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Somatic Symptoms and Depression: A Double Hurt

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"I am no better in mind than in body; both alike are sick and I suffer double hurt."

–Ovid

Tylee and Gandhi[1] have written a timely review on the reciprocal relationship between somatic symptoms and depression. While this "soma-psyche" interface has been recognized for some time, the convergence of several factors makes this comorbidity particularly salient. Depression as well as anxiety most often present somatically. Primary care constitutes the front line for recognition and management of common mental disorders and, when such disorders are somatized, often the lone bastion. The concurrence of somatic and psychological symptoms amplifies their adverse effects on quality of life, occupational and social disability, and health care costs. Indeed, pain and depression are individually among the leading causes of lost work productivity and, when occurring together, their negative impact is synergistic.[1–3] The superb literature synthesis by Tylee and Gandhi[1] evokes 3 reflections on evaluation and management.

DIAGNOSIS IS MORE APPROXIMATE THAN PRECISE

I cannot fully support the declamation by Tylee and Gandhi[1]: "It is important that somatic symptoms associated with depression should not be confused with somatoform disorders . . . Indeed, results from several surveys suggest that depression, rather than somatoform disorders, may account for most of the somatization symptoms seen in primary care." This distinction between symptoms due to depression and somatoform disorders may be oversimplified. From a pragmatic standpoint, somatic symptoms are either clearly attributable to a distinct, usually medical disorder (e.g., dyspnea in the wheezing patient with asthma or sore throat in the patient with tonsillar exudates, adenopathy, and a positive throat swab for streptococcus) or not so readily explained. The latter symptoms can, in turn, be placed into 1 of 5 heuristic, albeit tenuous, categories: a somatoform disorder, another primary psychiatric disorder (often depression and/or anxiety), a functional somatic syndrome (e.g., irritable bowel syndrome, fibromyalgia, chronic fatigue syndrome), a "symptom only" diagnosis (e.g., low back pain, nonmigrainous headache, idiopathic dizziness), or a partially explanatory medical disorder in which the symptoms are not responding to standard treatment and/or are disproportionate to the pathophysiological severity. For example, angina burden in cardiac patients may be as strongly correlated with psychological factors as with ischemic burden on objective tests.[4]

Because symptomatic patients in primary care commonly qualify for more than 1 of the 5 categories, because physical examination and diagnostic testing are often unremarkable or inconclusive, and because empirical treatments either are lacking or impart a high placebo response, overconfident differentiation among multiple, potentially causative psychological and physical factors should be discouraged. Indeed, Tylee and Gandhi[1] embrace this view when they say: "The categorical labels used by psychiatrists may, therefore, be inadequate for the needs of primary care physicians. Indeed, in primary care, patients present with individual, complex, and often poignant narratives, which encompass the domains of both mind and body, and are influenced by multiple social, economic, and other forces. In this setting, categorization can be seen to either trivialize or amplify a patient's problems by removing the context."

THERAPY IS AS MUCH GENERIC AS SPECIFIC

Studies across somatic symptoms and syndromes show as many similarities as differences in terms of the proportion that are not readily explained, symptom-related expectations, psychiatric comorbidity, natural history, and response to pharmacologic and nonpharmacologic treatments, such as antidepressants and cognitive-behavioral therapy.[5–7] Three additional points should be emphasized. First, addressing symptom-related concerns and expectations may be important "therapy," particularly communication about symptom etiology and likely prognosis.[8,9] Second, getting the patient to reattribute unexplained

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somatic symptoms to psychological factors that may be contributory can be helpful if done gradually and sensitively.[10] However, patients who are resistant to psychological attributions[11] may find it more acceptable to conceptualize depression as a consequence of somatic symptoms (e.g., "it's not uncommon for patients who are sleeping poorly to get tired and feel moody") or as arising from a common pathway (e.g., "deficiencies in neurotransmitters—chemical imbalances in the brain—can cause physical symptoms such as pain and fatigue as well as emotional symptoms such as depression and anxiety"). Third, the approach to somatic symptoms is more often analogous to chronic disease management than acute care, more like diabetes than a respiratory infection, longitudinal in its time course rather than cross-sectional. Mental health professionals expect their evaluation and management of psychological disorders to unfold gradually over a series of visits. In contrast, both patients and physicians in primary care too often count upon a surgically efficient "find it and fix it" approach to symptoms, be they somatic or psychological.

