Dear Editor:

Somatoform disorders, first introduced as such in DSM-III, are a controversial category, and the concept of comorbidity seems to play an essential role in this controversy [1–3]. Presentation of depressive disorder or other psychological distress by medical symptoms is common in many cultures [4] as established in research in several countries and health care settings, and it has been established that depressed patients indeed do not feel well physically. This somatic presentation negatively influences recognition of the depressive disorder or other mental disorder by the general practitioner, which results in undertreatment of a majority of patients. Although comorbidity between somatoform disorders, mood disorders, and anxiety disorders is high [2,5,6], it is not handled as an uniform criterion in the heterogeneous set of somatoform disorders assembled as such in the DSM-IV. In some somatoform disorders, including pain disorder, hypochondriasis, body dysmorphic disorder, and the undifferentiated type, DSM-IV specifies the presence of a comorbid mental disorder as an exclusion criterion. In contrast, it does not do so for conversion disorder, somatization disorder, or somatoform disorder not otherwise specified. Furthermore, the exclusion criterion that is specified—that the symptoms are not better accounted for by the comorbidity than by the somatoform disorder itself—is difficult to apply in clinical practice. The question has been raised if not comorbidity, but co-syndromality is the case for depressive, anxiety, and somatoform disorder. Cosyndromality is the phenomenon that a symptom spectrum has physical as well as psychological symptoms that are classified in different syndromes that are nevertheless of similar kin [7]. An increasing literature on the Diagnostic Criteria for Psychosomatic Research (DCPR) has attempted to better capture the essential diagnostic issues in such patients, which can be useful in cases where anxiety and depression do not account for the symptomatology of functional disorders [8]. However, the need to redefine the concept of somatoform disorders in DSM-V is broadly felt, and in this letter, we would like to suggest a contribution to the discussion by focusing on reformulation of the concept of somatoform disorder in DSM-V.

Several authors have suggested the whole category of Somatoform disorders in DSM-V be scrapped. As an alternative, these authors suggest either physical illness with psychological factors be recorded on Axis I or functional physical symptoms on Axis III [9]. Otherwise, “physical symptom disorder” has been suggested by the Conceptual Issues in Somatoform and Similar Disorders Work Group to replace somatization disorder, undifferen-

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classification as the V-code “medical symptoms or medical illness with non compliance to treatment” in Axis I, with mentioning of the symptoms in Axis III. In the case of somatization disorder, we suggest classification as the V-code “multisymptomatic medically unexplained symptoms with non-compliance to treatment” in Axis I, with mentioning of the symptoms in Axis III. As can be seen, somatization disorder is thus removed, conversion disorder is moved to the dissociative disorders section, and body dysmorphic disorder, to the Anxiety Disorders section; in this letter, we focus on the comorbidity-related issues.

In summary, the decision to abolish the category of somatoform disorders as such and to compel clinicians to classify somatic symptom presentation as a behavioral feature of cosyndromal depressive or anxiety disorder or as noncompliance to treatment on Axis I is supported by a vast body of research and would offer a positive criterion for classification as well as clues for treatment that are badly needed in the clinical management of these patients.

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References

The proposed diagnosis of somatic symptom disorders in DSM-V: replace somatoform disorders in DSM-IV---A preliminary report

Author’s response to letters from Shröder and van der Feltz-Cornelis

We are pleased that the authors of these letters appreciate our efforts to be open regarding the proposed changes to the diagnostic criteria of the Somatoform Disorders chapter of DSM-IV [1,2]. It is gratifying also that they concur with our impression that the DSM-IV chapter needs extensive modification and they have made valuable contributions to the debate regarding these criteria. We agree with the suggestion in both letters that we should avoid the unhelpful terms ‘somatoform’ and ‘medically unexplained.’

Schröder and Fink [1] comment on the three criteria that have been proposed for the comprehensive diagnosis, provisionally entitled “Complex Somatic Symptom Disorder.” With regard to the first criterion point, we note their concern that the draft description, as provided in our article, seemed to give undue emphasis to matters such as patients’ difficulty coping with, and tolerating, physical discomfort. As a result of this and other feedback, we are likely to modify this section. What we are striving for is a description of the disorder that is precise and unambiguous.

We do respect the knowledge and experience of clinicians treating patients with “severe and chronic functional symptoms and somatization disorder,” but our proposed definition must define a much broader group of patients than this, including those seen frequently in primary care. Population surveys are therefore relevant, but we read the evidence differently from Schröder and Fink [1]. We do not interpret existing evidence as indicating that medically unexplained symptom clusters into gastrointestinal, cardiopulmonary, and musculoskeletal clusters “with specific neurobiological disturbances underlying these clusters.” Schröder and Fink [1] quote their own study in this respect together with several others in Table 1, but they omit three other important studies [3–5] all of which found evidence for a single factor underlying a large number of symptoms. Both the study of Deary [6] and a systematic review concluded that the data do not provide convincing support for a consistent picture of the clustering of somatic symptoms [7]. We believe therefore that it is premature to conclude that clusters of symptoms with specific underlying neurobiological disturbances can be used to build a diagnostic scheme. By proposing a single, inclusive diagnosis of complex somatic symptoms, we aim, in this section of DSM-V, to allow future research to test whether particular patterns of symptoms are indeed supported by epidemiological research and whether these are found to have biological substrates. We guard against making premature subdivisions which may limit the usefulness of future research.

The same approach would prevent us from accepting the evidence provided by Schröder and Fink [1] that health anxiety should be defined as a separate category from that primarily representing numerous bodily symptoms. We regard this as a premature conclusion as, once again, the evidence of overlap between numerous bodily symptoms and health anxiety is very considerable, up to 60% according to one study [7] and nearly 50% in Fink’s own study [8].

With regard to our third criterion, increased pattern of health care use, Schröder and Fink [1] reject this as a basis for making a diagnosis. In their view, the “evidence is unequivocal” that the Health System as a whole and the doctor/patient consultation in particular assume an important role in the initiation and maintenance of so-called medically unexplained symptoms.” They think therefore that it is wrong to blame the patient for what they regard as shortcomings in the health care system and doctor’s lack of communication skills. The workgroup accepts the evidence that there are difficulties in some doctor–patient encounters for the patients in this group and we have been exploring ways of operationalizing the unsatisfactory nature of the utilization.

In their letter, van der Feltz-Cornelis and van Balkom [2] support the suggestion, previously made by Mayou et al. [9], that the whole category of somatoform disorders be scrapped. They suggest (a) that the majority of patients previously diagnosed as “somatoform disorder” could be encompassed in the diagnoses of depressive or anxiety disorder and (b) that these latter diagnoses could be enhanced by subcategories indicating that the depression or anxiety is accompanied by pain, somatic presentations, or hypochondriacal worries.