

Somatization in Depression and Anxiety Disorders

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ÖZET

Depresyon ve anksiyete bozukluklarında somatizasyon

Genel olarak emosyonel disforiyi bedensel belirtilerle ifade etme eğilimi olarak tanımlanan somatizasyonda, "bedensel bir hastalıkla açıklanamayan fiziksel yakınmalar" mevcuttur ve kişi bu yakınmalarını bedensel bir hastalığa atfederek tıbbi yardım arayışına girer. Somatizasyon (bedenselleştirme) davranışı çeşitli psikiyatrik bozukluklarla ilişkilendirilmektedir, en sık olarak depresyon ve anksiyete bozukluklarına eşlik ettiği bilinmektedir. Anksiyete bozuklukları ve majör depresyon vakalarında, somatik belirtilerin somatize edilmiş disforiyi yansıttığı düşünülmektedir.

Psikiyatri ve genel tıp sınırında hala çözülmemiş bir sorunun temsilcisi olan somatizasyon, hastaların yaşadıkları sıkıntı ve huzursuzluğu arttırmakta, hastalıkların gidişatını kötüleştirmekte ve yeti yitimini arttırmaktadır. Diğer yandan somatizasyon, depresyon ve anksiyete belirtilerini maskeleyerek doğru tanı koymayı güçleştirebilmekte ve tedavinin gecikmesine neden olabilmektedir.

Bu sistematik olmayan gözden geçirme yazısında, somatizasyonun depresyon ve anksiyete bozukluklarının klinik görünümünü, tanı ve tedavi sürecini, prognozunu nasıl etkileyebileceği derlenen bilgiler ışığında değerlendirilmektedir.

Anahtar kelimeler: Somatizasyon, depresyon, anksiyete bozuklukları, disfori, bedensel

ABSTRACT

Somatization in depression and anxiety disorders

Somatization may be described as the tendency to express psychological dysphoria through bodily symptoms. Patients complain of physical signs which they attribute to a medical disease and seek medical help for, but the symptoms do not fulfill diagnostic criteria of an organic disorder. Although somatization is known to be associated with many psychiatric disorders, it mostly accompanies depression and anxiety disorders. Somatic symptoms are thought to be a manifestation of somatized dysphoria in depression and/or anxiety.

Somatization, still accepted to be an unsolved problem in the borderland of medicine and psychiatry, leads to an increase in psychological distress and disability of patients and worsens the prognosis of psychiatric disorders. On the other hand, somatization may mask real psychiatric symptomatology leading to a delay in true diagnosis and effective treatment.

This review aims to evaluate the effects of somatization on the clinical picture, diagnosis, treatment and prognosis of depression and anxiety disorders.

Key words: Somatization, depression, anxiety disorders, dysphoria, somatic

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INTRODUCTION

Somatization is generally defined as the tendency to express emotional dysphoria with physical signs (1,2). In somatization psychosocial or emotional problems are expressed with physical signs, such signs are attributed to a physical disease, and medical assistance is sought (3).

While no consensus has been reached on its definition and classification, the common expression used for somatization is "the presence of physical complaints that cannot be explained by a somatic disease" (3).

Somatization leads to individual suffering as well as the deterioration of family relationships and social and occupational functionality. Lipowski uses the term "somatizer" for people who express their emotional discomfort with somatic expressions (4). In "somatizers" who frequently present one or multiple somatic complaints, no pathological or pathophysiological mechanisms associated with somatic complaints can be generally determined despite detailed examinations and workups. Even if they are found, complaints and resulting loss of abilities tend to be exaggerated, compared to objective and physical findings

(5). According to the DSM-IV diagnostic system, individuals whose cases do not meet the “Somatoform Disorder” diagnostic criteria and yet experience intense discomfort due to somatic signs that they attribute to a physical disease, can frequently demand medical care with the hope of finding an explanation and a treatment for such signs; this can cause a material and moral burden in terms of healthcare services (6,7).

Lipowski defines somatization, which he sees as a major public health problem, as an “unsolved problem of medicine” (4,8).

“Somatization” is primarily the wide scoped clinical phenomenon of the somatic signs that are defined with mental processes instead of structural or somatic disorders. While somatization may also be a temporary complaint or primary symptom of many psychological diseases, it may also be a somatic stress expression influenced by culture and social life as a way of learned behavior, an exaggerated manner of discourse of an organic disorder or a representation of some personal characteristics (9-11).

