

Why DSM-III Was Right to Introduce the Concept of Somatoform Disorders

WOLFGANG HILLER
WINFRIED RIEF

An interesting debate about the adequacy of the somatoform disorders as a diagnostic and clinical concept has begun. The debate is stimulated by the announcement of APA's preparation of DSM-V, which is likely to follow DSM-IV as the world's most influential classification system for defining the terminology and diagnostic definitions of mental disorders. Because unexplained physical symptoms are extremely frequent and are associated with enormous economic burdens, adequate recognition, classification, and treatment are crucial. Different viewpoints for their classification may arise from different scientific positions but also from particular national, cultural, and professional traditions.

In a recent editorial in *Psychosomatics* by Mayou et al.,¹ the specific viewpoint of British consultation-liaison psychiatrists was expressed. The expertise of consultation-liaison psychiatrists in this field is plausible since the work of these colleagues provides the link between medicine and mental health, either for patients who are both medically and mentally ill or for those whose somatic symptoms are not attributable to a known medical disease. Mayou et al. make no secret of their disagreement with the current overall concept of somatoform disorders. Among others, their criticisms are with the following points:

1. They view the somatoform disorders as a "speculative category" for which sufficient validity is still to be proved.
2. They see "no clear reason why psychological reactions to functional symptoms are classified in a different manner to psychological reactions to physical disease."
3. They regret that the current terminology is not well accepted by medical and primary care colleagues.
4. They see the current concept as an "essentially dualist definition" in terms of physical or psychological alternative etiologies.
5. They question the reliability, validity, and utility of the

categories hypochondriasis and body dysmorphic disorder.

6. They miss "psychological criteria" for the categories relating to somatic symptoms, such as somatization disorder.

In all, their suggestions are in favor of a "radical change" by giving up the somatoform disorders as a common main category and diagnosing medically unexplained somatic symptoms under axis III (general medical conditions).

We agree with Mayou et al. that changes in diagnostic concepts should be based on sound empirical evidence. This seems to be the primary and declared aim of the revision process leading to DSM-V. However, having extensively worked in the field of somatoform disorders during the past 15 years, we are concerned that giving up this concept would ignore the large progress made in diagnosing and treating patients with these conditions. In fact, we believe that the introduction of the somatoform disorders in 1980 (DSM-III) has stimulated research and new clinical developments much stronger than any traditional concept in the pre-DSM-III decades. Therefore, we have to realize that future changes can lead to improvements, but there is also a risk of stepping back to this area before DSM-III.

One important aspect of the DSM-III category of somatoform disorders was the abolition of organ-specific diagnoses for functional syndromes (former category 306, called "physiological malfunctioning arising from mental factors," with the subcategories musculoskeletal, respiratory, cardiovascular, skin, etc.). This was certainly an im-

From the Psychological Institute, University of Mainz; and the Psychological Institute, University of Marburg, Marburg, Germany. Address correspondence and reprint requests to Dr. Hiller, Psychological Institute, University of Mainz, Staudingerweg 9, D-55099 Mainz, Germany; hiller@mail.uni-mainz.de (e-mail).

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portant step because empirical studies showed that many of these patients present single symptoms to their doctors, but a comprehensive diagnostic process reveals that the overlap between symptom profiles from different systems is substantial. Organ-specific diagnoses may therefore tell more about the doctor's speciality than about the patient's syndromes.²

Critics of DSM-IV sometimes seem to forget that its predecessor, DSM-III, represented enormous progress in defining and classifying mental disorders. DSM-III succeeded in overcoming a severe crisis in psychiatric diagnosis that had begun in the 1950s. Several studies had been showing that traditional diagnoses were hopelessly unreliable, their scientific value being close to zero. The complete reorganization of definitions and diagnoses through the Feighner Criteria in 1972, the Research Diagnostic Criteria, and finally DSM-III were the scientific answers. For the first time, researchers and clinicians had a common and accepted language to describe their patient groups.

The somatoform disorders were defined in the beginning and were not only a result of these developments. Diagnostic criteria for patients suffering from multiple unexplained somatic symptoms were among the first steps toward the general principle of operationalized diagnosis. Perley and Guze³ used modern statistical methods to analyze Briquet's syndrome and defined a list of bodily symptoms as well as other characteristics to serve as criteria for an objective and reliable diagnosis. Briquet's syndrome had been derived from hysteria and was later renamed somatization disorder. Many studies published in the 1960s/1970s evaluated etiological factors and course characteristics of this disorder. Its integration into DSM-III was a consequent step and thus far from "speculative." A category defined by multiple somatic symptoms from different organ systems is still valuable from today's perspective to differentiate this (polysymptomatic) clinical picture from (monosymptomatic) patients with only one type of symptoms or symptoms only in one organ (for example, patients with only gastrointestinal symptoms).

