Somatic symptoms and depression: diagnostic confusion and clinical neglect

RECOGNISING THE PROBLEM

Primary care is an ideal environment in which health professionals can recognise the complex inter-relationship between physical and psychological symptoms. Patients commonly present with a variety of partially understood or poorly differentiated physical, psychological and social problems. A central role for GPs is to offer a degree of clarity about the nature and cause of such problems, and provide guidance on their management.

Experiences of physical symptoms and depression raise complex issues about the distinctions between mind and body. While depression is commonly viewed as a disturbance of emotion, its behavioural aspects, such as social withdrawal or changes in eating behaviours, are equally important.

However, these complexities are not always satisfactorily reflected in our clinical practice. Our diagnostic and conceptual frameworks, deriving both from our medical training and from classification systems such as ICD-10 and DSM-IV, are based on relatively narrow, dualistic perspectives. They encourage us to see problems as primarily either physical or psychological and to introduce comorbidity as a means of recognising some degrees of complexity — with the diagnosis of 'medically unexplained' symptoms serving as a back-stop to deal with those patients who do not present their symptoms in ways that we can readily formulate.

Two areas of diagnostic and therapeutic concern are the confusion between depressive and somatic symptoms, in chronic disease, and in particular the neglected relationship between pain and depression.

In chronic obstructive pulmonary disease (COPD) for example, somatic symptoms such as fatigue, anorexia and weight loss may be simultaneously attributable to both the medical condition of COPD and to the psychiatric diagnosis of depression.[1] This raises substantial risks of diagnostic confusion. In a Dutch study of COPD and depression in primary care,[1] researchers found that the severity of depressive complaints apparently increased with the severity of the pulmonary disease. At first glance this finding has important clinical implications, arguing for more energetic treatment of depression. However, the association was explained mainly by increases in somatic symptoms of depression, while changes in cognitive and affective symptoms were less clearly associated with changes in COPD severity. So, it is not clear whether patients with severe COPD really are more depressed than those with milder versions, or whether clinicians are being poorly served by medical and psychiatric classifications that cannot adequately account for each other.

When considering the problem of pain and depression, the most important issue is clinical neglect. Pain is a common symptom in primary care, which is likely to affect a patient's mood, behaviour and sleep patterns. Chronic pain is increasingly recognised as a circumscribed problem in its own right, and the goal of therapy is often to treat the pain and improve functioning — yet it may be a symptom of another condition. Family doctors are thus faced with a dilemma between concentrating on relieving pain, or on seeking its cause.

A review of published literature on pain and depression[2] has drawn the following conclusions:

- interpretation of research into pain and depression is hampered by a lack of clear terminology;
- between two-fifths and two-thirds of depressed patients have painful symptoms, a rate four times higher than for non-depressed individuals;
- depression and pain may share common pathogenic pathways, possibly involving serotonin; they are associated with the same range of predisposing environmental factors and early childhood experiences, and may be perpetuated by similar cognitive behaviours;
- patients with depression and painful symptoms make greater overall use of health care — but lesser use of mental health services — than those with depression alone;
- doctors may contribute to increased resource use by pursuing unnecessary investigations into the cause of pain;
- the presence of pain may be associated with a poor response to treatment for depression; and
- tricyclic antidepressants such as amitryptiline are effective in reducing pain symptoms in depression, probably more so than serotonin selective reuptake inhibitors. Serotonin/noradrenaline reuptake inhibitors, such as venlafaxine and duloxetine, may also be effective in reducing pain symptoms in patients with depression.

TERMINOLOGY AND CLASSIFICATION

Physical symptoms in patients with depressive disorders are frequently regarded as 'medically unexplained'. A joint report from the Royal Colleges of Physicians and Psychiatrists[3] notes that the management of patients with such symptoms is largely inadequate. The report also states that it is unhelpful to think of these symptoms in either purely physical or psychiatric terms. The traditional classification of diagnoses into organic or psychological, and the use of terms such as 'functional', 'unexplained' and 'psychosomatic' to describe physical symptoms is of limited utility. For many people experiencing such symptoms, these terms generate frustration and distress, and offer little by way of treatment approaches, whether evidence-based or otherwise.[4]

Although ICD-10 and DSM-IV definitions of depression both mention pain, both describe it as a secondary or uncommon symptom. This emphasis on affective

symptoms may contribute to under-recognition of pain and other physical symptoms in patients presenting with depression. The next revisions of the ICD and DSM classificatory systems should be constructed to do justice to the extensive overlap between depressive and painful symptoms, and between symptoms which can be attributable either to depression or to chronic physical diseases.

CLINICAL ASSESSMENT

Since a large proportion of depressed patients suffer from some sort of physical symptoms, and in the light of the extensive evidence that such symptoms have an adverse effect on clinical outcome, family doctors should enquire about, and pay attention to, pain and other physical symptoms in patients diagnosed with depression. We should also take account of change in such symptoms in assessing patients' progress. The issue is as much the impact of the physical symptom on a patient's life as a description of its characteristics.

Patients who present with depression and multiple physical symptoms are likely to be perceived by doctors as 'difficult'. The feeling is often mutual. Such patients report less satisfaction with medical care than patients without mental disorders and those who present with a single symptom.[5] This may be, in part, because it is more difficult to arrive at a shared description of the problem when several somatic symptoms are presented.

As clinicians, we need to balance the need to exclude common causes, or those with a serious prognosis, with the danger of subjecting patients to unnecessary and costly tests. However, in the absence of explicable symptoms, or when tests prove negative, we should be careful about the common strategy of 'normalising', that is, implying that symptoms are within a common acceptable range of experience, do not indicate a serious disease, or are likely to be self-limiting. Such normalisation is a common response to unexplained symptoms in clinical practice. Sometimes, when linked with a plausible explanation and located within the patients' own conceptual framework it can be helpful. If not carefully framed, however, normalisation by the doctor may cause patients to intensify their presentation, and lead to an escalation of unnecessary interventions.[7]

PRINCIPLES OF MANAGEMENT

Although family doctors may consider themselves to lack the specialist knowledge to treat patients with depression and physical symptoms, they are in fact ideally placed to do so, given their skill and experience in making sense of the undifferentiated, complex range of biological, psychological and social problems that patients present. Patients with complicated problems often struggle to convey the reality of their symptoms.[7] Taking patients' physical symptoms seriously, therefore, may be therapeutic in its own right.

Key skills that can be acquired by family doctors, and utilised to proven therapeutic effect,[8] can be grouped under four main headings:

- *helping the patient to feel understood*: listening, taking physical complaints seriously, picking up cues of emotional distress, and exploring illness concerns;
- *broadening the agenda*: opening up the consultation to a discussion of physical and psychosocial issues in a manner that respects patients' views and encourages real negotiation;
- *making links*: providing explanatory models for how physical and psychosocial problems may be linked; and
- *negotiating treatment*: exploring concerns about treatment including side effects that are likely to be experienced.

These skills are — or should be — inherent in standard good general practice.

CONCLUSIONS

Physical symptoms in patients with depressive disorders have received inadequate attention in terms of recognition and treatment. When considering research and management strategies, it will be important to take patients' concerns into account, and consider outcomes that they value as important. Although many family doctors feel poorly equipped to manage patients with complex presentations, such as depression and pain, this combination of problems is well suited to problem-based learning. Family practice is an ideal setting for such educational activity, as long as the teaching practitioners are interested and well-informed.

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