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Short Communication

Evolution of Psychosomatic Diagnosis: From Masked Depression to Somatic Symptoms and Related Disorders

Vincenzo Prisco [1, *], Bernadette Donnarumma [2], Lorenzo Prisco [3]

1. Department of Psychiatry ASL Salerno. Professor at University of Naples Federico II and eCampus University, Italy; E-Mail: vinciprisco@gmail.com
2. Resident in Pediatrics, Department of Pediatrics, University of Naples Federico II, Naples, Italy; E-Mail: bernadette.donnarumma@gmail.com
3. Emergency medical Service ASL Salerno, Italy; E-Mail: lorenzo.prisco90@gmail.com

* **Correspondence:** Vincenzo Prisco; E-Mail: vinciprisco@gmail.com

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Abstract

This paper discusses the history and the concept of somatization from masked depression to somatic symptoms and related disorders in the Diagnostic and Statistical Manual of Mental Disorders (DSM). Evaluating the evolution of these terms and concepts along the time course is very interesting. DSM 5 revision was intended to increase the relevance of these concepts in the primary care setting. "Masked depression" is a form of depression in which somatic symptoms or behavioral disturbances dominate the clinical picture. Primary care physicians often treat patients who show somatic symptoms without a biological substrate. These patients may receive unnecessary or invasive tests and procedures. An accurate psychiatric screening is essential to diagnose somatic symptoms disorder. As a result, it is very useful to establish a strong therapeutic alliance, and acknowledge and legitimize the patient's symptoms. Cognitive behavioral therapy, mindfulness-based therapy, and pharmacotherapy are evidence-based therapies. In particular, selective serotonin reuptake inhibitors and

tricyclic antidepressants have effectively alleviated somatic symptoms when there is a hidden psychological substrate.

Keywords
Somatic symptoms disorder; masked depression; hypochondriasis; depressive equivalent

1. Introduction

Physical complaints without an identifiable organic substrate are common in health care. Symptoms like palpitations, headache, chest pain, dyspnea, joint pain, dizziness, and fatigue have often been difficult to describe for patients [1]. In somatoform disorders a physical symptom seems to subtend a physical disorder, but without a biological substrate, there is strong evidence for hidden psychological factors. In 1682 Sydenham thought hysteria “can simulate any medical illness." In 1799 Sims differentiated hysteria from hypochondriasis underlying that hysteria is associated with a fluctuating mood, whereas hypochondriasis is characterized by melancholy [2]. Freud and Breuer elaborated on the concept of hysteria-later known as “Conversion disorder”-which was seen as a translation of emotional suffering in physical symptoms [3]. Freud thought somatic symptoms could be attributed to unconscious mental processes. Menninger defined “somatization reactions” as the “visceral expressions of the anxiety which is thereby prevented from being conscious” [4]. Another milestone was Lipowski’s contribution to psychosomatic medicine [5]. However, when the Diagnostic and Statistical Manual of Mental Disorders and the International Classification of Diseases were published, the research in the field was stimulated and new clinical and nosographic definitions were assessed.

2. Masked Depression

Depression shows affective, cognitive, motor and vegetative components [6]. The mood is depressed, there is a loss of interest or pleasure, slow thought processes, and feelings of worthlessness or inappropriate guilt are often evident [7]. The effect may be hopeless and despairing, with difficulty thinking, sadness and motor retardation. A marked diminished interest or pleasure in all, or almost all, activities most of the day, fatigue or loss of energy nearly every day. According to Beck’s cognitive triad of depression [8], patients have negative views of the self, world and future. However, especially in old age, many patients when depressed complain less of sadness, and they often become excessively concerned about physical health. It refers to masked or somatized depression. “Masked depression” is a form of depression in which somatic symptoms or behavioral disturbances dominate the clinical picture. The term “Depressive equivalent” refers to symptoms that replace depressed mood and have a psychosomatic expression. These terms are not used in DSM 5, but they seem very useful from a psychopathological point of view. Masked depression or Depressive equivalent definitions describe important aspects of the clinical presentation of this type of depression: minimal expression of sadness, somatization or excessive physical complaints, and unexplained pain syndrome. Neither the patient nor the physician is immediately aware of the underlying mood disorder. For example, pseudo-anergic depression is expressed by energy loss, fatigue and tiredness. The patients also complain of having no interest, in

the absence of a striking depressed mood or other classic depressive symptoms. Although few symptoms incontrovertibly distinguish late-life from early-onset depression, there are differences in clinical presentation. Early-onset depression shows cognitive and ideative components, with feelings of guilt, sadness and despair. On the other hand, late-life depression is often a masked depression, in which pain is the chief complaint [9]. There is a growing awareness that depression may present predominantly with pain. The pain is often non-specific. Headache, abdominal pain or musculoskeletal pains in the lower back, joints, and neck are common. They may occur in combination so the clinician should have a high index of suspicion in patients presenting with multiple pain symptoms of unclear etiology. Once recognized, depressive equivalents have to be treated like other depressive symptoms. The complaint is chronic and diurnal variations are very frequent [10]. These patients have often a family history of depression and poor cognitive strategies [11]. On the other hand, young people and adults showing more creative components of depression, also have a higher level of mentalization and coping strategies to manage the illness [12].

