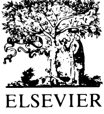

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EDITORAL

SOMATIZATION—FUTURE PERSPECTIVES ON A COMMON PHENOMENON

WINFRIED RIEF* and WOLFGANG HILLER

INTRODUCTION

Somatoform symptoms are among the most common reasons for seeking medical help. According to epidemiological data, between 4% and 5% of the general population suffer from multiple medically unexplained symptoms [1, 2]. Such problems are not only very prominent among adults, but also in children [3]. Despite the medical importance, research on somatoform disorders is less developed than for other mental disorders. This is due in part to their heterogeneity and problems in classification. This means that there is a lack of scientific study of the management and treatment of these patients. To review current approaches and to stimulate further research and clinical developments, an international meeting on somatoform disorders was organized in Prien, Germany, under the cosponsorship of the World Health Organization (WHO). In this editorial, we summarize some impressions of this meeting. Because the presentations and discussions revealed different viewpoints, problems, and proposals for future developments, we will not try to integrate these different views, but instead to outline some of these different approaches and to draw our own conclusions.

CLASSIFICATION OF SOMATOFORM DISORDERS: STATE OF THE ART AND CRITIQUE

Terminology

Before commenting on the classification of somatoform disorders, the terms "somatization" and "somatoform," as well as their conceptual background, need to be considered. Mayou[1] criticized the lack of a commonly accepted definition of this term. Using somatization as an idiom for distress [4] does not seem correct as people can be very distressed without somatoform symptoms, and people can have somatoform symptoms without experiencing high levels of distress. Furthermore, the term somatization may imply the traditional dualism between "psychic" and "organic," although it is evident that these two dimensions are not exclusive. Different

[1] Paper presented at the International Symposium on Somatoform Disorders, Prien, Germany, February 21–23, 1997.

* Department of Psychology, Klinik Roseneck—Centre for Behavioural Medicine, Prien, Germany.
Address correspondence to: Dr. W. Rief, Klinik Roseneck—Centre for Behavioural Medicine, Am Roseneck 6, D-83209 Prien, Germany. Fax: 80-51-683532.

combinations of psychological and physical interactions on well-being are possible (organic disease with strong psychological impact, mental disorder with low physical impact, medical conditions which trigger the exacerbation of somatoform symptoms, etc.). In the case of the diagnostic category of "somatoform disorders," the classification criterion requiring that no medical condition can fully explain the symptoms may be misleading. All somatoform symptoms are accompanied by a variety of central, autonomic, and peripheral physiological changes; they are not "just in mind" but have biological correlates.

Relationship to anxiety and depression

Some investigators have questioned the classification of somatoform symptoms as a discrete Axis I disorder. There is substantial overlap between depressive and anxiety symptoms, adjustment disorder, and symptoms of posttraumatic stress disorder. Particulary in in-patient settings, the rate of comorbidity in patients with somatoform disorders is extremly high [5]. On the other hand, clearly described subgroups with a "pure" symptomatology of somatoform disorders have been identified [6]. Moreover, the natural course of depression or anxiety with its variations is sometimes quite different from the often long-standing and chronic course of somatoform symptoms.

Relationship to personality disorder

It was argued that somatization disorder could be better understood as a personality disorder rather than as an Axis I disorder. Somatization is correlated with personality traits like neuroticism [7] or negative affectivity [8, 9]. The tendency to experience even minor body sensations as disabling and to misinterpret them as threatening symptoms can be interpreted as an enduring personality trait. The early onset of the disorder during childhood or adolescence as well as the persistence and difficulty in influencing the course of the disorder present further evidence for a strong association between somatization disorder and personality disorder [10]. On the other hand, Salkovskis[1] reported that, in patients with social phobia and avoidant personality disorder, the apparent ''personality disorder'' disappears when the social phobia is treated successfully. This points to the possibility that somatization disorder is persistent because of a lack of successful interventions, rather than because it is a personality disorder. There is also strong evidence that somatization symptoms may be a reaction to life events. Kirmayer[1] argued that somatization can be seen as a reaction and not as a disorder entity.