The relevance of the somatoform disorders concept cannot be discussed without emphasizing the interdisciplinary nature of this field. Although psychiatrists are involved as part of consultation-liaison services or when a severe "classical" psychiatric disorder such as depression is present as a comorbid condition, patients with medically unexplained somatic symptoms usually do not seek psychiatric or psychological help. It is mainly the task of general practitioners or other medical specialists to motivate these patients and refer them to mental health profession-

als. In Germany and many other countries, such specialized clinical management and treatment programs have been developed with good success. They are mostly provided by clinical psychologists or physicians for psychosomatic medicine, either as part of the tertiary care system or through psychotherapeutic treatment in private practices. The concept of somatoform disorders has been most valuable to establish these new treatments that have a clear focus on the patients' somatic complaints.^{4,5}

It is essential for good communication between different health professionals that terminology and diagnostic terms are well defined. We agree with Mayou et al. that our current definitions of the somatoform disorders need to be improved. However, it would be a step back beyond DSM-III to abolish a separate diagnostic category or circumscribed diagnoses. The clinical picture of unexplained somatic symptoms and associated psychological factors represents a disorder similar to many other disorders, defined by symptoms, a syndrome (cluster of symptoms), and other accompanying criteria, such as type of onset, course, degree of severity, and characteristics delimiting the disorder from other disorders. Since unexplained bodily complaints are extremely common in the population, we need tools to differentiate normal from clinically relevant conditions. Checking the criteria for a diagnosis is a good way to reach this goal. A variety of instruments with high psychometric standards are available and demonstrate the circumscribed nature of the somatoform disorders.^{6,7}

As frequently expressed in critical comments, a major source of dissatisfaction with DSM-IV lies in the mainly descriptive approach to this system. Almost all criteria are constructed by psychopathological or psychological signs and symptoms. On the other hand, clinicians (as well as patients) frequently want definitions that also "explain" the disorders. This is especially true for the somatoform disorders with "unexplained" symptoms as their main feature. A large variety of more or less speculative etiological hypotheses have been proposed, ranging from somatization as "somatic expression of psychological distress" to biological abnormalities. However, no single mechanism, either alone or in combination with other mechanisms, can be shown with our current research methods to cause somatoform symptoms. Instead, it is obvious that many different pathways exist, and etiological factors interact in a highly complex way. This situation is not different from almost all other mental disorders. Therefore, it has been a wise decision for DSM-III not to include questionable etiologies in its classification systems. Criteria of unproven evidence, such as the "psychological" etiologies demanded

by Mayou et al., would therefore limit the acceptance of a diagnosis as a common platform.

In sum, the situation is not as bad as the article by Mayou et al. emphasizes. Based on the descriptive approach used in multiple studies, there seem to be four major types of clinical presentations that should be reflected by diagnoses under the generic term of “somatoform disorders”:

1. Patients suffering from multiple symptoms in different parts of the body (polysymptomatic)
2. Those suffering from only one type of complaint or symptom in only one organ system (monosymptomatic)
3. Those with health anxieties and disease convictions as the prominent feature (hypochondriasis)
4. Those who are inadequately concerned with aspects of the outer appearance of their body (body dysmorphic disorder)

The first two types are primarily based on the presence of medically unexplained somatic symptoms, whereas specific emotional and cognitive variables are the core symptoms of hypochondriasis and body dysmorphic disorder. The differentiation of monosymptomatic and polysymptomatic is necessary because different studies have shown that the prognosis for course and outcome is worse if multiple symptoms exist.⁸ According to the comorbidity principle, the categories do not have to exclude each other, except that poly- and monosymptomatic somatoform disorder cannot coexist by definition. Moreover, these categories could also be used in combination with organic syndromes. Further studies provide empirical evidence supporting the diagnostic concept just outlined.^{9,10}

We also express our concerns about ideological debates on terminology. In our opinion, the term “somatoform” is a practical solution. It simply means that patients have symptoms suggesting the presence of a medical disease that cannot be verified through medical tests (somatoform = the form, not the identity, of somatic disease). We

never had difficulties explaining this meaning to medical colleagues or patients. The term “functional disorder” is also useful because it implies that the proper functioning of an organ or system, not the organ itself, is disturbed. However, today’s scientific literature is linked much more to the terminology of the somatoform disorders. The “functional disorders” had been part of the former DSM-II and ICD-8/9 classifications, but little research was done in that period, and the empirical evidence for disturbed organ functions as a general principle in somatoform disorders remained weak. The expression “medically unexplained somatic symptoms” should not be confused with a diagnostic term. Rather, it describes the symptoms that can also be called “somatization symptoms” or “somatoform symptoms” without making a difference. “Hypochondriasis” is a traditional diagnosis, although it may provoke misunderstandings in everyday language. A less stigmatizing term could be “health anxiety disorder.”

The exciting discussion about the right shape of DSM-V and the somatoform disorders will continue, and we are sure that many more suggestions will follow. Although it is foreseeable that particular interests or even political goals will influence this process, we hope that scientific evidence will be accepted as the most important yardstick. Thanks to the diagnostic basis provided by DSM-III, our knowledge about important diagnostic subgroups of somatoform disorders, the diagnostic value of single symptoms and cutoff scores, behavioral and cognitive features, and associations with health care use has substantially improved. In particular, for the category of the somatoform disorders, the participation not only of consultation-liaison psychiatrists in discussing the modifications of DSM-V but also of other medical specialities and experts of behavioral medicine and psychosomatics is required. These fields will continue to contribute substantial research and clinical developments, and an acceptance of these diagnoses in all medical fields is essential. A disintegration of terminology and diagnostic concepts is an unfortunate hurdle for further progress that will only be achievable through interdisciplinary efforts.

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