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Frequency and Severity of Depression in Patients Presenting with Somatic Symptoms Disorder

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Abstract

Somatic Symptoms Disorder (SSD) consists of physical symptoms which are not fully explained by a general medical condition, and must be associated with disproportionate thoughts, feelings, and behaviors regarding those symptoms. Depression is a common comorbid condition in SSD patients, confusing clinically and diagnostically in addition to therapeutically. Subject: This study investigates the prevalence and acceptance of depression in SSD patients. The research study, which is being carried out in a large medical center, aims to determine the frequency with which depression occurs in association with SSD, how severe it is, and what factors may be responsible for the development of depression among these patients. The findings offer important implications for clinicians in the treatment of patients with SSD, emphasizing that holistic treatments targeting somatic symptoms and the concurrent depressive condition are essential. The clinical relevance of these findings with respect to treatment planning and patient care will also be investigated.

INTRODUCTION

Somatic Symptoms Disorder (SSD) is a multifaceted psychiatric syndrome that consists by the presence of physical (somatic) symptoms (e.g., pain, gastrointestinal symptoms, fatigues, and somatic complaints) that result in substantial distress or impairment. These symptoms are generally unexplained by any medical disease or disorder, leaving patients and physicians without a clear explanation. This frequently leads to going to the doctor multiple times, obtaining unnecessary tests, and being involved in multiple interventions, none of which provide a definitive diagnosis or alleviation. SSD constitutes a significant challenge for health care systems as it places enormous resource demands and increases patient suffering (American Psychiatric Association, 2013).

In addition to the somatic complaints, SSD patients usually have significantly more emotional burden. Individuals with SSD have a higher prevalence of depression, which is a mood disorder characterized by sustained feelings of sadness, lack of interest, diminished ability to concentrate, changes in appetite and sleeping pattern (Kuehner, 2017). Depression is a prevalent comorbidity in SSD patients, and the onset of depression can interfere with diagnosis and treatment. The comorbidity of somatic and emotional symptoms obscures their delineation which is a barrier to their successful treatment. Symptoms such as fatigue, insomnia, and difficulties with concentration are common to both conditions, challenging diagnosis and management (Kroenke, Wu, & Bair, 2007).

SSD and depression have a complex cycle to their relationship. For instance, somatic complaints with a chronic nature can also predispose to depressive feelings, for these make patients feel helpless and hopeless from unresolved medical problems (Fava

et al., 2010). Conversely, distress present in depression could heighten awareness of the somatic elements and therefore the severity of SSD. This is a circular and reciprocal relationship, which further produces negative effects on one another, making the treatment more challenging and the patient more distressed (Kroenke et al., 2007).

In light of these challenges, it is imperative to obtain information about the prevalence and severity of depression in patients with SSD. The coexistence of depression in SSD is not only prevalent - but it is determinant of the condition of general health of the patient and the results achieved with the conducted treatment. There is evidence that as many as 50% of subjects with SSD have clinically significant depression symptoms (Kroenke et al., 2007). Severity of depression in patients with SSD varies from mild to severe, and dependent on the duration of the somatic symptoms, number of somatic complaints and additionally, co-morbidities of psychological distress (Kuehner, 2017)].

The present investigation is expected to facilitate clarification of the relation of SSD with depression, and severity and prevalence of depression in SSD patients. It will look at how depression taints the experience of SSD and how the two conditions are related. By examining these topics, the paper hopes to provide some guidance that will assist clinical practice in dealing with these dual-diagnosed patients. This study would give a perspective on treatment recommendations such as an integrated coordinated care in patients with the somatic core of SSD.

The significance of this work is to assist clinicians in gaining an in-depth perspective on this complicated relationship between SSD and depression. Improving knowledge of these states could help physicians to deliver better diagnostic and

treatment options. Currently, traditional SSD management addresses primarily somatic profile of SSD (i.e., pain and fatigue), with psychological discomfort overlooked.

The dual nature of SSD and depression forces clinicians to develop treatment plans and interventions specific to each of the conditions, in order to achieve better results and improve quality of life of patients.