Somatization behavior is associated with several psychiatric disorders. While the limits of these disorders, which are addressed individually, are transient and they can frequently have the comorbid diagnosis, it is not possible to make a clear distinction about the correlation with somatic symptoms. The most common associations of somatization among the psychiatric disorders include depression and anxiety (3,12).

Somatic signs are related to anxiety disorders and major depression. While somatized dysphoria is thought to reflect dysphoria in cases of anxiety disorder and major depression, the fact that the incidence of “somatoform disorder” and hypochondriac fears is higher in such cases cannot be overlooked (2,7). The data related to the relationship between depression and somatization suggest that somatic signs and mood signs increase linearly within a “severity spectrum” and more somatic signs may be associated with more severe mood disorders. In addition to more severe disease signs, the association of depression and somatization are considered to make the diagnosis and treatment more difficult (13).

The incidence of depression and anxiety disorder is higher in patients with “multiple somatic signs that

cannot be medically explained”. While somatization, depression and anxiety disorder are leading causes for initial physician visits, some patients exhibit somatic signs with a severity that meet the DSM-IV “Somatoform Disorder” diagnostic criteria and anxiety and/or depression may accompany to this disorder. As the number of somatic signs that cannot be medically explained increases, so, too, does the risk for anxiety and depression (14,15).

The objective of this non-systematic review is to evaluate the influence of somatization, which frequently accompanies to depression and anxiety and sometimes may mask these psychiatric diagnoses, on clinical manifestations, diagnoses, treatments and prognosis of these psychiatric cases.

Depression (Somatized depression)

It is common for major depression to be accompanied by somatic complaints instead of mood disorder signs (3,16).

In many studies, a history of recurrent major depressive disorder was present in two-thirds of cases with medically unexplainable (aversive) signs, like chronic fatigue, pelvic pains, chest pains, chronic back pain, tinnitus and irritable bowel syndrome (3,17,18). While in many of the cases these signs include medically unexplained symptoms that do not meet the DSM major depressive disorder diagnostic criteria during the period of evaluation, anxiety, depression and somatization related distress were determined in scaled questioning. Patients ‘psychological discomfort, with recurrent anxiety and affective disorders, continues between the episodes (18, 19). Akiskal suggested that depression occurring with somatic symptoms is the most common affective disorder type in the general population (20).

In an article written by Hagnell and Rorsman in 1978 regarding the association of depression with suicide and somatization, and based on the data obtained from 200 patients followed up in the Swedish Lundby study, they reported that somatic symptoms were present in 60% of the cases diagnosed as depression with psychotic features and in 20% of these, patients initiated their preliminary doctor’s visits because of

somatic complaints (21). Another study reported that 10% to 30% of the patients followed up by psychiatric clinics, with a diagnosis of depression on an outpatient or inpatient basis, reported somatic complaints during their initial visits (17). In a study conducted on 1,559 patients in 8 different health centers in Zaragoza, Spain, the prevalence of somatizers (those who somatize) was calculated at 9.4% (34.5% of all cases); 68.7% of these patients met anxiety and/or depression diagnostic criteria according to the DSM-IV. The majority of the patients were evaluated with intermediate depression on a severity scale; 66.6% of them showed chronicity and back pain was reported as the most common complaint in 71.4% of the patients (22).

Many studies, regardless of the methods, suggest that depressive patients presented more somatic symptoms compared to those who were not depressive, and that those who somatized were more depressive than those with diagnosed somatic diseases (5,16, 23). Diagnosing depression becomes more difficult because somatic symptoms can be very vague, and fewer than half of the patients who appeal to primary healthcare with somatic complaints (and those who really deserve a diagnosis of major depression) can receive accurate and appropriate psychiatric treatment (7). Researchers working contractually on the Lundby study found that the majority of the patients who attempted suicide due to endogenous depression, among 3,000 cases followed up for 25 years, appealed to healthcare services with somatic complaints masking the symptoms of depression (17,21).

Sometimes somatic complaints may be the leading symptoms of depression. Somatic aches and pains, intestinal irregularities and digestive problems are commonly encountered. Depressive patients presenting to primary healthcare frequently mention somatic complaints like headache, epigastric pain and chest pressure instead of sadness or depression (24,25).

