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Editorial

Somatic symptoms and general aches and pains in primary care: indicators for depression?

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Somatic symptoms are the leading reason why patients present to primary care. However, many common somatic complaints, such as lack of energy or general aches and pains, cannot be linked to an identifiable organic disease.[1,2] As such, general practitioners (GPs) frequently refer to these complaints as 'medically unexplained physical symptoms'.

Despite extensive investigations into the underlying pathologies of these unexplained somatic symptoms, specific diagnoses are seldom obtained. Indeed, in 1989, Kroenke and Mangelsdorff retrospectively reviewed the records of all visits made by 1000 patients at one primary care clinic in the USA over a three-year period, in order to assess the prevalence and causality of 14 somatic symptoms (including the eight most common specific complaints reported in primary care).[2] Nearly 40% of patients reported at least one somatic symptom; however, an organic diagnosis only explained the presence of 16% of the somatic symptoms.

As well as being the principal driver for help seeking in primary care, there is increasing awareness of the importance of somatic symptoms in depression. We now know that, alongside classical psychological symptoms (low mood, loss of interest, poor concentration and associated anxiety), depression presents with an array of somatic symptoms, including changes in appetite, lack of energy, sleep disturbance, and general aches and pains. Indeed, recently revised Diagnosis and Statistical Manual of Mental Disorders (DSM-IV-TR) criteria refer to 'excessive worry over physical health and complaints of pain (e.g. headaches or joint, abdominal or other pains' among the associated features of major depressive disorder.[3]

Thus, when faced with somatic symptoms in primary care, a psychological cause, such as depression, should be explored. Indeed, Kroenke and Mangelsdorff found that 10% of the somatic symptoms observed in their retrospective review of primary care records were attributed to a psychological cause.[2] Notably, the authors postulated that many more of the 74% of symptoms that had been classified as 'medically unexplained' probably also had an underlying psychological cause.

More recently, a large population survey conducted in 18 980 subjects in Italy, Germany, Portugal, Spain, and the UK specifically examined the prevalence of general aches and pains, organic disease, and depressive illness.[1] In total, 43.4% of patients with major depression (n = 748) reported experiencing headaches, gastrointestinal disturbances, joint/articular, limb, or back aches. An organic condition could only explain the presence of the general aches and pains in one-third of cases; thus, depression may be playing a role in the remainder.

Somatic symptoms are common in depression

Somatic symptoms are highly prevalent in depression. In the second Depression Research in European Society study (DEPRES II), lack of energy and disturbed sleep were among the three most common symptoms reported by patients with current depressive episodes.[4] Similarly, more than two-thirds (69%) of patients with depression in one recent US study complained of general aches and pains.[5]

In primary care, somatic symptoms often dominate the clinical presentation of depression.[6,7] Data from the World Health Organization (WHO) study on Psychological Problems in General Health Care showed that 69% of participants with major depression (n = 1148) had a chiefly somatic presentation.[6] Similarly, a retrospective study conducted in Canada found that 76% of patients with depression or anxiety disorders (n = 75) had presented to their primary care physician with a chiefly somatic complaint.[7] Of these patients, 78% were subsequently misdiagnosed. Crucially, the extent to which patients' symptoms were somatised affected whether they were correctly diagnosed – less than a third of patients with true somatization were recognised as having depression (see Figure 1).

Somatic symptoms influence the detection of depression

Primary care practitioners are frequently accused of failing to recognise depression in large numbers of cases. In actuality, depression is difficult to recognise initially and the majority of patients are usually recognised at subsequent consultations.[8] At worst, however, several years can elapse before depression is recognised and treated. During this time patients must bear the detrimental effects of depression on their quality of life.

Consequences of misdiagnosis

Somatic symptoms increase the already significant burden of disability associated with depression, therefore, it is imperative that efforts are made to improve recognition of depression in these patients, ensuring they receive timely and appropriate treatment. Indeed, compared with patients who do not have somatic symptoms, depressed patients with somatic symptoms typically have poorer physical and mental health, suffer from prolonged depressive episodes, rely more heavily on healthcare services, and are more difficult to treat.[1,5,9,10]