Furthermore, an integrated treatment plan may alleviate the health care burden of SSD. Patients who have SSD frequently receive unnecessary medical procedures and tests in an attempt to find a physical cause for their symptoms, further feeding the cycle of anger and frustration, the researchers note. By early identification and intervention in the psychological aspect of illness, there should be less need for high level medical investigations and treatments.

In sum, SSD is a psychiatric disorder related to depression closely, and they interacted with each other in a complex and circular pattern. Depression is a frequently comorbid condition in patients with SSD and may contribute to the severity of somatic symptoms and complicate the diagnoses and treatment. Frequency and severity of depressive disorder in SSD patients must be known for enhancing clinical results. It is hoped that the study will help further refine the understanding of this relationship and equip clinicians to provide integrated care to manage both the somatic and psychological dimensions of SSD. This holistic approach is essential for improving the QOL of patients, as well as health-related outcomes.

LITERATURE REVIEW

SOMATIC SYMPTOMS DISORDER AND DEPRESSIVE SYMPTOMS

Somatic Symptoms Disorder (SSD) is mental health disorder which involves the physical symptoms that lead one to experience severe distress or have an impact on the

individuals functioning. DSM-5 characterizes SSD as somatic symptoms that are not explained away by medical illness or other psychological disorders. These symptoms may include chronic pain, gastrointestinal problems, fatigue, and or dizziness and so forth (American Psychiatric Association, 2013). SSD can be similar to other conditions, like hypochondriasis and conversion disorder, but it differs in the intensity of both the emotional and behavioral reactions to the physical symptoms.

Patients with SSD tend to experience distress in response to symptoms that interfere with their daily activities and their anxiety about the symptoms may be reflected in excessive medical visits, diagnostic tests, and treatments by healthcare professionals (Fava, Mangelli et al., 2010). But interestingly, while these symptoms are genuine and troubling, they don't have any medical pathology at their root cause. Consequently, individuals may receive several unnecessary medical interventions, causing annoyance and further distress.

The SS is following with an important feature concerning the comorbidity with depression. Depression has been reported in as many as 50% of SSD patients (Kroenke et al., 2007). This is a significant problem as depression further amplifies the affective distress associated with somatic symptoms and possibly enhances the experience of somatic symptoms. The severity of depression in SSD patients is variable and it may be mild to moderate or very severe, and in several cases, the depressive symptoms are as much disabling as the somatic symptoms. Although the major depressive syndrome is most commonly reported among SSD patients and is characterized by the following depressive symptoms: sadness or irritability; lack of interest or pleasure; reduced ability to think or concentrate; psychomotor retardation or agitation; fatigue; and sleep and appetite disturbances (Kuehner, 2017).

The association between SSD and depression is two-way traffic: while depression worsens somatic complaints, the chronicity of somatic symptoms can cause emotional symptoms such as hopelessness and helplessness, which are typical of depression. Among other things, those who have chronic pain or fatigue may become more demoralized if they fail to see their symptoms improve, contributing to the emergence or exacerbation of depressive symptoms. Such a scenario represents a vicious circle whereby the 2 disorders reinforce one another, and which makes therapeutic action particularly complex (Kroenke et al., 2007). For that reason, its co-existence should be identified by clinicians at an early stage in order to respond equally to the physical and psychological dimension of the disorder to help in the better treatment of patients.

MECHANISMS FOR COMORBIDITY BETWEEN SSD AND DEPRESSION

The causes of coexistence of SSD and depression are complicated and are associated with the biological and psychological factors. The most common of the theories is the one that there is a shared neurobiological pathway between SSD and depression. For example, abnormal neurotransmitter systems – the serotonin, norepinephrine, and dopamine – have been associated with mood regulation and pain perception (Rosen et al. 2014). This similarity in central action may be responsible for the fact that subjects with depression are more probably referred with somatic complaints and subjects with SSD are more inclined to develop depression.

Furthermore, serotonin is an important mediator in the reward and punishment processing circuits influenced by addictive substances, and it is involved in the regulation of both mood and pain, with disturbances in the system contributing to the

pathology of both depressive disorders and increased sensitivity to physical pain (Rosen et al., 2014).