Cross-cultural issues and discrepancies between ICD-10 *and* DSM-IV

The current approach of the American system of *DSM* is strongly oriented toward and influenced by highly developed, ''Western'' culture. Somatoform symptoms, however, are frequent in all cultures. This has clearly been shown in two worldwide somatoform disorders studies launched by the WHO [11–13]. Sartorius,[1] a former director of the Division of Mental Health of the WHO and current president of the World Psychiatric Association, emphasized the necessity of a classification approach that can be used all over the world. *ICD-10* aims to take account of the clinical traditions and culture-specific beliefs of most countries. This leads, how-

ever, to an approach to the classification of somatoform disorders that is widely acceptable, but may lack empirical evidence.

Despite the rather limited knowledge about the disorders, *ICD-10* proposes four subgroups of somatoform disorders that are delineated from dissociative disorders as well as neurasthenia. It may be a disadvantage to have such a diversity of diagnoses without any clear scientific base. As a result of the differing approaches and considerations, there is only insufficient concordance between somatization disorder as diagnosed in *ICD-10* and *DSM-IV* [5, 14]. In a recently published study, we reported concordance rates of kappa=0.53 between somatization disorder diagnosed according to *DSM-IV* and *ICD-10* [5]. This is, however, an optimistic rating that does not take into consideration the *ICD-10* criterion that somatoform autonomic dysfunction may be a diagnosis excluding the diagnosis of somatization disorder. Further examples of discrepancies are shown in the definitions of hypochondriasis: *ICD-10* defines the body dysmorphic disorder as hypochondriasis, whereas *DSM-IV* separates both disorders. Moreover, *ICD-10* requires that patients with hypochondriasis may only anticipate a maximum of two threatening diseases. In sum, *ICD-10* and *DSM-IV* use comparable labels, but differing criteria for somatoform disorders, leading to quite discrepant classification results.

Another example is neurasthenia, which is used infrequently as a diagnosis in North American or European culture, whereas it is one of the most common diagnoses in the area of mental disorders in China. The overlap of *ICD-10* criteria of neurasthenia and somatoform disorders means it is possible to make different diagnoses for the same patient, depending on whether he or she is diagnosed in China or Europe.

There is not only a difference in the frequency of common symptoms between different countries, but also a difference in the meaning of such symptoms as well as in illness belief models. Although Western cultures prefer illness beliefs like viruses or fungus (c.f. the discussion about chronic fatigue syndrome [15]), in India many symptoms are explained as being possessed by a spirit or deity (Chandrashekar[1]). In Japan, other symptoms result from imagined body odor (Ono[1]). Kirmayer[1] stressed the necessity to consider not only symptoms, but also a cultural and anthropological perspective of health beliefs.

Multiple somatoform symptoms

For health care systems, patients with multiple somatoform symptoms represent an important subgroup. The classification systems provide the diagnosis of somatization disorder for the most severe subgroup of this syndrome. Hiller[1] claimed that the rules of classification systems should be empirically based and evaluated. Neither the current criteria for somatization disorder nor proposed alternatives such as SSI-4/6 [1] or ''multisomatoform disorder'' [16] fulfill this criterion. Guze,[1] as one of the conceptual fathers of the modern classification of somatoform disorders, acknowledged that cut-off points for classifying somatization disorder are quite arbitrary. However, he argued that research on ''Briquet syndrome,'' as well as on *DSM-III* "somatization disorder," has proven its usefulness in multiple studies on familial transmission and biological issues. New approaches should first demonstrate a comparable usefulness before the old traditions should be replaced.

Somatization disorder according to *DSM-IV* or *ICD-10* represents, however, only a small portion of the patients presenting to doctors with multiple symptoms. This leads to a high proportion of patients with quite heterogeneous symptoms being classified in the residual group of ‘‘undifferentiated somatoform disorder.’’ A classification system, however, should appropriately describe clinically important phenomena. One criticism of the concept of somatization disorder concerns the core criterion for the diagnosis; that is, the dependence on counting the number of symptoms. Most speakers agreed with Fink[1] [17] that merely counting symptoms is not an appropriate way to assess the severity of a disorder. An alternative would be to consider aspects of disability or reductions in subjective well-being or quality of life caused by the symptoms. Patients suffering from just a few symptoms may be extremely disabled, whereas others with numerous symptoms may continue to work and do well in their social roles. On the other hand, Sartorius[1] indicated that social functioning is culturally defined, whereas the definition of a disorder should apply for most cultures. However, a greater emphasis on disability may be helpful in the definition of somatoform symptoms.

