

Editorial

Somatoform disorders—new approaches to classification, conceptualization, and treatment

The importance of somatoform disorders

At least 20% of doctor visits are for somatic symptoms that are not explained by conventionally defined disease (see also Fink, this issue). For many of these patients, the symptoms are disabling and distressing and their management is very costly to health services [1] (see also Hiller, this issue). Somatic symptoms that are not better described by another diagnosis appear in the psychiatric classification as somatoform disorders. Despite their clinical importance, there is still little agreement on the best way of classifying, understanding, and treating the patients who receive these diagnoses.

In February 2002, an international group of clinical scientists working in the area of somatoform disorders meet in Marburg, Germany, to present their research and to discuss new approaches to classification and treatment. This editorial aims to summarize some of the ideas that emerged from “round table” debates at that meeting. Related studies and reviews are also presented in the articles that constitute this special issue of the journal.

Why somatoform disorder?

What do we call the problem?

The term “somatoform disorders” was introduced into the DSM III classification for this purpose [2]. Despite its psychodynamic heritage in relation to the concept of “somatization” and mixture of Latin and Greek, this term does fulfil the requirement of being essentially descriptive. The suffix “form” has frequently been used in psychiatry to describe a state which is close to or which mimics another syndrome or disorder (e.g., schizophreniform). Somatoform hence means like or mimicking a somatic (medical) disorder. However, although having being an official term for over 20 years, the label of “somatoform” remains poorly accepted in most areas of medicine and psychiatry.

Physicians rarely use the term somatoform disorder. Instead, every medical speciality has its own syndrome of “medically unexplained” or “functional” somatic symptoms. Fibromyalgia, irritable bowel syndrome, chronic fatigue syndrome, pelvic pain syndrome, and noncardiac chest pain are just some examples. However, recent evi-

dence suggests that these categories are not as distinct as they initially appear—indeed one may even argue that their similarities are greater than their differences [3]. Therefore, it is clear that a general label for this problem is required. Terms in use include “medically unexplained symptoms,” “functional somatic symptoms,” and “subjective health complaints.” None of these terms are ideal and it could be argued that too much energy has been expended trying to find a term that is perfect. So in the absence of a consensus for change and despite reservations, we continue to use the term somatoform disorders in this review.

How should we classify somatoform disorders?

Most clinicians and researchers working in this area agree that the current approach to classification is inadequate (see also Creed and Barsky, this issue). There is however less agreement on how exactly to change it. The core diagnostic category of the somatoform disorders is somatization disorder. This diagnosis is largely based on simply counting the number of medically unexplained somatic symptoms reported by the patient over their lifetime. This approach has however been criticized as being inadequate in its coverage of the clinical phenomena, implausible in clinical practice, and also as being inherently unreliable [4] (see also Barsky and Creed, this issue).

An alternative is to use an approach similar to that used for disorders such as eating disorders or panic disorder. For these disorders, a wider range of phenomena are included in the diagnostic criteria, including the patients’ beliefs and behavior. In the following, we will describe some of the phenomena that have been observed in somatoform disorders that might provide the basis for such an approach (see Table 1).

Somatic symptoms are the core feature of the problem and must therefore be retained as a criterion. However, determining the degree to which they are regarded as medically unexplained is a more difficult matter—both theoretically and practically. Theoretically, it implies that we can clearly define conditions that “explain” symptoms—a controversial premise. Practically, it means that the diagnosis is one of exclusion. However, despite these shortcomings, most doctors understand and place practical value on this distinction. The core of somatoform disorders

Table 1
Features of somatoform disorders and their relevance for classification

A. The patient suffers from physical symptoms not sufficiently explained by a known medical condition (specify: monosymptomatic–polysymptomatic).

B. A defined number of the following features should be present:

- A tendency to misinterpret bodily perceptions as signs of threatening diseases.
- Inability to tolerate somatic sensations
- Selective attention to physical processes/complaints
- Excessive medical help seeking (abnormal illness behavior)

C. A physiological mechanism may be identified.

D. The condition should be persistent and associated with distress and/or disability.

must therefore remain as somatic complaints unexplained by disease. Such complaints are universal among human beings, and it is therefore necessary to define a threshold for when these symptoms are sufficiently problematic to be regarded as an illness. The conventional approach is to use the additional descriptors of persistence, together with associated distress and/or disability.

