Diagnostic Criteria and Classification in Psychosomatic Research

I.	Pilowsky
----	----------

Department of Psychiatry, University of Adelaide, Adelaide, Australia

I. Pilowsky, The University of Adelaide, Department of Psychiatry, Adelaide 5000 (Australia)

The purpose of classification is to facilitate communication. In the clinical context it means that, instead of describing individual patients in great detail, it is possible to convey relevant information with only a few words. This, of course, only brings those exchanging clinical data to a starting point where they are looking in the same general direction rather than in completely different directions. This is a significant achievement for a classification or taxonomy. It is no criticism of a physician's diagnosis of 'mitral stenosis' to say that as far as the therapeutic decision-making process is concerned it is of limited help until one knows how tight the stenosis is, how calcified the valve, the state of the myocardium and the cardiovascular system as a whole, not to mention the patient's age and existence of any comorbidity.

In other words categorical diagnosis sets the stage for a dimensional evaluation.

Despite the effort which has gone into the production of the new multi-axial criterion-based classifications, namely DSM-IV and ICD-10, which are tools for clinical communication and research representing an enormous advance over what was available before, they have not provided as many benefits for psychiatrists working in general hospitals as they would have wished for.

Recently an international group of general hospital psychiatrists have collaborated to produce diagnostic criteria for use in psychosomatic research [1]. They advance the view that it will make more sense to think in terms of 'psychosomatic syndromes' to 'emphasize the varieties of associated somatic and mental responses that individuals offer to life situations'. The syndromes for which they have chosen to suggest criteria are Alexithymia, Type A behaviour, Abnormal illness behaviour (disease phobia, thanatophobia, health anxiety, illness denial), Functional somatic symptoms secondary to a psychiatric disorder, Persistent somatisation, Conversion symptoms, Anniversary reaction, Irritable mood and Demoralization.

Before commenting on individual syndromes I wish to make the general point that this seems to be a move in the right direction. I recall that my first reaction to DSM-III was a highly critical one, but that my second was delight at having something that it was worth being critical about, unlike the previous situation when there was nothing to 'get one's teeth into'. Indeed I was even prepared to put up with the term 'somatoform' which I felt told us a great deal about psychiatry's self-concept and its status within medicine as a whole. I wondered why physicians had not felt the need to coin the term 'psychotoform' to describe syndromes which presented as though they were psychiatric problems but turned out to be somatic conditions!

I will now comment on some of the individual syndromes. I expressed my thoughts about the concept of alexithymia in a previous paper. It seems to me that if one is to identify this syndrome in an individual it should be on the basis of simple operational criteria which do not assume the

existence of normative information which is not available to most clinicians – such as the most ‘appropriate words to describe emotions’ (Criterion A [1]) especially when taking sociocultural factors into consideration. The inclusion of the specifiers ‘pervasive’ and ‘situational’ seems a good idea and makes sense clinically. It is also worth bearing in mind that thinking and language become more concrete i.e. less abstract in stressful circumstances such as talking to a doctor or being in hospital. The concept of alexithymia awaits the attention of sociologists and sociolinguists to establish how context-dependent the behaviour is (e.g. do these patients have difficulty conversing with their relatives and friends because of this hypothetical impediment?). I previously suggested [2] that in the interim we might be better off using terms such as somatologia and thymologia, meaning, respectively, that the patient uses a predominantly somatic vocabulary or a predominantly psychological one. Presumably there will be use for a mixed

