Background review

In primary care, difficulty to distinguish somatic syndromes from depression with somatic symptoms, is recognised (Tylee, Gandhi 2005). In somatoform disorders co-morbid depression and anxiety have an additive detrimental effect on level of functioning (de Waal et al. 2004).

Method

Cohort is 106 consecutive patients referred to a specialist somatoform disorder clinic in east London as part of a naturalistic follow-up study. Assessments (ICD-10 based) were done by trained psychiatrists supervised by F.R. Tools used included Hamilton rating scale for depression (HAMD), Patient Health Questionnaire (PHQ-15; measures severity of somatic symptoms), Global Assessment of Functioning (GAF) (symptoms and functioning). This report focuses on analysis of baseline assessments. Statistical analysis were carried out using SPSS 17. Initial univariate analysis followed simple/multiple linear regression with multicollinearity diagnostics and residual testing.

Results

The cohort had a mean age of 41 years (SD=10.1). 65% of the cohort were females. Ethnic groups were as follows, 44% Asian (India, Pakistan and Bangladesh), 39% Caucasian (white British and other white) and 17% Black (black African, Caribbean and other black) (Figure1).

33% of cohort had only depressive disorder (ICD-10 F32-34, 38), 55% had a somatic syndrome (F 44-45, 48) and 12% with anxiety or psychotic disorders (Figure 2). 34% of somatic syndrome had co-morbidities, mainly depressive disorder. The ethnic groups did not significantly differ in the proportion of diagnosis.

In the depressive disorder group, generalised pain was the most frequently reported presenting complaint, followed by psychological symptoms and pain in specific areas. Whereas in somatic syndrome group (without co-morbidity), pain in specific areas was the major presenting complaint (Figure 3).

HAMD, PHQ-15, and GAF scores did not significantly differ between diagnostic groups. In the somatic syndrome group, HAMD and PHQ-15 scores negatively correlated with GAF (functioning) (t=-4.5, df=1, p=0.001 and t=-2.3, df=1, p=0.04). Here HAMD scores accounted for 50% variability of GAF (functioning) scores. Also in somatic syndrome, PHQ-15 scores correlated significantly with the HAMD scores (Pearson coefficient=0.59, p=0.003) (Figure 4). For the somatic syndrome group, with GAF (functioning) as the dependent variable, HAMD scores along with covariates PHQ-15, age, gender, ethnicity, co-morbidity and medication-use were entered in a multiple regression model using stepwise method. HAMD score was the only significant parameter remaining (F=17, t=-4.2, df=1, p=0.001) (Figure 5). Similar association was not seen in other diagnostic groups.

Conclusions

A considerable number of patients presenting with severe somatic symptoms and functional impairment have depressive disorder as primary diagnosis. In patients with somatic syndrome, depressive symptoms appear to influence the level of functioning and mediate the effect of somatic symptoms on level of functioning. These findings may have implication in diagnosis and treatment of patients presenting with somatic symptoms and needs establishing.

Reference
