a prolonged mental disorder was already developed was 46±13.7 years for men, and 43±13.4 years for women. Men sought the help of internists an average of 5 years after developing the somatic pathology, women a little later (7 years). Patients of Russian nationality 4.0±2.4 , and those of the Kazakh nationality, 6.5-2.5 years thereafter. In the analysis of self-reported assessment of their disease, women of both nationalities appeared to be more willing to undergo an assessment of their emotional status as they sought or visited the psychotherapist on their own more readily. In fact, 21.68 % identified themselves manifestations of mental disorders, whereas only 12.33% of men considered themselves mentally unhealthy and, as a result, were referred more frequently by doctors-somatologists or relatives. In turn, 34.5 % of men, and

27.5 % of women in the medical/somatic setting were convinced that they only had a physical disease as the cause of their distress, despite a psychogenic predisposition to "somatize" or experience physically painful manifestations ($\chi 2=443.00$, $p=0.000$). . The mean duration of somatoform disorders was 1.5 - 2.0 years in persons of Russian nationality, 2.5 - 3 years in Kazakhs. On the other hand, significant improvement or even psychological recovery after the addition of psychopharmacotherapy occurred in persons of Kazakh nationality in a shorter period and was conditioned by the active participation of family

members. The difference of the above indices is conditioned by organizational features of mental health services to persons with neurotic disorders in Russia and Kazakhstan.

Table 1 Basic indices characterizing specifics of mental health care in Russia and Kazakhstan

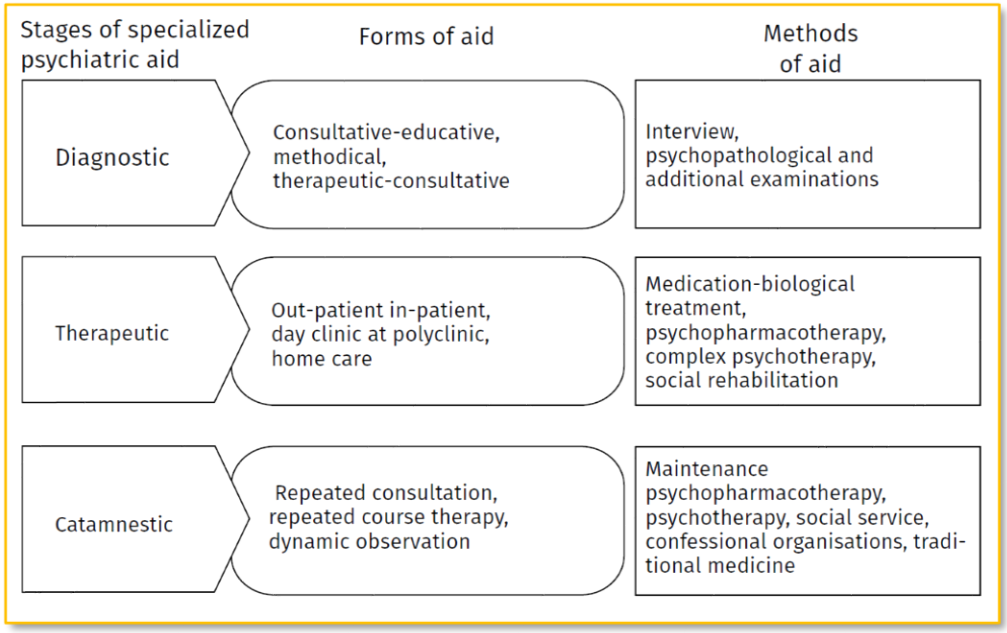
INDICATOR	RUSSIA	KAZAKHSTAN
Prevalence of neurotic disorders per 100,000 of the population	2.14	0.8
Number of psychiatrists per 100,000 of the population	9.9	5.1
Search for help per the entire population (in %)	2.8	1.15
Search for help in primary care with mental disorders (in %) – of them with neurotic disorders (in %)	56.6 79.9	42.0 35.7
Search for help in the first year of the disease by patients with neurotic disorders (in %)	34.3	17.3
Referral by physicians of patients of somatic polyclinics with neurotic disorders in the first year of the disease (in %)	53.0	39.0
Basic causes of visit of patients to primary care network	Somatization of mental disorders	Necessity of official procedure of disability, psychotic disorders

Patients of Kazakh nationality with neurotic disorders seek the out-patient medical network significantly less often than their Russian counterparts, and instead are referred to the psychiatrist later. Prevalence of neurotic disorders in Kazakhstan is nearly 3-fold lower than in Russia, and provision with mental health professionals is 2-fold lower. The greatest differences in the comparison of these ethnic groups were observed in connection with the nature of relationships with family members and close-relatives.

Traditionally, in the Kazakh ethnic group, the presence of harmonious relations, stable relationships with relatives, and a positive psychological perception of the family community was noted. In this ethnic group the relatives strive to render a maximum help to patient, not leaving him/her to face the problem alone; this leads to a decreased intensity of the psychotraumatic situation or to its resolution. Preservation of close relations with relatives promoted also more efficient rehabilitation efforts, creating conditions for a rather fast recovery of working capacity and social rehabilitation. Ultimately, these complex sets of biological and social-demographic factors can have a positive impact on the inner dynamics of psychosomatic disorders, and may be used for the development and/or improvement of preventive, therapeutic and rehabilitative programs (Lebedeva, 2013). According to the results of our investigations, the main stages of assistance to patients with psychosomatic disorders in out-patient settings include diagnostic, therapeutic and follow-up phases. Each one of them has certain forms and methods (Fig. 3).

