Asian Journal of Psychiatry 3 (2010) 99–107

Contents lists available at ScienceDirect

Asian Journal of Psychiatry

journal homepage: www.elsevier.com/locate/ajp

Review

Functional somatic complaints in depression: An overview

Kaustav Chakraborty, Ajit Avasthi, Sandeep Grover *, Suresh Kumar

Department of Psychiatry, Postgraduate Institute of Medical Education and Research, Chandigarh 160012, India

ARTICLE INFO

Article history:
Received 11 February 2010
Received in revised form 26 June 2010
Accepted 8 July 2010

Keywords:
Depression
Somatic complaints
Somatic symptoms

ABSTRACT

Depression is a disorder of major public health importance which often manifests through functional somatic complaints. Concept of functional somatic complaints dates back to the time of Wernicke and is later substantiated by various authors. Although considered as an alternative 'idiom of distress' in certain culture, functional somatic complaints are universal. Various international, cross-cultural, inpatient and outpatient based studies have reported that about two-third of subjects of depression present to clinicians with functional somatic complaints which often leads to misrecognition of their illness and in turn leads to increased utilization of health services. These functional somatic complaints can be related to various organ systems but show remarkable homogeneity in their presentation across culture. Various instruments have attempted to tap the functional somatic complaints but are limited by their cross-cultural validity. Among important correlates of functional somatic complaints are female gender, severity of depression, subsyndromal anxiety, alexithymia, somatosensory amplification and hypochondriacal worry are to name a few. Neurobiological understanding implicates neurotransmitters serotonin and norepinephrine, resultantly Serotonin Norepinephrine Reuptake Inhibitors have been found to be effective in treating functional somatic complaints in depression. Future revisions in the nosological systems should consider giving proper importance to some of these symptoms for diagnosing depression.

Contents

1. Introduction

Depression is a disorder of major public health importance, in terms of its prevalence and the suffering, dysfunction, morbidity, and economic burden. According to the Global Burden of Diseases report unipolar depressive disorders place an enormous burden on society and are ranked as the fourth leading cause of burden among all diseases, accounting for 4.4% of the total Disability Adjusted Life Years (DALYs) and are the leading cause of Years Lived with Disability (YLD), accounting for 11.9% of total YLD (Lopez et al., 2006).

Like other illnesses, depressive disorder clusters into signs and symptoms that constitute what ICD-10 *Classification of Mental and Behavioural Disorders and Diagnostic and Statistical Manual of*

* Corresponding author. Tel.: +91 172 2756807; fax: +91 172 2744401/2745078.
E-mail address: drsandeepg2002@yahoo.com (S. Grover).

1876-2018/$ – see front matter © 2010 Elsevier B.V. All rights reserved.
doi:10.1016/j.ajp.2010.07.003

Mental Disorders, Fourth Edition (DSM-IV) term as depressive episode. Apart from vegetative concomitants of depression, studies have shown that many patients suffering from depression also manifest other physical complaints which are not specifically identified by the nosological systems. At times, these functional somatic complaints dominate the clinical picture to such an extent that they exert a crucial influence on the perception of the illness. Many patients believe their illness to be physical in origin and this determines their pattern of consultation with medical services and subsequent misutilization of it (Llyod, 1983). These physical symptoms have been referred to in literature as *physical*, *bodily*, *functional or somatic complaints and somatization*. However, use of multiple terms has led to confusion. Some efforts have been made to operationalize such manifestations as medically unexplained somatic complaints and as hypochondriacal worry or somatic preoccupation (Lipowsky, 1987). As it is presumed that these somatic complaints are part of the depressive syndrome and there is no underlying physical cause for the same, we prefer to use the term *functional somatic complaints* (FSC) for these symptoms.

In this article a brief overview of the literature is presented with regard to the FSC *in depressive disorders.* This overview covers the conceptual issues, prevalence of FSC in depression in primary care and psychiatric setting, phenomenology of FSC, influence of culture on somatic manifestations, impact of FSC on depression, instruments for assessment of FSC, correlates of FSC, possible neurobiological underpinning and treatment of depression in the presence of FSC. For this overview the search strategies included both search of electronic databases as well as manual search of relevant publications or cross references. Electronic search included both PUBMED searches and searches using other search engines like Google, Google Scholar, etc. Cross-searches of key references (both electronic and hand-search) often yielded other relevant material. The search terms used (in various combinations) were: depression, somatization, physical, bodily, functional or somatic complaints, alexithymia, somatosensory amplification, hypochondriasis, culture, prevalence, scales, instruments, management, and treatment.

