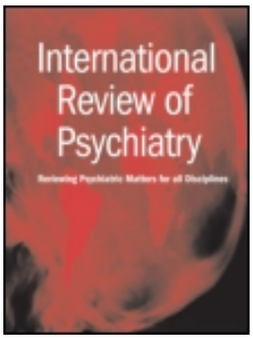

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EDITORIAL

Many faces of somatic symptom disorders

Somatic symptom disorders are disorders with prominent somatic or bodily symptoms. They are common in healthcare settings and with varied features. Many presentations can be confirmed by available investigations, many are not. The variability adds to the vagueness and variety of the presentations which make these disorders a charm, mystique and challenge of psychiatric practice. Somatic presentations are non-specific but prominent somatic presentations are more often noted in somatic symptom disorders.

The occurrence of somatic symptoms is understandably distressing for the person, and when these are medically unexplainable, these are mysterious for the family, and rather annoying for the health professionals. The marked prevalence of these symptoms puts great burden on the healthcare delivery system. Due to the physical presentation, individuals suffering with somatic symptoms seek help from a physician. Many investigations are conducted to determine the elusive aetiology, failing which, these individuals are referred to a psychiatrist. One reason for this could be that somatic symptoms are common in a number of psychiatric disorders, including depressive disorders, anxiety disorders and somatoform disorders.

Bodily complaints may be driven by bodily focusing, preoccupation and concerns. How these cause somatic amplification, or this amplification causes bodily concern is yet undetermined. The interpretation and misinterpretation of bodily sensations causes distress about bodily symptoms (Chaturvedi et al., 2006). The bodily distress disorders could be primarily arising from sensations due to a physiological process, which are misinterpreted and develop health worries and bodily concerns, senso somatisation or arise from ideas, ideo somatisation, wherein bodily worries and concerns could cause bodily sensations due to the pathophysiological disturbances and autonomic dysfunctions.

This issue of the *International Review of Psychiatry* has a collection of thought-provoking reviews on a number of the aspects of somatic symptom disorders. These include descriptions of somatic symptom disorders in primary healthcare, cancer, consultation liaison settings, post-traumatic stress disorders, and in women in low and middle income countries. Other essays focus on measurements of somatic symptoms and their disorders, the use of diagnostic criteria for psychosomatic disorders, and the psychopharmacological and behavioural management of these disorders and their ethical dilemmas and challenges.

Words of wisdom in this issue

The contributing authors have provided important take-home messages based on their reviews. Prior and Bond discuss the importance of illness behaviour in understanding the somatic symptom disorders. Behavioural aspects of somatic symptom disorders may be informed by the general sociological notion of illness behaviour, along with the associated literature on abnormal illness behaviour and health anxiety. They point out that the measurement of illness behaviour has been limited by the paucity of instruments which target overt behaviours specifically. The significance of abnormal illness behaviours in understanding somatic symptom disorders has also been addressed in other articles by Grassi et al. and Sirri and Fava. Sirri and Fava point out that classification systems of somatic symptom disorders neglect important features concerning abnormal illness behaviour and psychological factors affecting medical conditions, with a consequent narrow view of patients' responses to physical symptoms and illness. The Diagnostic Criteria for Psychosomatic Research (DCPR) capture psychological variables which do not find room in the customary psychiatric classification and expand the spectrum of information for clinicians' decision-making process. Grassi et al. support this view and declare that the current DSM classification of somatoform disorders and the forthcoming nosology of somatic symptom disorder do not seem to be useful for the area of somatization in cancer patients unless an integration with other psychosomatic tools (such as DCPR) is considered. More information on possible therapeutic intervention and on training of healthcare providers (e.g. GPs, oncologists) regarding somatization in cancer patients are necessary.

The awareness about somatic symptoms and disorders in well-known medical/physical diseases such as cancer challenges the views many physicians hold that somatic symptoms occur only in non-medical conditions. Grover and Kate discuss somatic symptoms in consultation liaison psychiatry units and

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describe how patients with medically unexplained symptoms (MUS) form a large part of patients seen in general practice, medical and surgical clinics and these patients often have significant psychiatric morbidity, distress and functional impairment. They recommend an integrated approach, between the physician and the consultation-liaison psychiatrist is required to adequately manage these patients.

