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2.10

Does the Somatoform Disorder Approach Broaden Our Perspective on Pain?Wolfgang Hiller¹ and Paul Nilges¹

Despite decades of intensive pain research, a surprisingly large number of questions relating to the diagnosis, aetiology, and treatment of chronic pain are still unanswered. Many mysteries continue to rank around this complex phenomenon. In the face of the immense number of people suffering from chronic pain conditions, it would be irresponsible not stepping up efforts to search for the causes and determinants of chronic pain, develop valid

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diagnoses and diagnostic tools, and improve treatment methods. Steven King's comprehensive review is clear in working out the limitations of our knowledge.

Some aspects may complicate research and clinical management of chronic pain patients. The field is interdisciplinary by nature, with anaesthesiology, neurology and psychiatry as the major groups of somatic medicine involved. Essential contributions, however, come from psychology and cognitive-behavioural science. Almost all diagnostic methods to assess pain and associated features are psychometric. The psychological treatments, all aiming to change the patients' perceptions, interpretations, and behaviours, are well developed. Their high standard as evidence-based treatments is documented through recent reviews of the Cochrane Collaboration [1, 2]. It will be important in future to investigate how psychological processes are associated with brain functioning. Modern neuroimaging techniques have already allowed new insights as to where and how pain signals are processed within the brain [3].

The subsumption of pain under the main chapter of somatoform disorders is a contentious issue. Somatoform symptoms are defined as "medically unexplained", but is often difficult or even impossible to decide whether or not a specified pain is due to medical disease or clear pathobiological mechanisms. Diagnostic uncertainty is common. Excessive diagnostic procedures, however, may lead to an overestimation of pathology. Hald *et al.* [4] demonstrated, in a large population sample of healthy and pain-free men between 17 and 25 years, that less than 5% had no demonstrable X-ray pathology of the spine. Why was the remaining majority free of complaints that would have corresponded to the somatic findings? On the other hand, there is evidence that the prevalence of post-surgery pain is frequently underestimated [5]. These examples demonstrate that the mechanisms leading to enduring and physically unclear pain are not yet understood.

Pain symptoms are very typical and frequent in patients who suffer from multiple unclear symptoms in different regions of the body [6]. An obvious advantage of the somatoform disorder approach seems to lie in its broader perspective. Pain is not seen as an isolated symptom. It is rather considered under a common perspective with many other possible somatic symptoms, which may have a common origin or similar underlying mechanisms. There are good reasons to expect that research on somatoform disorders will enrich our knowledge about pain. It seems to be of significance to differentiate between disorders characterized by pain alone, and those with pain embedded into a larger number of different non-pain physical symptoms. For example, Hiller *et al.* [7] found that pain patients with additional multiple somatoform symptoms had higher levels of affective and sensoric pain sensations as well as more pain-related disabilities. They were also less successful during treatment to reduce their pain-related depression and anxiety.

This confirms that general principles of symptom perception and evaluation might play a central role in these patients, rather than specific reactions typical only for pain.

Cognitive-behavioural models of somatoform disorders try to describe how perceptions of bodily discomfort are developed and maintained. One valuable contribution is Barsky's notion of somatosensory amplification [8], assuming that individuals may be predisposed to experience somatic and visceral sensations as intense, noxious, and disturbing. It is likely that such disposition enhances the development and maintenance of many pain complaints. Another example of relevant research is a study by Rief *et al.* [9] who identified a set of characteristic cognitions in patients with unclear somatic symptoms, such as the catastrophizing of physical perceptions ("bodily complaints are always a sign of disease"), a low tolerance of bodily discomfort ("if something is wrong with my bodily sensations, it upsets me at once"), or a negative attitude towards the body ("I am physically rather weak and sensitive"). Pain complaints may be accompanied by a large variety of illness behaviours. These may include persistent efforts to verify a positive medical diagnosis, the expression of symptoms in the presence of others, or the use of unnecessary medication in order to affirm the self-perception of being physically sick [10]. The types of illness behaviours found in patients with somatoform and pain disorders are almost identical. Such similarities of chronic pain and somatoform disorders will hopefully lead to more stringent research and clinical practice in the future.

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2.11

Diagnosis and Treatment of Pain: Consultation-Liaison Psychiatry AspectsAlbert Diefenbacher¹

Pain is a complex experience that involves both physical and mental components [1]. Though it is a common condition, it seems that physicians often feel uncomfortable in helping patients, especially those suffering from chronic pain. As King points out, this may lead to multiple physician contacts and many unproductive diagnostic procedures. Reasons for that may lie in the lack of adequate training with regard to pain issues during medical school and residency [2], and in the failure to pay adequate attention to the multifaceted aspects of communication between physicians and other staff and patients: up to 50% of patients are critical of the communication aspects of their hospital care [3]. In addition, there is noticeable overlap of pain states with psychiatric morbidity.

This commentary will discuss issues of psychiatric service delivery in the treatment of pain syndromes under the perspective of consultation-liaison (C-L) psychiatry.

Despite the well-known comorbidity of psychiatric disorders with pain syndromes, psychiatrists usually are called very late in the diagnostic and treatment process of pain patients. This is not a specific feature of pain patients, but a well-known phenomenon in C-L psychiatry. Obviously, somatic physicians use to apply their own specialist portfolio of knowledge first, and only call on additional psychiatric support once their usual armamentarium fails to succeed. This attitude may contribute to longer lengths of stay in hospitals of patients with somatic-psychic comorbidity [4, 5].

It has been argued that the most widely used form of co-operation between somatic physicians and psychiatrists, consultation psychiatry proper, does not lead to a sufficient number of referrals and often takes place late in the treatment process, as somatic physicians may not recognize the necessity and usefulness of an additional psychiatric perspective, and may discourage patients who think that a referral to a psychiatrist after other treatment efforts failed is equivalent to being abandoned and being declared as "being

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