Psychological factors play a role in the development and continuation of SSD and depression. Those with depression and anxiety are also more likely to have both conditions if they are constantly stressed or emotionally distraught. According to Fava et al. (2010), individuals with SSDL might be more stress sensitive, rendering them more vulnerable for developing depressive symptoms. This enhanced vulnerability might result from an increase in attention to body sensations, that may lead to emotion's reactivity, such as anxiety or frustration. This emotional strain can eventually exacerbate physical symptoms, establishing a vicious cycle between somatic and depressive symptoms.

Moreover, the catastrophizing is often one of the most prominent symptoms among individuals meeting SSD criteria, that is, a cognitive distortion in which individuals interpret their physical symptoms as catastrophic or life threatening, and this is seen as further perpetuating both emotional distress and physical symptoms (Kroenke et al., 2007). This cognitive bias could interact with the development and maintenance of depression, as constant thinking about bodily feelings could cause negative emotions like hopelessness and despair, which are specific symptoms of depression.

Chronicity of SSD may also be of relevance for the risk of depression. The durable presence of such bodily symptoms, particularly when they flare up suddenly and inexplicably, can wear away at the spirit. Patients who are unable to find relief or resolution of their symptoms may continue to regress into a state of helplessness; a state closely associated with depression. Due to the chronicity of SSD symptoms,

hopelessness, self-doubt and frustration, as core facets of depression (Fava et al., 2010), could develop. These emotional states don't just exacerbate depressive symptoms, they also make it harder for patients to cope with their physical symptoms.

CLINICAL RELEVANCE OF CONCURRENT SSD AND DEPRESSION

The presence of SSD with depression has important clinical implications because both disorders are difficult to diagnose and treat. The latency in onset or insidious nature of SSD and depression, is the main difficult in differentially diagnosing of the two conditions. For example, fatigue, lack of concentration, sleep disturbances and bodily complaints occur in both disorders. Failure to systematically assess comorbid but distinct symptoms may lead to the erroneous conclusion that such symptoms belong to SSD per se, depression is overlooked, and treatment opportunities are missed (Kroenke et al.

Addressing somatic and psychological aspects of SSD has important implications for SSD diagnosis and treatment. If the health service provider treats only the physical symptoms of SSD including, for instance, pain and weakness, and fail to understand the emotional side of the patient, it becomes difficult to make the patient feeling emotionally satisfied. Healthcare professionals must also understand that SSD has an emotional component, and they need to help patients to overcome their poor condition as regarding the body and potential treatment.

The treatment of SSD and concurrent depression generally involves psychotherapy, medication, or a combination of the two. Cognitive-behavioral therapy (CBT) is a widespread approach in the treatment of SSD and depression. CBT helps to identify and reframe negative thinking in order for individuals to develop new,

healthier-replacement coping skills and manage emotions more effectively (Fava et al., 2010).

For people with SSD, CBT may be especially beneficial for addressing catastrophic thinking, a frequent cognitive distortion associated with both somatic and depressive symptoms. It diminishes physical and emotional suffering by teaching patients realistic, evidence-based evaluations of their symptoms.

Regarding pharmacotherapy, antidepressants, mainly selective serotonin reuptake inhibitors (SSRIs), are often recommended for treatment of depression in SSD patients. SSRIs exert their effect by elevating serotonin concentration in the brain, treating depression symptoms as well as the possible serotonergic disbalance underneath the somatic symptoms (Rosen et al., 2014). But the response to medicine can be a big difference person to person, some patients responding better to antidepressants than others. Such differences emphasize the need for personally adjusted treatment including not only psychopharmaceutic but also psychotherapy that can meet the individual's demands.

Furthermore, recent studies have indicated that an integrated treatment plan including medical and psychological therapies may represent the optimal intervention for SSD and depression. Focusing on both the somatic and psychological dimensions of the disorder, the clinicians can deliver care that is less partial, and quality of life of the patient can be enhanced (Fava et al., 2010).