The ethical issues related to somatic symptom disorders, their understanding, management and communication about these are seldom discussed. Chandra and Satyanarayana assert that ethical dilemmas are more challenging in developing countries where literacy, poverty, under-nutrition, infections and poor access to healthcare are common. Issues of equity are a major concern. In situations where major health problems such as infections and nutritional disorders are the priority, somatic symptom disorders may not get the kind of attention they require. They suggest that cultural issues need to be integrated into care and that an ethical approach to managing somatization in this context would include side-stepping the physical versus psychological dilemma and using an integrated and simultaneous medical and psychiatric approach. To ensure patient beneficence, the medical, psychological and social assessment and investigations should be undertaken side-by-side as much as possible and should be cost-effective. They also reiterate respecting patient autonomy by using adequate communication methods, and the patient's cultural model of the illness as part of management is integral to ethical practice.

Measurement of somatic symptoms is essential in understanding the phenomenon and making an accurate diagnosis. There are many scales and instruments available for measuring somatic symptoms, but they have some strengths and some limitations. There are essential features of somatic symptoms that need to be measured along with the associated phenomena. The common and not so common measures of somatic symptoms have been described by Chaturvedi and Desai. The impact of somatic symptom burden on disability and healthcare use in patients in Qatar is described with a research survey by Bener et al. The study concludes that the primary healthcare physicians, who are the focal point of healthcare services, could play an important role in identifying and treating patients with somatic symptoms, as these symptoms could reflect underlying psychiatric problems.

Two articles on management issues discuss the psychopharmacological and behavioural methods of dealing with somatic symptom disorders. Somashekar et al. provide evidence for pharmacological treatment, and note the overwhelming evidence for antidepressant medication, with the choice determined by specific symptom profile and tolerability. Treatments should be symptomatic with emphasis on relieving suffering whilst simultaneously trying to find causes, rather than overemphasizing psychosocial causation and undue focus on cognitive behaviour therapy. Sharma and Manjula point out that the behavioural and psychological treatment of somatic symptom disorders is still in its infancy, and that research provides evidence for the efficacy of cognitive behavioural therapy (CBT) for somatic symptoms disorders. However, process research to establish impact of CBT on somatic symptom disorders is limited.

The review on somatic symptoms in post-traumatic stress disorder (PTSD) confirms their association with 'ill-defined' or 'medically unexplained' somatic syndromes, e.g. unexplained dizziness, tinnitus and blurry vision, and syndromes that can be classified as somatoform disorders. Gupta further explains the mechanism of these symptoms through 'limbic instability' and alterations in both the hypothalamic–pituitary–adrenal and sympatho-adrenal medullary axes, which affect neuroendocrine and immune functions, have central nervous system effects resulting in pseudo-neurological symptoms. The systematic review on association of somatoform disorders (SD) with anxiety and depression in women in low and middle income countries by Shidhaye et al. suggests a strong association between SD and depression/anxiety, though they also observed that the majority of women with SD did not have depression/anxiety.

Future directions for research

A number of ideas for future research and works have been proposed by the contributing authors in this issue. These could guide future researchers in their quest to understand and manage somatic symptom disorders. Some of the suggestions by the authors in this issue are as follows.

- Long-term follow-up studies on somatic symptom disorders are needed.
- Study of the cultural factors in the expression of the symptoms is needed.
- Study of the attitudes of the clinician/therapist and patience in dealing with patients with somatic symptom disorders plays an important role and needs further investigation.
- Assessment of possible somatization mechanisms underlying certain somatic symptom dimensions (e.g. pain, fatigue) should consider new integrated diagnostic systems.
- New specific therapeutic interventions for somatizing patients and training protocols for healthcare professionals should also be developed and tested.

