British Journal of Psychiatry (1994), **164,** 562–567

Correspondence

Contents: Somatisation in general practice/Declining incidence of schizophrenia/Maintenance therapy for schizophreniform disorder/Onset of the antidepressant effect of ECT/Psychosis and cannabis/Nasal decongestant and psychiatric disturbance.

Somatisation in general practice

SIR: In describing the natural history of 'acute' somatisation in general practice, Craig *et al* (*BJP*, November 1993, **163,** 579–588) address the least well understood aspect of this phenomenon. However, I would like to raise two concerns about the method of this study. Firstly, despite their concern to improve upon the least defensible criterion used by Bridges & Goldberg (1985), the authors omitted to describe their own method for assessing subjects' symptom attributions, arguably the *sine qua non* of somatisation (Lloyd, 1986). Secondly, although ostensibly a longitudinal study of the course of somatisation, it would appear that outcome data were ascertained retrospectively, from interviews two years after the index consultation. If so, such data would have been highly susceptible to both subject and observer bias.

While those working in secondary care prefer to define somatisation as "persistent consultation for medically unexplained somatic symptoms" (Creed *et al*, 1992), primary-care researchers conceptualise somatisation as "the somatic presentation of psychiatric disorder" (Bridges & Goldberg, 1985). This difference reflects the diversity of clinical phenomena subsumed within a single term (Kirmayer & Robbins, 1991), and the complex relationship between physical and psychiatric morbidity. As Craig *et al* point out, there is little evidence that the forms of somatisation seen in primary and secondary care are indeed part of a single spectrum. Nevertheless, these authors share the commonly held assumption that 'functional' somatic complaints can be distinguished from those which reflect 'genuine' organic pathology. Despite independently rating the likely 'organicity' of subjects' somatic symptoms, it was disappointing that (once again) no attempt was made to validate such judgements prospectively.

By concentrating on "one rather narrow view" of somatisation, Craig *et al* may have lost sight of the most important issue in the primary care of psychiatric disorder. The presentation of somatic symptoms by the majority of patients with psychiatric morbidity results in low rates of psychiatric case detection by general practitioners, and contributes to prolonged morbidity, inappropriate (and costly) use of health service resources, and iatrogenic illness (Murphy, 1989). Craig *et al* found that only 44 out of 1220 consecutive attenders (3.6%) met their criteria for incident cases of somatisation. The practical implications of their findings are unclear, particularly since ten times this proportion (34.6%) were identified as probable cases of psychiatric morbidity using the General Health Questionnaire, of whom as many as two-thirds were likely to have presented only somatic symptoms to their doctor.

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SIR: With respect, I suggest that further pursuit of the concept of 'somatisation' is not worth the money or effort, because, like earlier obfuscatory labels, it offers no help to doctors who have the task of treating sick and suffering people.

Lipsitt (1973) described hypochondriasis as "a diagnosis in search of a disease", and added "our persistence in trying to retain such terms may lead not only to further inappropriate application ... but worse to a stifling of investigations into complex conditions". However, by that time Parsons (1951) had added another term – in "the sick role", soon to be quoted by aspiring *cognoscenti* at scientific meetings as the latest in advanced thinking. "Illness behaviour" cam next, coined by Mechanic in 1968, and "abnormal illness behaviour" followed (Pilowsky, 1969). Mayou's warning in 1986 was therefore wholly justified when