3. Conceptualizing Somatoform Disorders: The Development of Psychosomatic Diagnosis in DSM

Somatization is a process that appears as a way of responding to stress. Somatosensory amplification, where somatic symptoms are experienced as intense and disturbing, is an interesting process leading to somatization. Somatization is a public health problem. It can lead to social impairment, occupational problems and increased healthcare use. The prevalence of somatic symptom disorder in the general population is estimated from 5% to 7% [13]; females tend to present with somatic symptoms disorder more often than males; furthermore, higher unemployment rates and impaired occupational functioning are found in patients affected by somatic symptom disorder. After the Second World War, the first Diagnostic and Statistical Manual of Mental Disorders (DSM I) was developed. Psychoanalysis deeply influenced the first edition of DSM: many mental disorders were seen as “reactions” [14]. DSM I included a section called “Psychophysiological autonomic and visceral disorders." Physical symptoms were thought to be caused by repressed feelings, producing an excessive response. Indeed, Franz Alexander, a Member of the Psychoanalytic Institute was a prominent figure in the psychosomatic field and a member of the committee that developed DSM I. In 1968, the second edition of the manual was published. In DSM II the term “reaction” was excluded and terms like “neurosis and psychosis” were adopted. In DSM III the term “Disorders” was used to describe pathological conditions and a list of specific criteria was used to make a diagnosis. Furthermore, for the first time we have a categorical approach. Another feature of DSM III was the multiaxial format, in which concomitant medical conditions, personality disorders and global functioning were included. An interesting new category appeared: “Psychological factors affecting physical conditions." This category underlined the possibility that psychological problems might exacerbate some physical conditions. Furthermore, according to DSM III, to state that psychological factors influence physical conditions we need evidence of a strict correlation between the external stimulus and the exacerbation of the physical condition, based on a cognitive misinterpretation of the stimulus itself. This category was distinct from “Conversion Disorder," in which neurological symptoms, such as blindness or paralysis, are inconsistent with a well-established organic cause [15].

4. Somatic Symptoms and Related Disorders in DSM 5

DSM 5, published in 2013, includes a variety of changes that have been made from previous editions [13]. The new category “Somatic symptoms and related disorders” group “somatization disorders” and “Psychological factors affecting a medical condition." DSM-5 eliminated the diagnoses of somatization disorder, undifferentiated somatoform disorder, hypochondriasis and pain disorder; most patients who previously received these diagnoses are now diagnosed in DSM-5 with Somatic Symptoms Disorder. Somatic symptoms disorder is diagnosed when there is a significant focus on physical symptoms, such as pain, weakness or other symptoms, to a level that results in major distress or poor general functioning. An important change in DSM 5 is that Somatic symptoms disorder diagnosis does not require that the somatic symptoms are medically unexplained. Diagnostic criteria for Somatic Symptoms Disorder include one or more distressing somatic symptoms that result in significant disruption of daily life and excessive thoughts, feelings or behaviors related to the somatic symptoms or associated health concerns. Affected individuals experience substantial impairment in social functioning, with the risk of social withdrawal [13]. Subdiagnoses of Somatic Symptoms Disorder include the following: conversion disorder, illness anxiety disorder, psychological factors, and factitious disorder [16].

5. Conclusions

Somatic symptom disorders are generally chronic. Good communication with the patient is essential at all disease stages and care levels. Specific treatments include cognitive therapy, dynamic psychotherapy, group therapy, family therapy, and physical and relaxation therapies [17]. It is important to consider antidepressant medication for predominant pain or depression. They seem to reduce somatic symptomatology in the long term and may have specific effects on pain, and may be approved for pain fibromyalgia and diabetic neuropathy [18]. Anxiolytics are useful at the beginning of the therapy. In conclusion the new biopsychosocial model could be useful to understand such a complex and polymorphic symptomatology to better recognize and manage it.

Author Contributions

Vincenzo Prisco, MD, PhD performed the structure of the study, in particular introduction, material and methods section, discussion and conclusion of the case report; Lorenzo Prisco, MD performed reference section; Bernadette Donnarumma, MD performed language editing.

Competing Interests

The authors have declared that no competing interests exist.

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