2. Concept of FSC in depression

Historical conceptualization of somatic symptoms in depression has been discussed in detail by Kapfhammer (2006). Here we would discuss this in brief; interested readers can go through the article by Kapfhammer (2006).

For a long time, various researchers have stressed basic bodily alterations as core features of depressive states. Wernicke (1906) used the term "vital feelings" to describe certain FSC occurring in affective psychoses. Accordingly vital feelings were understood as somatic affects localized in different parts of the body. Dupré (1974) referred to FSC as "coenestopathic states" which means a distressing, qualitative change of normal physical feeling in certain areas of the body during an episode of depression. Schneider (1920) considered the disturbances of vital feelings to be the core of cyclothymic depression. In his psychopathological assessment FSC were of paramount diagnostic significance in depressive illness, more or less equivalent to the first-rank symptoms in schizophrenia. However, Huber (2005) tried to discriminate "vital disturbances" from vegetative symptoms in depression. According to him, vital disturbances refer to the vital feelings and it comprises loss of general vital tone of the body, a prevailing fatigue or exhaustibility, and various forms of somatic dysesthesia, typically of a static, more localized character affecting head, chest, heart region, or abdomen. Although the vegetative symptoms are closely associated with these vital disturbances, it included disturbances of sleep, appetite, and digestion and many other vegetative symptoms in depression like disordered salivation, transpiration and lacrimation, cardiac arrhythmias, dyspnea, loss of libido and various sexual dysfunctions, dys- or amenorrhea, loss of or increase in body weight, decreased turgor of the skin, loss of hair, decrease in body temperature, nausea, vomiting, meteorism, dizziness, sweating, or sensations of coldness. It was understood that both vital disturbances and vegetative symptoms are typically coexistent with the well-known affective, behavioral, and cognitive symptoms of depression.

In spite of the long-standing psychopathological view on the somatic foundation of depressive mood, at least in moderate and severe clinical states, it is surprising that the current psychiatric classification systems [*Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV) and the *ICD-10 Classification of Mental and Behavioral Disorders*] only marginally appreciate somatic symptoms as diagnostic criteria for depressive disorders while focussing on the psychological symptoms of affect and cognition (Kapfhammer, 2006). Klerman (1990), before he chaired the DSM-III committee on affective disorders, wrote that bodily complaints were a feature of depression: "*Depressed patients frequently suffer multiple bodily complaints*; *almost every organ system may be involved*. *Complaints include headache*, *neckache*, *back pain*, *muscle cramps*, *nausea*, *vomiting*, *sour taste in the mouth*, *dry mouth*, *constipation*, *heartburn*, *indigestion*, *flatulence*, *blurred vision*, *and pain on urination*". He acknowledged that people of different cultures might show depression in different ways. However, neither DSM-III nor subsequent revision included such a list. Currently, DSM-IV lists only three criteria of FSC for major depressive disorder: sleep disturbance, appetite disturbance, and fatigue or loss of energy. In ICD-10, reduced energy leading to increased fatiguability and diminished activity, disturbances of sleep and appetite and loss of libido are the only somatic symptoms considered to be of diagnostic significance for depression. Beyond this short list of predominantly vegetative symptoms, no painful physical symptoms are mentioned in either the DSM-IV or ICD-10. However, in day-to-day clinical practice, painful physical symptoms are quite frequently noted in patients with depression. Due to the same, appropriateness of using current nosological systems (especially DSM-IV) as a universal diagnostic and classification system of mental disorders has been questioned by many authors because of its heavy emphasis on a biomedical model for mental disorders (Lewis-Fernandez and Kleinman, 1995; Thakker and Ward, 1998).

3. FSC in depression and culture

It is presumed that depression has some symptoms that occur universally and there are some that vary transculturally (Draguns, 1994). Westermeyer (1989) categorized depression as a pathoplastic and culture-bound disorder that has substantial variation in prevalence and manifestation across cultures (Draguns, 1994; Bhatt et al., 1989). The most striking cultural variation in depression is presence of FSC. This symptomatology is very common in non-Western populations, particularly in some Asian countries, because of cultural disapproval of strong expressions of emotion, especially negative emotions. It has been said that medical help-seeking in many cultures is organized around the presentation of bodily complaints rather than explicit mention of emotional disturbance or family conflict (Conrad and Pacquiao, 2005). In Asian and Arabic nations, open demonstration of emotion, in any form, is considered socially unacceptable (Thakker and Ward, 1998). Kleinman and Good (1985) have described FSC as an alternative 'idiom of distress' that is prevalent in cultures where psychiatric disorders carry a great stigma. FSC might be emphasized by patients to ensure that they get appropriate attention and also be regarded as legitimate reasons for consulting a clinician