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Diagnostic Criteria for Somatic Depression in Clinical Psychiatric Practice

Kuchimova Ch. A.
Samarkand State Medical University

Abstract: Somatic depression represents one of the most complex diagnostic problems in modern psychiatric practice. This disorder is characterized by the predominance of somatic symptoms over classical affective manifestations, which significantly complicates the timely diagnosis and adequate treatment of patients.

Keywords: somatized depression, masked depression, diagnostic criteria, somatic symptoms, psychiatric practice, depressive disorders, clinical diagnosis, somatoform manifestations, affective disorders, psychosomatic disorders, differential diagnosis, screening methods, bodily symptoms of depression, latent depression, alexithymia, general psychiatry, clinical assessment, somatic complaints, medically unexplained symptoms.

Introduction. According to numerous epidemiological studies, from 50% to 80% of patients with depressive disorders seek medical help precisely with somatic complaints, unaware of the mental nature of their illness. This creates serious difficulties for general practitioners, therapists, and psychiatrists, as traditional diagnostic approaches often prove ineffective in identifying this pathology. The clinical significance of the problem of somatic depression is determined not only by its high prevalence but also by significant socio-economic consequences. Patients with this disorder are characterized by increased medical activity, frequent visits to specialists of various profiles, multiple expensive examinations, and ineffective symptomatic treatment.

Developing clear clinical criteria for diagnosing somatic depression in general psychiatric practice is particularly relevant. Modern international classifications of mental disorders (DSM-5, ICD-11) provide only general frameworks for diagnosis without considering the specific features of somatic manifestations of depression in various clinical contexts.

The purpose of this study is to systematize and analyze the clinical diagnostic criteria of somatized depression, adapted to the conditions of everyday psychiatric practice. Developing practical recommendations for diagnosing this disorder will improve the quality of medical care for patients and reduce the risks of hypo- and hyperdiagnosis of depressive states with predominant somatic symptoms.

As the prevalence of affective disorders increases, long-term somatized depressive disorders are receiving increasing attention . According to statistics of the World Health Organization (WHO) , "by 2030, somatized depression will become the main cause of disability of the world population. According to epidemiological studies, the prevalence of the phenomenon of somatization among the population is 25-30% (Schepank N. et al., 2020), AJ Macdonald et al. (2019), according to R. Kellner (2016), somatized symptoms are observed in physically healthy individuals in 10-80% of cases, in which panic and restlessness are observed. N. Ursin (2017) noted that 40% of patients with “persistent pain compensation” (temporary incapacity) and 40% permanent incapacity were observed in patients whose complaints did not correspond to objective findings. Tendency to somatization is one of the most characteristic symptoms of the modern pathomorphosis of depression, regardless of the nature, depth, and expressiveness of the depressive affect.

The diagnostic criteria of masked subdepressions are represented by the expression of depressive affect and the concealment of various skin sensations. As a "facade" of depression, when disorders of

the autonomic nervous system predominate, various somatoform disorders appear, imitating cardiovascular diseases, gastrointestinal diseases, and other system diseases. Also, conversion disorders, persistent idiopathic algias, headaches, neuralgias of different localization are observed. Similar disorders are often interpreted by doctors as diseases of internal organs, in fact, they are considered symptoms of mental illnesses, and patients are treated inadequately and for a long time. In all cases of somatized subdepressions, on the one hand, inconsistency between many complaints is observed, and on the other hand, symptoms characteristic of somatic diseases are not observed. It is important to make an early diagnosis of the disease, determine the adequate tactics of its treatment in time, and reduce the cases of disability. Prolonged subdepressive disorders are one of the medical and social problems that threaten the economic and social spheres.

Materials and Methods. The investigation was carried out at the outpatient department and day-care unit of the regional psychiatric facility in Samarkand between 2019 and 2022. The study encompassed 134 individuals diagnosed with mood disorders, presenting mild to moderate manifestations of somatized depressive conditions, identified through clinical and psychopathological assessment techniques.