This condition characterized as "Depressio sine depressione" or "Masked depression" (21), evaluated in the first group, is thought to be a special and original subtype of depression/ anxiety, according to the position suggesting that somatization and depression intersect each other in three ways (10,26).

The other two groups were summarized: 1)

depression and somatization correspond to each other and 2) somatization is one of the main symptoms of depression and should remain within the DSM-IV depression diagnostic criteria (17).

Deterioration in self-perception, low self-esteem, lack of self-confidence, and self-evaluation as deficient or damaged in depressive individuals lead to exaggerated perception of somatic senses and an expectation of suffering from disease and pain (17,27). Self-directed attention increases in the depressive person and his/her mental preoccupation concerning his/her self (body) leads him/her to interpret even unimportant, simple physiological changes as a symptom of a somatic disease in an exaggerated manner (10,28). It is suggested that there is a distinct relationship between depression and exaggeration of somatic senses (2,29).

According to Bibring, the ideal self that wishes to feed its narcissistic needs (i.e. to be good and loving, powerful and superior) becomes frustrated when these expectations are not realized, and depression is triggered. Frequently observed is that these individuals adopt a role of "ill" and complain of somatic diseases in order to fulfill their need for attention and love (25).

Negative and pessimistic cognitive schema in depression keeps the memories of previous diseases fresh, triggers the negative judgments of the individual with regard to their health status and prognosis and eventually leads to the attribution of the simplest somatic senses to an illness (somatization) exaggerated by increasing the awareness of unpleasant senses (26,28). Somatization is closely associated with how the individual interprets and attributes to the somatic senses (30,31).

While it was reported that the most common somatic symptoms of depression include pain, fatigue, tiredness, dazedness, shortness of breath, palpitation, gastrointestinal complaints, tingling in several regions of the body, and sexual dysfunction, it should be kept in mind that these are not specific only to depression or a psychiatric disorder (7,8,17,19). Equally, the relationship between "pain" and depression deserves further study. Headache presented in an average of 54% of depressive patients. Depression prevalence in "chronic idiopathic pain" was reported to be between 10% and 100% in several studies, but recent studies reported that a prevalence between 30%-60% was more accurate (17,26).

The pain and frequently accompanying hypochondriac attentiveness observed in many somatic depressive patients is thought to be associated with several characteristics of depression like masochistic tendencies, self-anger and aggressiveness (7,17,32).

What depression means is varies from culture to culture and the clinical manifestation reflects that variation accordingly. While people from underdeveloped societies reflect their discomforts through somatization, and gain the support and approval of their society, spiritualization (psychologization) is more widespread in developed western societies. However, the demand for diagnosis associated with somatic symptoms that are considered a more legitimate form of the disease tends to increase in western societies in order to avoid the stigmatization of a mental disease (5,9,33,34).

The word “depressive” does not exist in the languages of certain cultures. But the absence of the word does not mean the emotion also does not exist. (35-38). In cases where an individual cannot verbally express a mood, they will use non-verbal methods. For instance, what defines the limits of depressive disorders in Mexican and Iranian societies is hostile expression towards family members, instead of affections (37).

Most important evidence regarding the comorbidity of somatization and depression suggest that somatic symptoms can be associated with the mood symptoms linearly across a “severity spectrum” (13). In one of a limited number of forthcoming studies that investigate the correlation of depression and somatization, Zweigenbaum et al. demonstrates that the risk that adolescents (13 to 16 years of age) who exhibit multiple somatic symptoms will develop depression within the next four years was markedly increased (39).

According to Bridges and Goldberg, 50% to 80% of patients who are diagnosed with anxiety or depression initially present to the physician with somatic symptoms (38). Given the frequency of the comorbidity of depression and anxiety, somatized anxiety deserves attention as much as somatized depression.

Anxiety (Somatized anxiety)

Anxiety disorders are a major public health issue.

In a study conducted on a large population presenting to a family practice center, one in 80 applications was found to be associated with anxiety. However, it is believed that the rate is much higher (3). The word “anxiety” derives from the Latin “ango” and “anxio”, with “anxietas” denoting a continuous fear and of “angor” a condition similar to panic disorder. The description of angor is closely akin to “being somatic” and also constitutes the root of the word of “angina” (25).