METHODOLOGY

This cross-sectional study aims to investigate the prevalence and severity of depression in newly diagnosed patients with SSD. This trial was conducted in Khyber Teaching Hospital, Peshawar, a large medical facility of the region. This study is interesting given

that different type of patients from all ranges of medical and social condition are presented to the hospital and in this way the patients studied reflects the whole population. The study enrolled adult patients visiting the hospital because of somatic symptoms, to obtain a representative set of SSD patients in a hospital. With this hospital as the case, we ensured the availability of a mature patient resource, and could estimate the comorbidities between SSD and depression in a more accurate and stringent mode. The study sample consisted of 200 adult (between 18 and 65 years of age) patients who met the DSM-5 (American Psychiatric Association, 2013) criteria for SSD. Inclusion criteria Patients who were attending Khyber Teaching Hospital for treatment of their somatic symptoms were included. Both male and female patients were specifically depicted to have equal gender composition. The exclusion criteria were proposed to minimize any potential bias in findings. Consequently, patients with previous diagnosis of hypothyroidism, cancer, or any other disorders that were independently expected to influence mood, weight, or the severity of somatic complaints were excluded from the study. These patients have been excluded in order to focus purely on SSD and to attenuate the impact of other medical related variables on the ending point (Kroenke, et al., 2007).

Data from standardized validated instruments and structured clinical interviews were used for the study. The clinical interview elicited information on patients' medical history as well as on the type and duration of their somatic complaints and symptoms of depression by trained medical staff. This qualitative information was more accurate in reflecting the subjective experiences of the patients and hence a more accurate diagnosis. Apart from the clinical interviews, two principal measures were used for assessment of somatic symptoms and depression severity, respectively, in each patient:

Somatic Symptom Disorder-B Criteria Scale (SSD-12) and Beck Depression Inventory (BDI-II).

The SSD-12 is a valid instrument to measure the severity of somatic complaints and how those complaints affect daily life. It is also an appropriate tool for the present study since the PHQ-15 is a widely used instrument that measures somatic symptoms, and is used in clinical and research settings (Kroenke et al., 2007). Depressive Symptoms The BDI-II is a self-report instrument that assesses the severity of depressive symptoms in the individual. Scores on the BDI-II measure emotional, cognitive, and physical symptoms of depression, yielding a global index of the magnitude of depression (Beck et al., 1996). Both instruments have demonstrated good reliability and validity and data collection was reliable and consistent within individuals.

Demographics of the patients (age, sex, and duration of SSD symptoms) were recorded using descriptive statistics. Sample characteristics and trends/patterns in the data were analyzed using descriptive statistics. In addition, the prevalence of depression in the patients with SSD was recorded and the distribution of different degrees of depression (mild, moderate and severe) were also analysed. The relationships between various factors and the presence of depression were tested with the chi-square test. By taking this statistical approach, the authors were able to establish if the gender, age and the onset of having SSD symptoms were significantly associated with developing depression (Fava et al., 2010). Chi-square tests were used to examine demographic and clinical variables that might influence the appearance or severity of depressive symptoms in SSD individuals.

Multivariate regression analysis was conducted to further investigate the predictors of the severity of depression among SSD patients. This advanced statistical technique

allows the inclusion of many variables, which are assumed to affect depression severity simultaneously. For instance, that investigation could investigate whether demonstrated predictor variables (eg, duration of somatic symptoms, sex, or number of physical complaints) indeed predict the severity of depressive disorder. The findings of multivariate regression analysis provide a broader insight into the inter-play of these factors and their integration into the full clinical representation of SSD and depression. Nothing this is even more true in studies of complex and comorbid conditions (e.g., SSD and depression) when important predictors for outcomes may not be revealed through more common statistical analyses (Rosen et al., 2014).

Apart from these major statistical analyses, using the severity of somatic symptoms as a dependent variable and that of depressive symptoms as an independent variable, this study attempted to investigate whether any relationship exists between the severity of somatic symptoms and that of depressive symptoms. It was also expected that the patients who had severe somatic symptoms also would be more likely to have co-occurring depression as the two are closely related. Appreciation of this relationship is of major importance, as it provides a basis for evidence-based treatment plans that target developmental components of SSD. By examining the moderating effect of severity of somatic symptoms on depressive symptoms and depressive symptoms on them, the study can provide the useful knowledge about one disease supporting other with itself, co-morbidity of both, intertwined with each other in sample.