Study findings were derived from comparative statistical analysis between primary and control patient cohorts. Analysis of disease chronicity and frequency of subdepressive episodes in the primary cohort revealed that 47.6% experienced prolonged illness onset, with the initial extended subdepressive episode marking disease debut. Prior to the first extended phase, 35.9% of cases demonstrated 1-2 preliminary subdepressive episodes. In the secondary patient group, examination of disease duration versus subdepressive episode frequency showed 9.0% had prolonged onset patterns, with the inaugural extended subdepressive phase representing illness commencement. Among this group, 14.0% exhibited 1-2 subdepressive episodes preceding the first protracted phase.

Disease duration in the primary cohort ranged from 6-20 years in 86.8% of cases, while the secondary group showed 2-15 years duration in 80.0% of patients (mean disease duration: 15.4±1.6 years in cohort 1 versus 9.02±2.4 years in cohort 2).

Examining previously documented subdepressive episodes by duration revealed that cohort 1 predominantly experienced 6-month to 2-year episodes (57.1%), whereas cohort 2 showed more reliable observations of 1.5-3 month episodes (50%). Episodes lasting 1.5-6 months occurred in 42.9% of cohort 1 and 100% of cohort 2, indicating non-prolonged patterns, though 57.1% of cohort 1 demonstrated extended duration compared to previous episodes.

Acute subdepressive onset occurred in 53.6% of cohort 1 and 34.0% of cohort 2 patients. Severe anxiety combined with depressed affect, sleep disruption lasting 3 weeks-1.5 months, appetite loss, tachycardic episodes, and reduced work capacity were observed. Subsequently, hopelessness and decreased interest developed, prompting immediate psychiatric referral. The remaining 46.4% of cohort 1 and 66.0% of cohort 2 demonstrated gradual symptom emergence. Over 2.5-4 months, appetite reduction, irritability, severe fatigue, tearfulness, cephalgia, and sleep disturbances (non-restorative sleep) preceded complete nocturnal insomnia. Episodic tension and restlessness were noted. Patients experienced attention and memory deficits with diminished self-confidence. Depressed mood, tearfulness, and rapid irritability accompanied anxiety. Additional manifestations included perspiration, tachycardic attacks, chest discomfort, constipation, weight loss, and libido reduction.

Remission periods were shorter in patients with chronic somatized depression. Cohort 2 achieved complete subdepressive recovery, while cohort 1 retained mild affective alterations and residual symptoms. Somatogenic factors predominated in cohort 1 compared to cohort 2 (48.8% versus 16.0%, $p<0.001$). Cohort 2 demonstrated greater psychogenic predisposition than cohort 1 (78.0% versus 21.4%, $p<0.005$).

Patient evaluation emphasized premorbid brain exogenous factors (BMEO). Exogenous influences encompassed perinatal complications (complicated gestation, preterm delivery, prolonged labor, birth asphyxia), early-life infections and convulsive states with evident intoxication, neuroinfections, and

mild-to-moderate cranial trauma. These pathologies occurred in cohort 1: perinatal complications (10.7%), childhood infections (48.8%), and brain trauma (40.5%), with 70.1% experiencing consciousness loss during cranial injury. Childhood infections showed highest prevalence in cohort 1 (48.8%).

Clinical examination identified predominant symptoms: hypothymia, anhedonia, severe fatigue, emotional lability, psychomotor retardation, psychomotor agitation, suicidal ideation, sleep disruption, appetite loss, circadian variations, and hypochondriacal/non-hypochondriacal visceral anxiety. Mood depression occurred in both cohorts (85.7% and 88.0%). Vitalized subdepressive affect in cohort 2 manifested as "sudden mood drops" ("cardiac heaviness," "chest sinking/scratching," "bitter, exhausting heartache," "painful heart," "cardiac stone," "chest pressure"). Hypothymia reflected melancholic states ("gloomy disposition, gray-tinted perception"). Cohort 1 experienced anxiety ("unsettled mind," "impending catastrophe sensation").