Further features of somatoform disorders

Many speakers at the Prien meeting agreed that, beside the factor disability, additional features of somatization should be used to improve clinical description and classification. Such features include aspects such as abnormal illness behavior [18], catastrophizing misinterpretation of body sensations, health anxiety, focused attention to body signals, illness beliefs, etc. The cognitive features may interact with physiological reactions, which are usually of minor pathological value. However, for more severe medical conditions, the interaction of cognitive and physiological processes may also be of importance. For the understanding of the disorders, the consideration of social and iatrogenic reinforcement can be of major importance. Therefore, the role of health care providers as people who may be iatrogenically exacerbating symptoms and disability should also be emphasized.

Some speakers (cf. Mayou[1] and Salkovskis[1]) suggested that health anxiety may have a fundamental role in the exacerbation or maintenance of somatoform symptoms. It may be useful to replace the stigmatized term ‘‘hypochondriasis’’ by the concept of health anxiety. Health anxiety, however, should not be restricted to a single category, but as a process that may be important for a number of different mental disorders as well as for coping with medical conditions. The categorical approach is valuable for communication purposes in simplifying phenomena that are sometimes better understood as dimensions. Both the dimensional and the categorical approach have advantages.

PROPOSITIONS FOR FUTURE CLASSIFICATION APPROACHES

Although most scientists at the Prien symposium agreed that the current classification systems are far from being ideal, opinions about how to improve the systems diverged substantially. We therefore make proposals, which are our personal views.

The present diversity of diagnoses with regard to the section on somatoform disorders not only hinders the acceptance and usability of the classification system as well as the communication between scientists and the diversification of results, but

may be of little help for changing to an empirically based system. Therefore, we propose the reduction of diagnoses in the section on somatoform disorders to the following subgroups:

(a) A diagnosis for disorders characterized by multiple somatoform symptoms (e.g.,"polysymptomatic somatoform disorder")

For the health care system, this is the most important subgroup. The present diagnosis of somatization disorder, however, covers only a small proportion of these patients. Therefore, there is a need for more inclusive criteria. The proposition by Escobar and Canino [19] of a Somatic Symptom Index (SSI-4/6) is less strictly defined. Although the SSI-4/6 has been used in many scientific investigations, the empirical basis of this proposition is poor. Moreover, it seems to be overinclusive. If symptom counting continues to be one of the core features for diagnosis, there is a need for an empirically derived cut-off point. Such an approach was proposed by Hiller et al. [20] leading to a cut-off point of eight symptoms out of the list of 35 symptoms proposed by *DSM-III-R* somatization disorder. The symptom list, however, should consider more international and multicultural features of the clinical picture. The data of the worldwide WHO study may be helpful to develop such a list of relevant symptoms.

Such a category should allow the specification of subgroups. The current formulations of "somatization disorder" may be maintained as a subtype of this disorder to ensure continuity with earlier results. Further specifications of this subgroup would then allow the description of distinct syndromes like chronic fatigue syndrome, accompanying health anxiety, and so forth.

(b) A diagnosis for patients with only a few, but highly disabling somatoform symptoms (e.g., "specific somatoform disorder")

The use of residual categories to diagnose patients with highly disabling symptoms should be avoided. Therefore, the core feature of this subgroup is disability and not the number of symptoms. Specific subcategories could be described as subtypes (e.g., conversion subtype; perhaps also chronic fatigue subtype, irritable bowel syndrome, etc.).

(c) Pain disorder

Because patients presenting exclusively with pain syndromes are very common, it may be useful to include such a category (e.g., as proposed by *DSM-IV*). However, there is still a need to conduct more descriptive studies about the overlap between pain disorders and (other) somatoform disorders. Perhaps future results would suggest classifying pain disorders merely as a subtype of the category just proposed (syndrome with only few, but highly disabling somatoform symptoms).

(d) Health anxiety disorder

The psychological mechanisms involved in health anxiety can be somewhat different from those involved in other somatization syndromes [6]. Whereas somatization has a high comorbidity rate with depressive disorders [21] there are some studies indicating a close relationship between hypochondriasis and anxiety disorders [22]. The term "hypochondriasis," however, is associated with a strong social

stigma. Therefore, the more neutral term of health anxiety may be more acceptable. A diagnosis of health anxiety could also be used as concomitant condition with physical illness.