ETHICAL CONSIDERATIONS

Each procedure used in the study was in compliance with the ethical principles. All participants provided informed consent prior to any data collection, after being informed about the research, the procedure, and any risks involved. Participants were

informed about their option to confidentiality and the data was aptly de-identified to secure their privacy. Furthermore, the research was conducted with respect to the rights and safety of participants and was in compliance with the ethical standards established by the authors' Institutional Review Board.

This approach is well-suited to assess depression in SSD patients in terms of frequency and severity. Structured interview and validated instruments used in combination with rigorous statistical analysis make the results of this study reliable and a reflection of the intricate relationship between SSD and depression. The study was conducted on a heterogeneous sample of patients and used robust scientific approaches, and thus, it provides important knowledge on the relationship between SSD and depression, which may enhance clinical decision-making and help in the design of more effective interventions tailored to these patient groups to be suitable for these co-occurring conditions.

RESULTS

PARTICIPANT DEMOGRAPHICS

The sample composed of 200 subjects with a DSM-5 diagnosis of SSD: gender was rather equally distributed between men and women. Out of the 200 respondents, 60% were females and 40% were males. The average age of the recruits was 35.4 years and their ages ranged from 18 to 65. This wide age range permitted inclusion of a heterogeneous patient population and resulted in the opportunity to glean early clues of how, or how differently, SSD and depression may present at various ages.

Regarding SSD symptoms duration, most of the patients (72%) stated that they had been suffering from somatic symptoms for more than a year. This indicates that a substantial portion of the patients in the study could experiencing symptoms in a

prolonged manner that may increase the severity of depression. The other 28% reported symptoms for six months or less. This difference in duration of symptoms would be particularly relevant, because it may inform us on the potential relationship between duration of chronicity in SSD and the presence and severity of depression.

THE PREVALENCE OF DEPRESSION IN SSD PATIENTS

Among the 200 patients with SSD, 55% of them had significant depressive symptoms indicating a BDI-II score of 14 or higher. This result highlights the high rate of depression in SSD. It demonstrates the need to recognize depression as a comorbid diagnosis in SSD and the fact that the presence of depression contributes to the complications of addressing somatic complaints.

The severity of depression was diverse among patients with severe depressive symptoms. Major depression (BDI-II > 29) was found in 25% of patients. This indicates that a large proportion of patients with SSDs have depressive symptoms that are so severe that they affect their daily functioning to a large extent. After excluding depression, mild-to-moderate depression (BDI-II score, $\geqslant$20 to $\leqslant$28) was present in 30% of the sample. This means that nearly one third of SSD sufferers are currently in a condition where they have moderate depressive symptoms. Mild depressive disorder occurred in 45% of the patient sample, with BDI-II scores from 14 to 19. This might indicate as much as, despite depressive symptoms are common among patients with SSD, most of them may not qualify for clinical depression as a major depression.

Curiously, the 45% of participants without clinically significant depression did indeed report low-level depressive symptoms. This result reminds the heterogeneity of depression in patients with SSD; some with no more than mild or subclinical severity of depression, which could exert substantial effect on their overall quality of life.

DETERMINANTS OF DEPRESSION SEVERITY IN SSD SUBJECTS

The associated factors for depression severity among patients with SDD were also investigated. Moreover, there was significant correlation between the duration of somatic symptoms and the severity of depression. In particular, those who had been experiencing SSD symptoms for a longer duration had more severe depression ($p < 0.05$). This result implies that long-lasting somatic symptoms could augment emotional distress, which could result in more severe depressive episodes in patients with SSD. Pain is a well-known contributor to feelings of hopelessness and helplessness, both of which are cardinal features of depression (Fava, 2010).

Furthermore, the severity of depression was found to be higher in female SSD patients. Severe depression was more common in female patients than males, the p-value was 0.02 for the difference which was statistically significant. This is in line with findings of women's greater likelihood of depression and its correlates, which may be due to a combination of brain disease, society, and psychology (Kuehner 2017). This gender discrepancy may suggest that female SSD patients require more specific treatment for somatic symptom and depression.

