

Don't change a winning horse

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Introduction

There is surprising excitement about the adequacy and future of the somatoform disorders (SFDs) as a circumscribed diagnostic group [1–4]. Some authors wish to take the forthcoming fifth revision of the *Diagnostic and Statistical Manual (DSM)* as a welcome occasion to remove an unloved diagnostic term. However, eliminating the SFDs would devalue the progress of research and clinical practice made during the past 25 years. It would lead to insecurity and confusion in an interdisciplinary field where clear terminology and common understanding is of high value. This contribution attempts to summarize some of the major reasons why *DSM-V* should continue with the SFDs. Some suggestions will be made on how to improve and refine the current system.

Advantages of the current classification

Diagnostic categories are indispensable

Symptoms, syndromes, and diagnoses represent three separate diagnostic levels. The term “medically unexplained somatic symptoms” refers to the symptom level. A group of characteristic symptoms constitutes a syndrome. For example, low mood, loss of energy, sleep disturbance, concentration difficulties, and related symptoms constitute a depressive syndrome. Analogously, a group of coexisting medically unexplained (somatoform) symptoms can be considered a somatoform syndrome. Diagnoses go one step further and add inclusion and exclusion criteria, minimum duration, or severity definitions (e.g., in terms of psychosocial impairment). Therefore, a description on symptom level cannot replace a diagnosis. The presence of symptoms does

not necessarily imply that the person also fulfills the criteria of a diagnosis.

“Somatoform” is an ideal term to label medically unexplained somatic symptoms

The term “somatoform” communicates that the clinical condition initially suggests the existence of a somatic disease that is, however, afterward ruled out through appropriate medical examination. Only the outer appearance and not the real existence of somatic disease is indicated. Comparable examples from the field of the mental disorders are “maniform” (manic symptomatology not sufficient to fulfill the criteria of a manic or hypomanic episode) and “schizophreniform” (typical symptoms of schizophrenia but not persistent enough). The term “somatoform disorder” can be explained easily to patients and is not associated with negative stigma.

SFD should be considered as a mental disorder and not as a somatic disease

The core feature of the SFDs is the absence of a known organic disease that could explain the somatic symptoms. There is ample evidence that psychological factors such as perception, cognition, and illness behavior play a central role (see, e.g., Barsky's somatosensory amplification). It is not decisive whether or not patients see or accept these psychological factors. It may be the result of good treatment that patients are able to acknowledge the psychophysiological dimension of their complaints. Behavioral treatments currently belong to the most important and best validated therapies for patients with SFDs [5]. Since usual somatic treatment is of limited value, primary care physicians are trained how to react to the patients'

emotional and behavioral problems. Cognitive–behavioral approaches follow the same principles as for typical mental disorders such as depression, anxiety disorders, eating disorders, substance dependence, and so on. Therefore, the mental disorders classification is the appropriate place for the SFDs. By definition, SFD is not a somatic disease, just as *DSM* is not a classification system for somatic diseases.

A primarily descriptive classification is adequate

Clinical research aims to understand the causes and pathogenetic mechanisms of a clinical condition. However, the etiology of the SFDs is still unresolved despite increasing research during the past decades. Although there is evidence that biological as well as psychological and social factors interact and contribute to the development of “unexplained” somatic symptoms, a common etiological pathway has not been found. It is consequential to restrict the definition of the SFDs to descriptive features and avoid speculative etiological assumptions. It must be emphasized that we have an identical situation for most of the other mental disorders (*DSM-IV* includes etiological criteria only for very few disorders: mental disorders caused by a general medical condition, substance-induced disorders, adjustment disorder, and posttraumatic stress disorder).

Suggestions to improve the SFDs

A number of weaknesses with the current diagnostic labels and criteria have been described in the literature. Many of these criticisms are justified and should be resolved in the future. The following are some suggestions that could be considered by *DSM-V*.

All clinical presentations can be reduced to three major forms of SFDs

Many authors agree that the manifestations of somatoform symptomatology can be reduced to three principal forms: (i) polysymptomatic, that is, patients presenting with multiple symptoms from different organ systems; (ii) monosymptomatic, that is, those with only one type of symptoms (such as pain); and (iii) hypochondriacal, that is, those with strong fears and convictions to have a serious disease. While poly- and monosymptomatic presentations exclude each other, hypochondriasis may be present either alone or additive (people may or may not react with strong health anxieties to their somatic symptoms). Different subtypes could be defined for the monosymptomatic group: pain type, gastrointestinal type (e.g., irritable bowel syndrome), cardiac type (e.g., noncardiac chest pain), neurological type (e.g., motor disorders or sensory loss), or fatigue type (e.g., chronic fatigue syndrome).

The restrictive somatization disorder should be broadened

This category covers only the most severe cases. There should be a well-defined second category beneath the severity level of somatization disorder for polysymptomatic presentations. Suggestions made in the literature were “abridged somatization disorder,” “Somatic Symptom Index” with at least 4/6 or 8 symptoms, or “multisomatoform disorder.” The current category of undifferentiated SFD is not defined precisely enough. It should be given up because of the vague meaning of the term “undifferentiated.”

Symptom lists should be comprehensive enough

Any unexplained physical symptom may constitute the basis of an SFD, whether or not it is on a given symptom list. Although some symptoms are rare, they may be of high importance for the individual and thus of high diagnostic relevance. Symptom lists have been proven to be valuable for systematic diagnostic examination (e.g., when using diagnostic interviews such as the SCID) or for the construction of questionnaires [6]. If symptom lists are too short (such as for ICD-10 somatization disorder), there is a risk that patients are erroneously not recognized as somatoform if they have other symptoms than those on the list.

Symptoms should be judged for severity

When diagnosing SFDs, physical symptoms should be considered only if they are of clinical significance. Unclear bodily complaints are very common in the general population and not necessarily associated with distress or impairment. A good solution is provided by the diagnostic interview procedures (e.g., SCID and CIDI): Patients are asked whether they took medication, visited a doctor, or changed their lifestyle because of a particular symptom. If all three points are negated, the particular symptom is not of clinical relevance. This decision rule could be included into the classification system to distinguish clinical from sub-clinical symptoms.

Subtypes to be differentiated

The various facets of the SFDs could be taken into account by defining subtypes. For example, SFD may or may not be associated with excessive illness behavior (“high utilizers” of medical care). The status of the disorder may be acute or chronic. The finding that there is no adequate physical cause of the symptoms may be refused or accepted by the patient. Subtypes such as “with illness behavior,” “chronic,” or “low acceptance of psychophysiological factors” could serve as a tool to define more homogeneous groups without enlarging the number of diagnostic categories. Specifications have been useful for many other *DSM* diagnoses (e.g., melancholic type of major depressive disorder and subtypes of schizophrenia).

Conclusions

The forthcoming *DSM-V* is a chance to improve the SFD classification. Past and ongoing discussions show that different experts agree on a number of weaknesses that became apparent since the introduction of the SFDs in 1980. Some of these problems can be resolved (e.g., number and type of categories and single diagnostic criteria), while others must stay open (e.g., etiology). Simply giving up the name does not improve our incomplete knowledge about the nature of disorders characterized by somatic symptoms not related to organic disease. Eliminating the SFDs from the classification of mental disorder would ignore the progress achieved from the fields of psychiatry, behavioral medicine, and clinical psychology during the past years. These disciplines aim to integrate biological, psychological, and social aspects to enhance our understanding of clinical phenomena. This is exactly where research on the SFDs must continue.

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