(e) A residual category of somatoform disorders NOS (not otherwise specified)

This proposed classification would result in the diagnosis of ''undifferentiated somatoform disorder'' becoming superfluous. We believe that there is no need for two residual categories of somatoform disorders and that the expression is inadequate (i.e., who wants to be undifferentiated?). Moreover, we would like to omit the category of somatoform autonomic dysfunction (SAD) which introduced *ICD-10*. The empirical results support the view that if multiple symptoms are present, they concern all or almost all body sites [5]. It is unlikely that future research will demonstrate that an identifiable subgroup of patients, with symptoms only from autonomic innervated organs, exists. Therefore, a single diagnostic category for persons with multiple somatoform symptoms seems sufficient.

Despite respect for traditions in China and other countries, the diagnosis of neurasthenia should also be omitted. We propose this not because of the label, but because it is unacceptable to have two diagnoses for the same clinical picture. Each nation's translations of the labels allow for consideration of cultural interests; however, international terms should have a high degree of worldwide scientific acceptance.

In all of the diagnostic classes, psychological and psychobiological aspects should be considered more explicitly [17]. Somatosensory amplification [23], catastrophizing minor body experiences, excessive help-seeking behavior, seeking reassurance, psychobiological properties [24], demoralization, and reductions in subjective well-being and social functioning may be just some examples of features that may be used to define a somatoform disorder.

In sum, the new classification approach just outlined above may help to clarify and facilitate the acceptance of the concept of somatoform disorders. Our proposals should not be regarded as final, but as a starting point to test proposed criteria, cut-off scores, etc., within scientific studies and to enhance the validity of the proposed diagnostic rules.

MANAGEMENT OF SOMATOFORM DISORDERS

With regard to the extraordinary relevance for the health care system, there is a major need for the treatment of a large number of patients. The few approaches proposed for the management of patients with somatoform disorders may be divided into three categories according to the proposed setting. Following the needs of the health care system, this section is not limited to the treatment of patients with somatoform disorders, but is concerned with patients with the whole range of medically unexplained symptoms.

Management by primary care physicians

Primary care physicians will continue to be the first address for those seeking help. Rost and Smith[1] (see also Smith et al. [25]) developed educational training for

primary care physicians. In their studies, they demonstrated that such training led to a reduction of treatment costs.

Psychological interventions

Other investigators have proposed highly elaborate out-patient treatment programs that may be conducted by professionals trained in psychological treatment (e.g., Salkovskis[1] or Barsky et al. [26] for hypochondriasis; Sharpe[1] for chronic fatigue syndrome). A disadvantage of these approaches is that they cannot be undertaken within the time limitations of a GP practice; therefore, for the vast number of patients with somatoform disorders, these treatments may be too expensive.

Integrated treatment programs

A subgroup of severely disabled patients cannot be treated successfully by the current methods (severely disabled patients with highly chronified somatization disorder and comorbid problems). For these patients, in some countries, highly specialized in-patient treatment settings have been developed. Rief and Hiller[1] described German "psychosomatic hospitals" in which interdisciplinary teams consisting of internists, psychiatrists, clinical psychologists, social workers, nurses, and others work together in integrated and intensive treatment programs.

Psychopharmacological treatment

Finally, in all three settings described (GPs, out-patient psychological or psychiatric intervention, in-patient setting) psychopharmacological treatment may be an option. However, the scientific evidence for pharmacological treatment of patients with somatoform disorders is poor (Volz[1]; see also Volz et al. [27]).

CONCLUSION

A generally agreed-upon conceptual framework and terminology is lacking for somatoform disorders. This hinders not only the research, but is confusing for medical colleagues and for the general public. Therefore, in the present article, we propose possible conceptual and diagnostic developments.

The development of treatment strategies should follow a cascade model of intervention. First, we need programs to improve primary care not only for financial reasons, but in order to prevent chronicity and improve subjective well-being. The development of specific out-patient treatment programs as the second stage in treatment (e.g., cognitive-behavioral interventions) is just beginning (e.g., see Speckens et al. [28]).

We will have to consider the significant proportion of patients with high chronicity, severe comorbidity with physical conditions, and/or severe disability, especially in the subgroup of patients with multiple somatoform symptoms. For these patients, a third step of interdisciplinary treatment may be helpful. We believe that the German psychosomatic in-patient treatment units may also be a model for specialist out-patient clinics. Furthermore, in all of the three settings described, it may also be useful to counsel the families in a subgroup of the patients. This may help to reduce risk factors like the reinforcement of illness behavior [29].

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