- We need to educate and train physicians about MUS, its significance, and how to best deal with patients with MUS.
- There is a need to develop programmes in collaboration with physicians that identify patients with MUS, evaluate patients with MUS for psychiatric disorders.
- Special psychosomatic clinics need to be developed to address the needs of the patients with MUS.
- Future studies should compare the DCPR with the proposed classifications of somatic symptom disorders according to both their prevalence and their sensitivity in predicting patients' psychosocial functioning and treatment outcome.
- There is a need to examine whether the application of specific therapeutic strategies to the DCPR syndromes will improve patients' quality of life and clinical outcome.
- A comparison is needed of cost-effective field-level interventions that can be used in low resource settings where often the first point of care may not be a physician.
- A study of the effectiveness of a stepped care approach to treatment is needed so that those who require specialist care are able to get it.
- Training methods for physicians and mental health professionals dealing with somatization need testing.
- Qualitative research is needed, especially in cultures where mind–body dualism is not so clear. These should focus on the patient's subjective experience of the physician–patient interaction and their satisfaction and dissatisfaction with the same.
- Future research needs to distinguish between the state-based and trait-based characteristics of illness behaviour more specifically.
- The potential value of adaptive illness behaviours in either reducing the risk of developing a somatic symptom disorder or minimizing the adverse psychosocial consequences of such a presentation is worthy of empirical exploration.
- A detailed reliable and valid measure and a brief screening version of the somatic symptom scale are needed.
- Examination of the diagnostic and prognostic value of somatic symptoms using such measures is needed.
- Longer duration of trials with larger sample sizes, comparing psychotropics and non-psychotropics and psychological interventions are necessary to guide practising clinicians.
- Ways to improve training of physicians in the management of depression, anxiety and other mental disorders may therefore be valuable for improved care of patients with somatic complaints. In the future, developing better management strategies for medically unexplained, persistent somatic symptoms is a healthcare priority which needs to be addressed in the future.

Cultural underpinnings

Certain aspects of somatic symptom disorders of importance are related to cultural presentations and understandings. One such view is of somatic symptom disorders as idioms of distress or popular hidden illnesses. Idioms of distress are social and cultural ways of experiencing and expressing distress in local worlds. Idioms of distress are culturally and interpersonally effective ways of expressing and coping with distress, and they are indicative of psychopathological states that undermine individual and collective states of well-being. Idioms of distress express personal and interpersonal distress beyond that associated with universal disease processes (Nichter 1981, 2010). Somatization is considered as an important idiom through which distress is communicated. The concept of 'cultural idioms of distress' was introduced to draw attention to the fact that reports of bodily distress can serve a communicative function.

'Medically unexplained symptoms' have acceptable 'traditional explanations' or 'folk medical explanations'. Folk medicine has perhaps no 'unexplained symptoms or illnesses'; in much the same way medically unexplained somatic symptoms can be explained by some psychodynamic and psychoanalytic mechanism, including somatization being a defence mechanism. Disparities in the views of medical professionals and lay people are a cause of distress, poor compliance, chronicity and abnormal illness behaviour. The social meaning of somatic symptoms includes their use as ways of talking about or alluding to other forms of distress. Many patients with somatic cultural idioms of distress will acknowledge the social problems that exacerbate their symptoms if they find a sympathetic listener (Kirmayer & Sartorius, 2007). Somatic idioms of distress commonly embody combinations of somatic, emotional, and social meanings. Complaints that seem (to the medical practitioner) to be evidence of a syndrome of somatic symptoms may, in reality, encode an ethnomedical theory (Kirmayer & Young, 1998). Many times somatic symptoms appear as a defence – a cultural defence or bodily defence against greater distress or hurt, and preventing or avoiding more severe psychiatric disorders (Chaturvedi & Desai, 2006).

Lastly, the nosological status of somatic symptom disorders and an acceptable suitable nomenclature seems to be a never-ending saga. Reynolds (2012) suggests an interdisciplinary approach to classification problems for somatic symptom disorders with comparable neurological involvement, preferably in

one, not two, universal classifications, so that psychiatrists and physicians/neurologists can attempt to agree common principles and terminology, including bearing patient acceptance in mind. Currently, physicians and neurologists use their own terminologies, most often 'functional', non-organic or medically unexplained symptoms; psychiatrists use their own names for such disorders, but patient preference is hardly ever heeded.

Classifying somatic symptom disorders is likely to remain a challenge, as much as understanding the mechanisms which underlie these disorders. The confusing and misleading 'medically unexplained symptom' disorders need a fresh and appropriate replacement. Some suggestions can be calling these idiopathic somatic symptom disorders or bodily distress disorders, or using a multi-axial method, which could include the duration, aetiology, and bodily organ or system involved, for example chronic idiopathic low back pain with or without sensory symptoms. The classificatory systems are undergoing revisions, and one hopes a progress in the classification of somatic symptom disorders. The charm of dealing with individuals with bodily symptoms is in their challenge and intrigue; one hopes some mysteries will be unravelled, only to be replaced by newer ones.

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