When a variable for several somatic symptoms (35) (eg, as pains, gastrointestinal problems, fatigue) was added into the analysis, the odds were even higher for those with more severe depressive symptoms. This is consistent with the bidirectional relationship between somatic and depressive symptoms, in which the severity of one symptom is likely to exacerbate the other (Kroenke et al., 2007). For instance, patients with chronic pain or complex symptoms at presentation may feel more 'let down' and 'stuck' than those who do not, the latter potentially serving to compound the type of emotional pain experienced for patients in the setting of a depressive disorder. Also,

presenting with multiple somatic symptoms simultaneously may be less manageable for the patient; resulting more pronounced psychological distress and the severity of depressive disorder.

These findings have crucial implications for identifying the predictors of severity of depression in SSD patients. They suggest that chronicity of SSD symptoms, gender and numerous somatic complaints play a role in patients with these diagnoses with respect to the severity of their depressive disorder. These results may have implications for the assessment of depression severity in patients with SSDs, as well as for the management of such patients, which should also target somatic and psychological components of the disease.

DISCUSSION OF RESULTS

The high prevalence of depression with SSD patients found in the present study was still consistent with other studies that had indicated depression is common among individuals with SSD (Kroenke, Jackson, & Chamberlin, 2007). The heterogeneity of the disorder, several patients have mild depressive symptoms, but often other patients have a severe depression that is striking and with an impact in quality of life, the different severities of depression in the sample.

The above observations highlight the need for a holistic approach of evaluation and management of SSD patients and emphasize interventions that target both the psychological and somatic components of the disorder.

The strong association of time of SSD symptoms duration and its contribution to depression severity implies that long-term somatic distress could lead to severe depression symptoms. This highlights the importance of early intervention to help to care for physical and emotional symptoms before they become severe. Furthermore, the

differences of gender on severity of depression have drawn the attention of treatment that must have a personalized approach and female patients could be a high-risk group for severe depression.

The correlation between a higher number of somatic symptoms and increased depression severity also implies that for patients with a more complex presentation of SSD greater treatment exposure or combinations of treatment may be needed. Understanding and addressing all somatic symptoms and the emotional impact that these symptoms have can likely contribute to alleviating both physical and psychological distress related to the disorder.

DISCUSSION

PREVALENCE OF DEPRESSION AMONG SSD

The present study demonstrates a high burden of depression among patients with SSD with over half of the patients experiencing clinically significant depressive symptoms. This is also consistent with previous studies, showing that the rate of comorbidity of depression and SSD was relatively high (Kroenke et al., 2007). Of particular concern are the high levels of depression in SSD patients, because depression may significantly affect the prognosis of somatic symptoms. Comorbid depression with SSD not only increases the emotional and psychological burden for patients, but also challenges treatment strategies. Two out of four patients were diagnosed as a severe depression type, so when treating SSD patients, clinicians should be cautious and pay attention to somatic symptoms and mood problem. Neglecting to acknowledge the existence of depression can result in suboptimal management, and attending only to the physical symptoms of SSD may cause the emotional distress that is causing the patient to

distress to be overlooked. These results highlight the need for a truly systemic treatment intervention that will have regard to somatic and psychological sides of SSD.

In previous investigations and in line with previous evidence, depression has been found to be one of the most frequently occurring comorbidities in patients with SSD. The affective despair from the experience of the chronicity of physical complaints very often appears in some degree of depression and this conversely. In this respect, it is important that clinicians consider depression as a part of the SSDs and not an isolated SSD in SSDs patients as at least this differentiates these types of patients from the mental disorders whose diagnosis should be excluded according to the DSM-5. This will help clinicians to create more efficient treatment plans that cover the entire spectrum of patient requirements. If successful, it may enhance the mental health and health status of SSD patients.

5.2 Duration of SSD and Depression Longitudinally, both the time-varying covariates showed significant positive associations with the likelihood of depression following the baseline measurement (SSD: HR = 1.30, 95% CI = 1.11, 1.52; depression: HR = 1.32, 95% CI = 1.24, 1.41, for 2-year follow-up).

A crucial discovery in the present study is strong link between the duration of SSD symptoms and severity of depression. As expected, the longer the duration of somatic symptoms, the more severe the depressive symptoms. This makes sense in the context of the existing literature which suggests that chronic pain and continual discomfort can lead to depression; with ongoing physical symptoms causing feelings of helplessness, hopelessness and emotional exhaustion, all recognized symptoms of depression (Fava et al., 2010). The chronic nature of SSD symptoms generates a positive

feedback loop in which persistent physical distress intensifies the depressive mood, whereas the depressive mood increases the insightful sense of somatic symptoms.

