Somatization: Syndromes or Processes?

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The accompanying paper [1] is Robert Kellner's last, published posthumously. In it, he provides a scholarly review of a number of psychosomatic syndromes, discussed in further detail in his recent book [2]. As Weiner [3] has commented, such 'reviews of the state of knowledge in a field illuminate the gaps in its fabric: they highlight what still needs to be accomplished'.

Kellner's review elegantly demonstrates the problems with existing diagnostic classifications in psychosomatic medicine. While evidence is presented supporting the validity of the disorders reviewed, there are clearly also problems with the existing nosology. Although current research shows considerable differences between syndromes (one prerequisite of any useful classification), Kellner reminds us that such differences are deceptive, for two main reasons. First, there is considerable heterogeneity within syndromes. Secondly, within individuals, presenting symptoms might have different causes over time. Also, it is difficult to distinguish somatizing patients from others on the basis of their presenting symptoms alone [4].

One response to this diagnostic conundrum is to reject the need to reach a diagnosis, as a putative means of fostering an holistic approach to the individual's problems. Such a stance has been rightly criticized [5] because it

severely limits attempts to reach a more complete understanding of the aetiology and prognosis of psychosomatic syndromes. It is worth remembering that similar arguments were applied only a few years ago to the diagnosis of schizophrenia [6]. The opposite response to such difficulties in achieving accurate diagnosis is illustrated by the development of the diagnosis of Briquet's syndrome. Detailed and restrictive criteria were applied [7] and validated by follow-up and family studies [8]. Such an approach may well be valuable in research, but might be less useful in everyday clinical practice [9], where the prevalence of such 'pure' syndromes is low, and most patients present in ways which fall outside the definition of the syndrome. The DSM and ICD 10 classifications illustrate another approach, namely the classification of syndromes by operational definitions or diagnostic guidelines. However, it may be extremely difficult (as Kellner states) to classify a given symptom within the somatoform disorders of DSM-III-R. Perhaps this is not as surprising as it might seem. The DSM classification is descriptive and atheoretical [10]. Such a classification works most effectively when the operational criteria (or, more accurately, semantic criteria [6]) happen to define syndromes which can be distinguished also in their aetiology and prognosis. As Kellner's review illus-

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trates, this does not apply to the somatoform disorders. It is easy to see how DSM can therefore provide diagnoses of the psychosomatic syndromes which are reliable (because of the explicit criteria for each diagnosis) but possibly of dubious validity.

Kellner offers some evidence for the novel suggestion that in people who present with psychosomatic disorders, psychosomatic syndromes tend to cluster together. Little evidence is available, because of the strong tendency among researchers in psychosomatic medicine to confine their attention exclusively to one or another particular syndrome [11]. However, this view implies that it might be helpful to focus attention more on the mechanisms underlying the psychosomatic syndromes than on the syndromes themselves.

Numerous factors are identified by Kellner which could influence presentation with psychosomatic symptoms in individual cases. These include physiological factors, psychiatric disorders (notably anxiety or depression), heightened perception of bodily sensations, selective attention to such sensations or symptoms, and lowered pain threshold. To this list should be added personality disorder, and influences due to family and culture. Presentation with psychosomatic symptoms, or unexplained somatic symptoms, is associated with personality disorder [12, 13]. Personality disorder is also associated with transient hypo-chondriasis among patients attending medical outpatient clinics [14], probably via a predisposition to amplify benign bodily sensations [15]. There are strong social and cultural influences on somatization [16,17]. Surprisingly little work has been done on ways in which families might influence the development of somatization. If a parent is predisposed to attribute bodily complaints to a pathological cause [18], it is easy to see how this could affect their child's behaviour, and foster the development of somatoform complaints in adulthood.

A further factor in somatization, as yet poorly characterized, is the relationship between patient and doctor. It is intriguing that, uncommonly among psychiatric disorders, the somatoform disorders can sometimes be managed by an intervention aimed exclusively at the doctor rather than the patient [19-21]. The importance of the doctor-patient relationship in somatization is underlined in some of the definitions of somatization quoted by Kellner which include help-seeking, and is probably best exemplified by the concept of abnormal illness behaviour [22]. Perhaps it will be possible eventually to characterize individual psychosomatic syndromes according to the rigorous criteria applied to Briquet's syndrome. The debate is likely to continue on the choice of this as an appropriate goal, and on the prospects of success in pursuing it. In the meantime, in view of the multiplicity of diverse mechanisms underlying somatization, it might be helpful to classify individual cases not merely according to presenting symptoms (with or without psychiatric disorder) but in terms of the contributions of these factors in individual cases. This idea is not new. Kellner himself elaborated it [23]. It is implicit in his own Illness Attitude Scales [24], and also in the components of Pilowsky's abnormal illness behaviour [5].

Formulating individual cases in terms of the relative contribution to the patient's presentation of the mechanisms above may not answer fully the vexed question why an individual develops syndrome A and not syndrome B. However, such an approach may be more helpful in everyday clinical practice than the pursuit of every more closely defined syndromes, and will at least allow the wider application of available biological [25] and psychological interventions [26-30] targetted not at psychosomatic syndromes but at the processes underlying them.

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