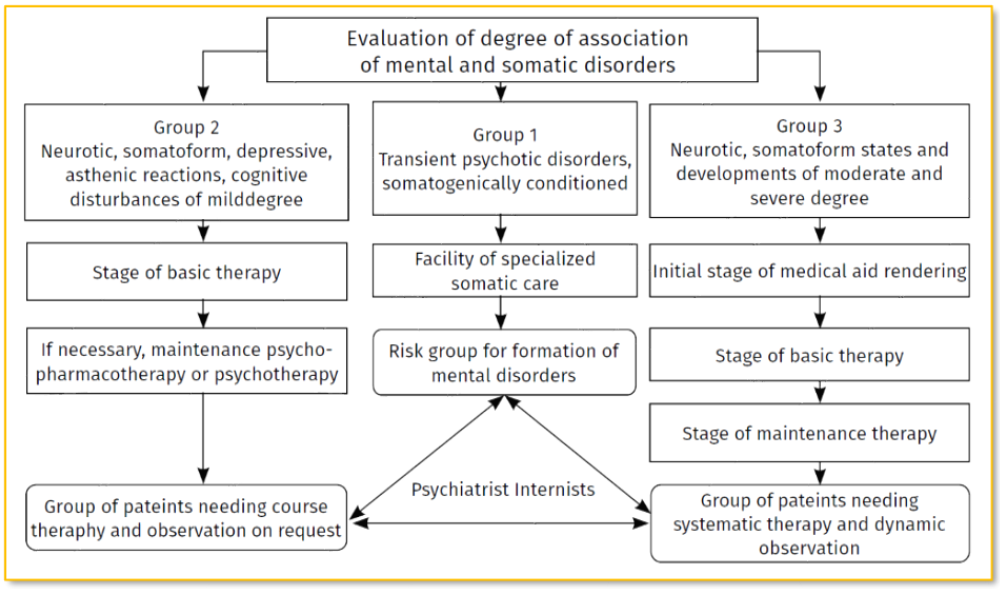
An integrative approach in the provision of medical care to psychosomatic disorder patients allows it to be done directly in primary out-patient units at the earliest stages of the disease, making it less costly and less demanding (Lebedeva, 2007). A biopsychosocial approach to the treatment of psychosomatic disorders is fundamental and makes for a successful outcome. In our opinion only the psychiatrist can conduct these therapeutic processes, correct and estimate their efficiency.
The highest indices of efficiency of integrative care were noted in patients with psychosomatic disorders: the number of referrals to doctors-somatologists (internists) was reduced 3.5 times when the psychiatrist or psychotherapist joined the management process. When the needs of patients with mental disorders in the general medical network were assessed, it was found that 47.3% of them required transfer mental health facility for the provision of an adequate specialized psychological-psychotherapeutic assistance. For more than 50%, such assistance can be provided in a primary outpatient unit with involvement of internists in well differentiated rehabilitative programs.

Figure 3 Forms and methods of specialized psychiatric aid to patients with psychosomatic disorders at the out-patient stage



Groups of psychiatric observation allow the provision of such differentiated programs of psychoprophylactic and rehabilitative nature making it possible the application and use of forms and methods of specialized mental health services. In turn, this integrated approach defines the place and role of the psychiatrist, the internist, social worker and other professionals in the implementation of an efficient and effective therapeutic program.

Figure 4 Algorithm of medical aid rendering to patients with psychosomatic disorders



CONCLUSION

Ethnocultural factors have a significant impact on the prevalence of neurotic disorders, on their clinical course and, to a certain degree, on their outcome. Specifics of traditional cultural-psychological interrelations may have positive psychotherapeutic and rehabilitative effects. Preservation of a positive, close relationship with family members, a psychological disposition and orientation of the family to helping the patient contribute decisively to the establishment of a psychotherapeutic environment under which an effective control of emotional symptoms may occur, and thus, the terms of the improvement and rehabilitation periods may be reduced. The strategies, determining efficiency of medical care for patients with psychosomatic disorders were found, in general, equally relevant for both Russian and Kazakh patients. According to our findings of this inquiry, and in agreement with studies in other regions and countries, the following points are of fundamental importance:

1. The use of the biopsychosocial approach in the provision of mental health services allows the achievement of efficient social, physical and psychological functioning.
2. Development of extramural (outpatient and community-oriented) forms of mental health services, available to the whole population, with a precise algorithm of methods to be used and legislative support.
3. Development of socially oriented psychiatric services, with emphasis on psychological and social aspect of recovery.
4. Interaction of psychiatric services with primary medical care links, together with possibility of access to the necessary amount of specialized help for patients with early-stage mental disorders and provision of information about prevalence of, planning for and specification of financial costs for organization of innovative types of mental health services.
5. Development of psychoeducational programs for the population, directed at the formation of a psychological culture that will lead to the lowering and eventual disappearance of stigmatization of mental disorders.
6. Development of precise diagnostic criteria for psychosomatic disorders, taking into account, among other factors, ethnocultural characteristics directed at an homogeneous and correct understanding of the borders between mental health and mental illness.
7. Provision of telepsychiatry services for remote areas, as a possible access to innovative forms of specialized help for populations with insufficiently developed social infrastructure.
8. Involvement of social agencies and religious organizations, among others, in the organization of specialized mental health assistance.
9. Basic principles of rendering of medical assistance have been structured: complexity, sufficiency, individual-differentiated approach, continuity, cooperativeness.
10. Use of national culture as a rehabilitative method in psychological recovery.

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