The observation that duration of somatic symptoms is a major predictor of depression severity is of capital importance for clinicians. It also implies that the earliest intervention to control SSD may help preclude or attenuate the onset of depression in these patients. Physicians should be aware of the psychological burden of SSD to patients with especially prolonged symptomatic history. Treatments targeting the bio-psychosocial aspects of the disease are probably more promising in the therapeutic management of the patient. For example, cognitive-behavioral therapy (CBT) with medication management for somatic symptoms may be effective in interrupting this pattern of depression and physical suffering.

In addition, knowledge concerning the influence of time spent of depression severity can be useful for clinicians when selecting treatment option according to the duration of the patient's SSD symptoms. Patients with longer durations of SSD might need more intensive or enduring treatment strategies targeting somatic and depressive symptomatology, while more recently developed SSD might be addressed through focused and brief treatments. This individualized approach is critical to maximizing treatment efficacy while improving patient outcomes.

SEX DIFFERENCES IN DEPRESSION

An interesting result of the present study is that female respondents were more frequently depressive than male respondents. This is also consistent with extensive previous research that demonstrated women are more likely to suffer depression than men and that the prevalence difference is especially pronounced in clinical samples, including patients with somatic symptom disorders (Kuehner, 2017). There are a number

of reasons as to why these gender differences may exist; hormonal effects, social roles, and coping techniques.

Biologically, hormonal variations, especially from the menstrual cycle, pregnancy, and menopause, are associated with mood regulation and higher rates of depression in women. Take estrogen: It's been found to affect serotonin, a neurotransmitter that's part of mood regulation and pain perception. This could increase vulnerability of women to symptoms of both depression and somatic problems such as pain that are core to SSD (Rosen et al., 2014).

Furthermore, social and cultural variables have an important impact on the severity of depression related to gender,9394 and this may contribute to the sex differences in depression severity. Women have a tendency to ruminate over problems more often than men, a style of thinking primarily implicated in depression risk (Nolen-Hoeksema, 2012). Furthermore, women might be more likely to present themselves and report emotional distress and be treated for it, and men less likely to recognize and articulate signs of depression. These sociocultural and sex-related confounding factors may account for the higher depression symptoms reported by female SSD patients and argue for specific treatment approaches targeting these risk factors.

One possible reason could be the influence of gender-based sources of stress on women's lives, including gender discrimination, caregiving responsibilities, and societal demands, which might impose extra emotional and psychological stress on women. These are the types of factors that may lead to experiences of stress, frustration and helplessness, and which are all related to both SSD and depression (Kuehner, 2017). Furthermore, it is possible that female patients are more prone to internalize these stressors making them more vulnerable to developing depression.

In the clinic, these differences need to be taken into account through gender-appropriate interventions in the management of SSD and depression. Because of the high prevalence and severity of depression, the female patient more likely would benefit from a gender-based intervention that specifically tends to the biological and psychosocial elements underlying their condition. For instance, interventions with an emphasis on enhancing emotional regulation and coping and the management of somatic aspects could be particularly effective in female patients. Moreover, gaining insight into how gender, in turn, influences the severity of depression may assist clinicians to anticipate issues arising during the treatment process and to increase patient-centered care.

CLINICAL AND RESEARCH IMPLICATIONS

The results of the current study have significant implications for patient and clinical management. As SSD patients have a very high prevalence of depression, it will be important for the providers to screen depression prior to the establishment of the diagnosis and the treatment of SSD. For this, standardized measures like Beck Depression Inventory (BDI-II), which was used in this study to determine the severity of depression, can be applied. Timely recognition of depression in SSDs may provide targeted, integrated interventions that target both somatic as well as the emotional features of the illness.

The strong association between SSD duration and depression severity also implies that early prevention and long-term treatment strategies should be developed in patients with chronic SSD symptoms. A comprehensive intervention strategy taking psychological interventions such as cognitive-behavioral therapy (CBT) and pharmacological treatments such as antidepressants into account may be indicated in

dealing with the bidirectional relationship between somatic and depressive symptom factors.