KAHGER

E-Mail karger < karger@karger.ch Fax + 41 61 306 12 34 <http://www.karger.ch>

© 1996 S. Karger AG, Basel 0033-3190/96/0653-0115\$10.00/0

or intermediate category. I am not proposing this in place of the criteria suggested, possibly it could be used in parallel. But I do think it is important to record whether or not the interviewer and the patient share the same sociocultural background and, if not, how far apart they are. In the case of Abnormal illness behaviour criteria are offered for various elements or presentations of this phenomenon. The role of medical reassurance is mentioned in Disease phobia and Illness denial, where there is an inadequate response and in Health anxiety, where at least the immediate response is good. This is clearly a difficult criterion to assess and implies that a definitive diagnosis cannot be made with confidence after only one interview. A way around this may be to accept a provisional diagnosis after the first interview based purely on the patient’s subjective experiences, with the final diagnostic decision being postponed until the response to medical information can be fully appraised. Neither DSM-IV nor ICD-10 seem to have properly resolved this issue although both mention the lack of response to medical reassurance, but in different ways. Thus ICD-10 regards this as a feature of somatoform disorders in general and specifically in the somatization and hypochondriacal disorders. [Conversion disorders are placed with the Dissociative (conversion) disorders]. In DSM-IV this criterion is listed only for hypochondriacal disorders.

Another significant difference between ICD-10 and DSM-IV concerns the issue of psychogenic aetiological factors. The descriptive approach adopted for DSM-III was stated to be ‘atheoretical with regard to aetiology or pathophysiological process except for those disorders for which this [was] well established and therefore included in the definition of the disorder’ [p 7]. Thus the presence of aetiologically significant psychological factors was a criterion in the case of conversion disorders and what were then known as Psychogenic pain disorders. This criterion has been retained in DSM-IV for both Conversion disorders and what are now known as Pain disorders.

The question of psychogenic aetiological factors has been elaborated on in ICD-10 in a significant way. In the volume dedicated to clinical descriptions and diagnostic guidelines, the following passage is to be found in the description of the somatoform disorders:

Even when the onset and continuation of the symptoms bear a close relationship with unpleasant life events or with difficulties or conflicts, the patient usually resists attempts to discuss the possibility of psychological causation; this may even be the case in the presence of obvious

depressive and anxiety symptoms. The degree of understanding, either physical or psychological, that can be achieved is often disappointing and frustrating for both patient and doctor. This feature of somatoform disorders does not appear in any diagnostic guidelines or criteria, although the non-response to medical reassurance is among the criteria for somatization disorders and hypochondriacal disorders. Thus ICD-10 recognizes the salience of this aspect of the doctor-patient interaction in these diagnoses but has been unable to find a way of incorporating it into the diagnostic process. Certainly it is not easy to think of another condition where diagnosis is so much a process – an integral part of the doctor-patient relationship [3]. Establishing criteria for this diagnosis is, therefore, bound to be difficult since it demands so much of the doctor in terms of appropriate behaviour. For this reason alone it is worth persevering. Perhaps it will be possible to take some steps in this direction during the field trials since one of the criteria for conversion symptoms (B2) states that there is ‘precipitation of symptoms by psychological stress, the association of which the patient is unaware’.

There is some empirical evidence indicating that the attitude towards the possibility of non-physical explanations for one’s illness does discriminate between patients with a physical illness and pain clinic patients where there is considerable uncertainty as to the presence of a somatic process capable of accounting for the amount of pain and disability the patient is suffering. It is the patients with the established physical illness who are more likely to accept that non-physical factors are of importance in their illness [4].

The other syndrome on which I would like to make a specific comment is ‘anniversary reaction’. The criteria as presented do not take into account a feature often encountered clinically. I refer to the situation when a child with whom the patient is very much identified reaches the age when the patient experienced severe psychological traumas associated, perhaps, with the sorts of events described in criterion C. This is certainly an association of which patients are rarely aware.

References 1 Fava GA, Freyberger HJ, Bech P, Christodoulou G, Sensky T, Theorell T, Wise TN: Diagnostic criteria for use in psychosomatic research. *Psychother Psychosom* 1995;63:1-8.

Pilowsky I: Abnormal Illness Behaviour. *Psychother Psychosom* 1986;46:76-84.

Pilowsky I: Low back pain and illness behaviour (inappropriate, maladaptive, or abnormal). *Spine* 1995;20:1522-1524.

Pilowsky I, Bassett D, Barrett R, Petrovic L, Minniti R: The illness behaviour assessment schedule: Reliability and validity. *Int J Psychiatry Med* 1983;13:11-28.