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CONCEPT OF SOMATOFORM DISORDER

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Patients presenting with bodily symptoms and complaints that are not sufficiently explained by organic pathology or well known pathophysiological mechanisms present a major challenge to any health delivery system. From a perspective of psychiatric classification these medically unexplained somatic symptoms may be diagnosed as primary psychiatric disorders such as depressive and anxiety disorders on the one hand, as somatoform disorders on the other. Among medical specialties a separate diagnostic approach is taken to conceptualize functional somatic syndromes. Unfortunately, both diagnostic systems do not conform to each other very well.

The concept of somatoform disorders as outlined in DSM-III to DSM-IV-TR and in ICD-10 refers to a group of heterogeneous disorders with prominent somatic symptoms or special body-focussed anxieties, or convictions of illness. These disorders seem to indicate medical conditions that cannot, however, fully be explained either in terms of medical diagnostics or of other primary psychiatric disorders. There is one major conceptual assumption that postulates a decisive impact of psychosocial stress on the origin, onset and/or course of these somatic symptoms and complaints. And there is one major path of diagnostic steps to be taken, i.e. just to count the number of medically unexplained somatic symptoms, to determine their reference to any main organ system, to prove that they are not self-induced, to put special stress on prevailing pain symptoms and to separately assess dominant health anxieties or illness convictions.

Since introduction of the diagnostic concept of somatoform disorders there have been arising many critical issues regarding the soundness of this diagnostic category. These issues, among other things, refer to a problematic mind-body dichotomy overemphasizing psychosocial and psychological factors and neglecting major neurobiological processes, to the impracticable criterion of “medically unexplained”, to the demand of conceptual clarity and coherence of this diagnostic category, to the rather trivial diagnostic procedure of just counting the number of medically unexplained somatic symptoms whereas not assessing typical dimensions of illness behaviour in a corresponding way, to the major overlap between subgroups of somatoform disorders on the one hand and factitious disorders, anxiety disorders and depressive disorders on the other, to a principal focus on the epidemiologically rare condition of somatisation disorder as core disorder thereby undervaluing much more prevalent subthreshold conditions, to the difficult communication of the whole diagnostic group to medical colleagues dealing with the same problems by using a different conceptual approach, however.

These critical issues surrounding the concept of somatoform disorder will be reflected in respect of some major revisions projected in future diagnostic classification systems of DSM-V and ICD-11.

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