Further studies may be conducted to further investigate the possible mechanisms underlying the high comorbidity between SSD and depression, in particular, the role of biological and psychosocial factors in gender differences in severity of depression. Large-scale longitudinal studies for following SSD patients might offer further hints for the causal effect of somatic symptoms on depression, as well as early management effect on long-term course. Furthermore, research in gender-specific treatments of SSD and depression might further facilitate clinical practice and patient care.

CONCLUSION

The current study offers solid proof for the high prevalence and multiple grades of depression in the patients diagnosed with (SSD) at Khyber Teaching Hospital Peshawar. More than 50% of the patients with SSD reported clinically significant depressive symptoms; a high proportion of these suffered from severe depressive symptoms. This underscores the importance of being attuned to the somatic and psychological aspects of SSD through which it is experienced by the patients.

The results of the present study substantiate that depression is a common comorbid in SSD. Data in a pretreatment sample have been consistent with such pattern, with the majority of SSD patients suffering from depressive symptoms that muddy the clinical picture (Kroenke et al., 2007). Taking into consideration the high rate of depression in SSD cases, physicians should perform regular screenings for depressive symptoms in patients with somatization symptoms. This whole person approach could assist with clinicians recognizing and treating depression at an early stage and relieve both psychological and physical health issues experienced by people with SSD.

The study also found that the degree of depression was significantly correlated with the duration of SSD symptoms, such that the more the lengthy-durational patients would experience severe depressive symptoms. This is in line with the hypothesis that chronic pain, fatigue, and other enduring physical symptoms might contribute to experiences of helplessness and hopelessness, which are central to depression (Fava et al., 2010). The chronicity of SSD may further tend to feed a vicious circle in which somatic complaints increase depressivity, while on the other hand depression, being present, exacerbates the individual's experience of pain and discomfort. As such, early intervention for both somatic and depressive symptoms may potentially prevent the mutual exacerbation of the disorders.

As well as duration of symptoms, gender difference also had important impact on severity of depression. Severe depression was relatively commoner in female SSD patients than in male SSD patients, corresponding to the more general epidemiological observation that women have greater incidence of depression than men (Kuehner, 2017). These sex disparities may be due to hormonal, social, and coping strategies differences between men and women. Higher levels of depression in female SSD patients may demand more personalized approaches to treatment for these gender specific factors. For example, healthcare providers may specifically have to attend to the psychosocial needs of female patients versus male patients, with attention to the possible impact of social stressors or hormonal variability, and emotional control.

The present study suggests that SSD patients need a full treatment program. Clinicians should not just treat physical symptoms, but also address the psychological distress caused by DSD. Aritso-ag approach involving both medical and psychological treatments is likely to be most helpful.

CBT, which assists patients in cognitively restructuring negative thought processes and learning healthy coping skills, has been beneficial for SSD and depression (Fava et al., 2010). Along with psychotherapy, pharmacotherapy, particularly with antidepressants, including selective serotonin reuptake inhibitors (SSRIs), can be used to treat the depressive aspect of SSD and in turn improve the patients' general quality of living.

In addition, the results of this study highlight the importance for healthcare professionals to be aware of the relationship between somatic and psychological symptoms in patients with SSD in both directions. Interventions should be comprehensive, addressing both the physical and emotional components of the condition. This way you break the chain of symptoms going downhill and you potentially treat SSD patients better. Clinicians need to be aware of the risk of untreated depression on exacerbating somatic symptoms and complicating treatment of SSD. Thus, treating depression with appropriate measures can benefit physical as well as emotional health.

Finally, the high prevalence and severity of depression in SSD patients underscores the need for a more holistic approach to their management. By targeting the somatic and mental aspects of the syndrome, healthcare professionals can offer more efficient treatment to SSD patients and a better state of health. It remains necessary for future research to investigate the intricate association between somatic symptoms and depression, to specifically test and develop integrated treatment models that cover both parts. This will enable in providing patients with SSD the best possible care, to enhance quality of life and reduce the burden of somatic and psychological symptoms.

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