Over half of cohort 2 (66.0%) and most cohort 1 patients (94.0%) exhibited visceral anxiety attacks with hypochondriacal content featuring intracorporeal danger preoccupations, suggesting generalized anxiety disorder symptoms. Hypochondriacal anxiety attacks showed significant prevalence in cohort 1 ($p<0.001$).

Most patients in both groups (86.9% and 88.0%) demonstrated anhedonia, frequently accompanied by satisfaction loss ("nothing brings pleasure," "no motivation," "compulsory actions," "indifference"). Universal severe fatigue was observed, predominantly in cohort 2 (94.0%) ("effortful functioning," "mental energy without physical strength"). Most patients in both cohorts (73.8% and 74.0%) exhibited heightened sensitivity alongside depressed mood. Patient reports indicated crying over trivial matters, whether positive or negative stimuli (86.9% and 60.0%).

Psychomotor retardation showed objective characteristics: "movement inhibition, minimal speech, difficult simple movements" or "slowed speech with delayed responses." Ideational inhibition manifested through patient complaints like "cognitive cloudiness, difficult thinking." Both groups equally demonstrated psychomotor inhibition. Psychomotor agitation appeared as restlessness ("unable to remain seated") and occurred more frequently in cohort 1 (56.0% versus 8.0%, $p<0.001$).

Sleep disturbances affected both groups as undifferentiated insomnia patterns. Appetite reduction showed similar rates across groups (82.1% and 82.0%). Circadian variations were observed: "morning immobility, afternoon improvement" occurred in 51.1% of cohort 1 and 72.0% of cohort 2 ($p<0.05$).

Somatized symptomatology encompassed: pain sensations in minimum four body regions; pain syndromes with pronounced gastrointestinal dysfunction (nausea, vomiting, food intolerance); sexual sphere pain and functional disorders; pseudoneurological manifestations (paraparesis, incoordination, diplopia, globus sensation, aphonia, urinary difficulty). This formed the basis for retrospectively categorizing cohort 1 patients into algic, gastrointestinal, sexual, and pseudoneurological variants.

Conclusion: Risk factors for persistent somatized subdepressive disorders and progressive courses included somatogenic provocations, hypochondriacal persistent anxiety attacks, vegetative dystonia syndrome, meteorological lability, and residual cerebral insufficiency manifesting as intolerance to hot, humid conditions. Somatized subdepressive patients showed increased annual and five-year psychiatric hospitalization frequencies with decreased inter-hospitalization intervals from the second five-year period ($p<0.05$). Non-somatized subdepressive patients demonstrated slightly reduced hospitalization rates in the second five-year period, remaining relatively stable in subsequent periods.

Multiple epidemiological investigations demonstrate that 50-80% of individuals with depressive conditions initially present with physical complaints rather than psychological symptoms, remaining unaware of their condition's psychiatric etiology. This phenomenon poses considerable challenges for primary care physicians, internists, and mental health specialists, since conventional diagnostic methodologies frequently fail to detect this clinical presentation.

The clinical importance of somatized depression extends beyond its widespread occurrence to encompass substantial social and economic implications. These patients typically exhibit heightened healthcare utilization patterns, including frequent consultations across multiple medical specialties, extensive costly diagnostic procedures, and receipt of ineffective symptom-focused treatments.

Establishing precise clinical diagnostic parameters for somatized depression within routine psychiatric practice represents a critical need. Contemporary international psychiatric diagnostic systems (DSM-5, ICD-11) offer broad diagnostic frameworks while lacking specificity regarding somatic depression manifestations across diverse clinical settings.

This investigation aims to organize and examine clinical diagnostic standards for somatized depression, tailored for routine psychiatric practice applications. Establishing evidence-based diagnostic guidelines will enhance patient care quality while minimizing diagnostic errors in depressive conditions characterized by prominent somatic presentations.

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