In addition to somatic symptoms, patient characteristics that might be considered for inclusion in the case definitions are as follows:

The patient's interpretation of the symptoms

Many patients with somatoform disorders and especially those described as having hypochondriasis manifest a tendency to interpret benign bodily complaints as signs of disease. This is a cognitive phenomenon that can be studied. For example, there is interesting preliminary evidence that patients appear to lack alternative interpretations that normalize the symptoms with anxiety about health as a consequence [5].

Focussing of attention

Another relevant and related cognitive process is the selective focussing of attention onto physiological processes and bodily sensations that one is concerned about. An extreme variation of this behavior is the scanning and checking of body functions seen in hypochondriasis [6].

Inability to tolerate symptoms (sensitization)

Normal sensations such as burning feet after a long walk may be perceived as aversive to the point of intolerability. Somatoform disorders can therefore also be understood as a reduced capacity to tolerate aversive somatic sensations. One process underlying this might be “sensitization” (see Ursin et al., this issue). In turn, sensitization might result from changes in the neurological and psychological processes involved in bodily perception [7].

Illness behavior

As well as interpretations and perceptions, we might wish to include behavior. Mechanic [8] described the

different ways that patients behave when they feel ill—so-called “illness behavior.” This concept was subsequently adapted to describe “abnormal illness behavior” [9]. Abnormal illness behavior was described as including behaviors such as seeking the verification of a medical diagnosis by multiple doctors (“doctor shopping”), urging doctors to do unnecessary investigations, taking unnecessary medication, social withdrawal, inability to go working, and many others [10]. Although individually these features are not specific to somatoform disorders and may occur with any illness, they are an important clinical feature of somatoform disorders.

Pathophysiology

As well as the above psychological processes, there is increasing evidence (see below) that somatoform disorders are associated with disordered biology (see Gaab and Ursin et al., this issue). The proposed classification should be able to capture these biological abnormalities, and we should arguably make greater efforts to measure them in clinical practice [24]. An example is the measurement of hypocapnia in patients whose symptoms are associated with hyperventilation [11].

A broader conceptualization

In keeping with this wider definition, we need a broader conceptualization which requires that important new questions must be addressed.

Should we place more emphasis on researching the biology of somatoform disorders?

Evidence is growing that biological processes contribute to somatoform symptoms [12]. For example, patients with multiple somatic symptoms may also have immunological abnormalities that differ from those of depressives [13], suggesting that depression and somatoform disorders are distinct syndromes. Finally, there are also early results from the use of functional brain imaging to assess cerebral and peripheral processes contributing to the development of physical symptoms [14,15]. These findings highlight the growing realization that somatoform symptoms are not only associated only with cognitive and behavioral features, but also with psychophysiological and psychobiological changes.

Should somatoform disorders be regarded as psychiatric disorders?

Historically, medically unexplained somatic complaints have variously been regarded as either medical or as psychiatric (see Jones, this issue). As somatoform disorders are relevant to all medical disciplines and indeed more frequently seen by nonpsychiatric physicians than by psychiatrists, it

could be argued that they should be placed in a completely new category (e.g., “section U”) in ICD-10 instead of under the F-category of psychiatric disorders. Another completely different and no doubt ambitious approach would be to modify the existing classification to add new axes for behavioral, emotional, and cognitive variables as described above. This might profitably be done for all illnesses.

Somatoform disorders or somatoform health care?

Somatoform disorder is commonly regarded as a problem that patients have. It may also be understood as a problem of the health care system. It is generally accepted that the medical system is heavily biased in its focus on disease. Consequently, the communication between doctors and patients is frequently difficult when patients do not have a clear organic pathology and the management of somatoform symptoms is frequently characterized by an apparent invalidation of the patients’ complaints (e.g., “There is nothing really wrong with you”) [16]. Therefore, our understanding of somatoform disorders must also consider the interaction of the patients with a somatically biased health care system [17].

Somatoform disorders or somatoform culture?