PRIMARY CARE SHOULD NOT GO IT ALONE

Poorly explained symptoms are ubiquitous in medical and surgical subspecialty settings,[12] yet too often trigger expensive testing and procedures, ineffectual patient communication (e.g., "nothing is wrong"), and unceremonious "dumping" back into primary care. Likewise, mental health professionals are often poorly trained and/or uninterested in patients with pain and other somatic syndromes, despite the potential benefits of psychological treatments. As Tylee and Gandhi[1] note: " . . . depressed patients suffering from general aches and pains made approximately 20% more visits to their health care providers each year than those without aches and pains . . . [but] were 20% less likely to see a mental health specialist than patients who did not report general aches and pains. Clearly, the burden of treating these patients falls heavily on the primary care health system."

Providing effective care for such patients is highly challenging[13] and a common source of frustration in primary care practice.[14] Every clinician—generalist and specialist alike—must be educated about the interplay between somatic and psychological symptoms and how to navigate their management in a patient-centered yet cost-effective manner. It should be a partnership among providers rather than a cat-and-mouse game of referral and bounce-back. Patients quickly sense when their symptoms are being de-legitimatized. Integrating the care of symptoms is essential. In the words of Leigh Hunt, a 19th century poet: "The mind may undoubtedly affect the body; but the body also affects the mind. There is a reaction between them; and by lessening it on either side, you diminish the pain on both."

REFERENCES

1. Tylee A, Gandhi P. The importance of somatic symptoms in depression in primary care. Prim Care Companion J Clin Psychiatry 2005;7:167–176
2. Stewart WF, Ricci JA, Chee E, et al. Cost of lost productive work time among US workers with depression. JAMA 2003;289:3135–3144
3. Stewart WF, Ricci JA, Chee E, et al. Lost productive time and cost due to common pain conditions in the US workforce. JAMA 2003;290: 2443–2454
4. Ruo B, Rumsfeld JS, Hlatky MA, et al. Depressive symptoms and health-related quality of life: the Heart and Soul Study. JAMA 2003;290: 215–221
5. Raine R, Haines A, Sensky T, et al. Systematic review of mental health interventions for patients with common somatic symptoms: can research evidence from secondary care be extrapolated to primary care? BMJ 2002;325:1082–1087
6. Kroenke K. Studying symptoms: sampling and measurement issues. Ann Intern Med 2001;134:844–855
7. Kroenke K. The interface between physical and psychological symptoms. Prim Care Companion J Clin Psychiatry 2003;5(suppl 7):11–18
8. Jackson JL, Kroenke K. The effect of unmet expectations among adults presenting with physical symptoms. Ann Intern Med 2001;134:889–897
9. Thomas KB. General practice consultations: is there any point in being positive? Br Med J (Clin Res Ed) 1987;294:1200–1202
10. Morriss RK, Gask L. Treatment of patients with somatized mental disorder: effects of reattribution training on outcomes under the direct control of the family doctor. Psychosomatics 2002;43:394–399
11. Stone J, Wojcik W, Durrance D, et al. What should we say to patients with symptoms unexplained by disease? the "number needed to offend." BMJ 2002;325:1449–1450
12. Reid S, Wessely S, Crayford T, et al. Medically unexplained symptoms in frequent attenders of secondary health care: retrospective cohort study. BMJ 2001;322:767
13. Hahn SR. Physical symptoms and physician-experienced difficulty in the physician-patient relationship. Ann Intern Med 2001;134:897–904
14. Wetterneck TB, Linzer M, McMurray JE, et al. Worklife and satisfaction of general internists. Arch Intern Med 2002;162:649–656