Anxiety leads to negative cognitive evaluations of the individual regarding his/her health. It can incite a more dangerous, alarming and ominous interpretation of somatic symptoms. Anxious people catastrophize somatic senses and attribute the uncertain causes of vague and suspicious symptoms to severe physical conditions. Anxiety also leads to the exaggeration of previously existing symptoms or to the elevation of previously unrecognized sensations, as the individual’s self-focus and self-attention rises to a more extreme level of consciousness. In experimental studies anxiety was shown to lower the threshold of unpleasant sensations and symptoms like pain, and reduces the tolerance to these sensations (28). In parallel, patients with anxiety disorder also tend to exaggerate their somatic senses, similar to depressive patients, and this condition plays an important role in somatization (30).

Anxiety disorders are associated with hypochondriasis, depression and somatization. In fact, anxiety disorders are engaged with somatization (7), so much so that the DSM diagnostic criteria for panic disorder and diffuse anxiety disorder include multiple somatic symptoms. While muscle pain, fatigue, diarrhea, dazedness and abdominal swelling are observed in diffuse anxiety disorder, typical symptoms of panic disorder include shortness of breath, sensation of chest pressure and pain, sweating, drowning sensation and palpitation (25,40). A study of patients diagnosed with panic disorder revealed that only 11% of patients presented to the physician with psychosocial problems; the remaining patients reported somatic complaints like tachycardia, chest pain, irregular heart beat and epigastric discomfort and the most common complaint was pain, with a ratio of 81% (3).

That anxiety and depression have comorbid diagnosis leads to confusion in the evaluation of the

relationship between anxiety and somatization.

However, different studies have demonstrated that the correlation of somatic symptoms with anxiety is stronger than depression in neurotic patients (5). Mumford et al. calculated the frequency of patients who appealed to primary healthcare services with somatic symptoms and were diagnosed with major depression or anxiety disorder to be 70-80%, using Bradford Somatic Inventory (29,41,42).

In a study comparing Asian and Caucasian patients with somatization, it was found that somatic signs were associated with anxiety and depression scores and a stronger correlation, particularly with anxiety, was determined (29,43,44). Beliefs and fears related to becoming ill (due to somatic symptoms) in anxiety disorders, particularly in panic disorder, are quite common (5,25). This condition has led some researchers to evaluate hypochondriasis as a diagnostic characteristic of anxiety responsible for intense healthcare service demand (7). Hamilton stated that the majority of somatic signs in individuals with depressive disorders were associated with anxiety (45). Studies indicate that a depressive mood heightens sensitivity to the somatic discomfort resulting from the anxiety. Bridges et al., suggested that somatizers were more anxious and those who were psychologized were more depressive (38).

If somatic signs are manifestations of underlying anxiety, they lead to more anxiety and consequently an increase in the frequency and intensity of somatic symptoms by triggering selective perceptions activated with somatic interest and fear; causing a circular effect. (29). But somatic signs in anxiety disorders recede with early and efficient treatment; demand for general healthcare service decreases. But the tendency for somatization and demand for healthcare service in somatizing depression patients is of a chronic nature and more resistant to treatment (4,7,46). The course

in anxiety disorder cases who believe they are “cardiac patients” due to complaints of chest pressure and pain is closer to the course of somatic depressive patients.

Anxiety disorders are associated with many organic diseases and can also be a manifestation of organic diseases. Neurological diseases, thyroid diseases, cardiovascular diseases and drug intoxication, as well as alcohol or benzodiazepine abstinence, may also lead to anxiety (47).

CONCLUSION

Somatization schizophrenia, which represents an unsolved problem in the boundary between psychiatry and general medicine, is also associated with psychiatric conditions like alcohol and substance use. It frequently accompanies to anxiety disorders and depression, or emerges secondary to them. Somatization increases a patient’s discomfort and distress, deteriorates the course of disease and intensifies the loss of abilities.

Somatization may complicate diagnosis by masking symptoms of depression and anxiety (4,7).

These patients in particular, in appealing to primary healthcare services, have a tendency to reflect their somatic symptoms rather than their psychological distress. This condition may lead medical personnel to overlook the symptoms of anxiety and depression.

Although the somatizing depression or anxiety disorder patients cannot express their psychosocial distress spontaneously, when they are questioned properly, observers have noted that they have a tendency to share their emotional discomforts and related psychological stresses (40).

Psychiatric questioning and evaluation should absolutely be kept in mind for accurate diagnosis and treatment in time for the patients with somatic complaints or somatic signs that cannot be medically explained.

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