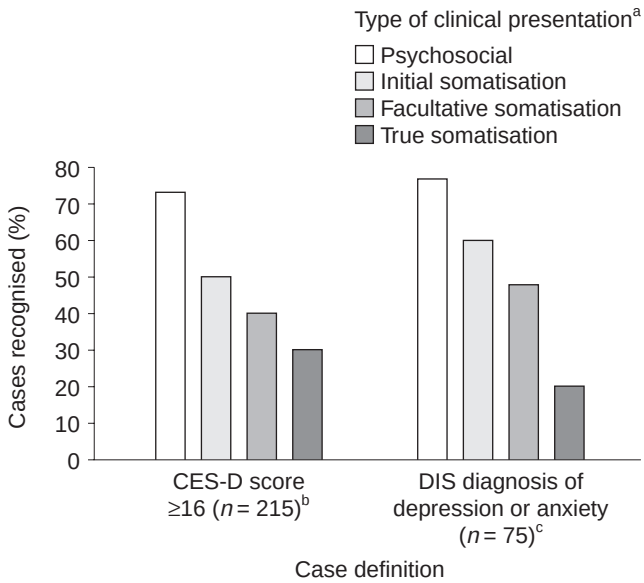

Figure 1 Effect of clinical presentation on primary care physicians' recognition of true psychiatric cases.[7] CES-D, Centre for Epidemiologic Studies Depression Scale; DIS, Diagnostic Interview Schedule.
[a] Psychosocial presenters presented with at least one psychosocial symptom or problem. Initial somatizers presented with only somatic symptoms but when asked what caused their somatic symptoms spontaneously identified a psychosocial or psychiatric contributor. Facultative somatizers presented with only somatic symptoms and made only somatic attributions but when prompted with a direct question accepted the possibility of such a psychosocial explanation. True somatizers presented with only somatic symptoms and somatic attributions and even when prompted did not accept "worries" or "personal problems" as a possible cause of their symptoms.
[b] $\chi^2 = 16.9$, df = 3, $p<0.001$.
[c] $\chi^2 = 7.4$, df = 3, $p<0.06$.

Barriers to diagnosis

Somatic symptoms present both patient- and physician-related barriers to the detection of depression. Patients' beliefs about their symptoms, which ultimately lead them to consult in the first place, and how they attribute their symptoms are key.[11,12] Somewhat paradoxically, patients with depression tend to attribute unexplained somatic symptoms to a normalising non-pathological cause, rather than a somatic or psychological cause.[11] For example, a patient might remark that their fatigue was due to overexertion (a normalising attribution), rather than anaemia (a somatic attribution) or emotional exhaustion (a psychological attribution).[11] Normalising attributions are an important cause of misdiagnosis. Indeed, at one primary care practice in the UK, depression (or anxiety) went unrecognised in 85% of patients who had a normalising attributional style, compared with 38% of patients who had a psychologising style.[11]

The way in which a physician interviews a patient is clearly a critical determinant in the detection of depression.[13] While empathy is the cornerstone of the physician–patient relationship in primary care, a solely empathic response to a normalising attributional style could lead a physician to minimise or dismiss a psychological diagnosis. Instead, empathy should be the first of several steps to encourage patients to reattribute symptom causality. Open discussion of the results of a patient's physical examination and medical history should follow, leading on to an explanation of the link between lifestyle, somatic symptoms and psychological factors. Finally, the question of psychological illness should be raised. Interestingly, patients visiting primary care physicians trained in reattribution skills attribute their psychological symptoms less to somatic cause.[14]

Regardless of their attributional style, most primary care patients will express some 'cues' to their psychological distress – whether verbal, vocal (i.e. tone of voice or sighing) or postural – during the course of a consultation. Physicians need to detect and respond to these cues through the use of an open approach and directive questions about psychological issues, at appropriate times during the patient narrative. The use of closed, hypothesis-driven questions can suppress verbal cues and discourage patients from revealing their psychological symptoms at all.[13]

Notably, most patients with mental illness wait until close to the end of a primary care consultation before expressing verbal psychological cues.[15] Therefore, symptoms mentioned late in the consultation should be viewed with equal diagnostic importance as those mentioned at the start. In practice, however, increasing pressure on consultation times and competing demand between somatic and psychological symptoms, means that important cues expressed later in the course of the patient interview are sometimes missed. For example, during one study conducted at 36 primary care practices in the UK, patients were about five times less likely to have their depression recognised if psychological symptoms were mentioned late rather than early (i.e. within the first four symptoms) in the consultation.[15]

Summary

In summary, somatic symptoms, including general aches and pains, are a core component of depressive disorder, and are frequently the only symptoms reported by patients when visiting their primary care physician. Patients with somatic symptoms feel an increased burden of disease and rely heavily on healthcare services, but they are generally harder to diagnose due to the nature of their symptoms. Improving awareness of the importance of somatic symptoms in depression, and training primary care physicians in reattribution skills should improve recognition of depression in general practice.

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CONFLICTS OF INTEREST

None.

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