The definition of somatoform disorders has also to take culture into consideration (see Janca and Gureje, this issue). Somatoform disorders are a Western concept with other cultures often not making a distinction between “physical” and “mental” disorders [18].

Somatoform disorders: key stone of the western medical edifice?

Finally, we need to consider the function of somatoform disorders in context of medicine as a whole. Somatoform disorders are often depicted as a marginal, neglected wasteland between the walled citadels of medicine and psychiatry. However, there is an alternative view. Far from being unimportant, somatoform disorders are an essential keystone to maintaining the integrity of both medicine and psychiatry. Hence, it can be argued that the existing disease focussed approach to illness practiced by modern Western medicine can only survive as long as the large numbers of patients whose somatic symptoms are not “explained” by disease are conveniently removed. Similarly, modern psychiatry is based on the concept of psychopathology. That is, patients are assumed to have “mental disease.” Inconvenient for this approach are those patients who present with somatic symptoms not explained by psychopathology. The concept of somatization associated with somatoform disorders performs this function. Hence, somatoform disorders serve both medicine and psychiatry by providing a disposal for the patients who would otherwise challenge the theoretical models upon which practice is based. If this argument is correct, one might predict that the abolition of somatoform disorders would

threaten both medicine and psychiatry; medicine would have to accept that many of its patients are poorly served by a focus on pathologically defined disease, and psychiatry would have to acknowledge that many of their patients are not well served by a focus on psychopathology.

From psychiatric treatment to integrated health care?

Patients with somatoform disorders do not fit easily into either medical or psychiatric services and are often considered treatment-resistant and difficult to help [19]. However, many positive trials of interventions have been published in recent years that show that specialist psychiatric and psychological treatment can help to improve the symptoms and the quality of life of patients with somatoform disorders.

What treatments seem to work?

Most of these trials have used cognitive–behavioral techniques (see Blanchard and Bleichardt, this issue). The disadvantage of cognitive behavior therapy (CBT) is that despite the empirical evidence supporting it, it is infrequently applied in practice. Moreover, the effect sizes of treatments for patients with somatoform disorders are substantially lower than those of treatments for panic or depression, and new approaches to treatments are still required, especially for those with chronic multiple symptoms [20].

There is also evidence for the efficacy of pharmacological therapy. This is mostly for the so-called antidepressant agents, even though these seem to work independent of an effect on depression [21] (see Fallon, this issue). Other potentially more specific agents have also been tried. In Germany, a randomized clinical trial using the drug opipramol has shown some positive effects in patients with multiple somatic symptoms [22]. More research into drug treatments for somatoform disorders is required.

An exciting new development is the attempt to translate specialized CBT treatments for use in primary care. A number of studies that have aimed to train general practitioners in the use of CBT to treat these patients are in progress. While we must await the findings of these, it is already clear that it is possible to adapt psychological approaches so that they are feasible for delivery in primary care [23], and the feed back from those choosing to receive training in these is encouragingly positive.

Where do we go from here?

Training primary care doctors is unlikely to be a sufficient solution to the problem of somatoform disorders—some will also require additional specialist help, whether that is located in primary or secondary care. We argue that the existing specialist “mental health services” are unlikely to provide this. Specialist liaison psychiatry and health psychology services have an important part to play. Arguably, however,

they represent a transitional phase in the move toward a psychologically sophisticated health care system in which psychological assessment and intervention are fully (re)integrated into medical care as it was 100 years ago [24]. Such a development will require not only an increase in the psychological treatment skills of the existing medical and surgical workforce but also an increased awareness and understanding of the psychological impact of medical investigations and procedures themselves.

Summary

In this editorial, we have attempted to highlight some of the threads of argument and discussion that emerged from the conference together with signposts for future research. What needs to be done? The first stage, which is descriptive research making the case for the size importance of the problem, has arguably been achieved. The second stage of developing a logical and clinically meaningful classification (and terminology) is work in progress. The new challenges will be an improved understanding of the biological and social as well as the psychological mechanisms associated with this clinical phenomena and the development of more refined treatments to go with these. The ultimate aim will be the creation of an evidence-based psychologically sophisticated healthcare system that addresses patients' symptoms as systematically as the current system addresses their bodily pathology.

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