A Two-Year Follow-Up Study of Patients With Somatoform Disorders

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Thirty inpatients with multiple somatoform symptoms admitted to a psychosomatic hospital were diagnosed using the Structured Clinical Interview for DSM-III-R and questionnaires. Two years later, a reexamination by interview and a follow-up questionnaire took place. The authors found high comorbidity rates not only for affective disorders (lifetime 86%), but also for anxiety disorders (lifetime 43%). Comorbidity is of high prognostic relevance: whereas patients with only somatoform disorders at first assessment may remit until second assessment, in those patients with comorbidity with other psychiatric disorders, some somatoform symptoms still remain. The rate of misdiagnosed organic disorders is estimated at lower than 10%.

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The roots of the classification of somatic complaints without sufficient organic etiology go back to the concept of hysteria. The first attempt at a descriptive diagnosis of these symptoms was undertaken by Briquet in 1859.[1] As early as in the middle of the 19th century, Briquet described possible symptoms of the disorder, the strong association with depressive symptoms, the possible influence of life events, and the overproportional rate of patients from lower socioeconomic classes. Guze[2,3] continued the development of Briquet's hysteria syndrome, which has been called "somatization disorder" in DSM-III. This is the prototype of somatoform disorders, but the definition criteria are very restrictive. Patients must have 13 out of a list of 35 somatoform symptoms; the disorder must begin before the age of 30; symptoms must not occur only during panic attacks; and the symptoms must lead to doctor visits, medications, or lifestyle alterations.

Because of this restrictive definition, there is a low prevalence[4] of somatization disorder, which does not reflect the high prevalence of somatizing patients seen in today's health care system. Therefore, Escobar et al.[5] propose a new class for patients with multiple somatoform symptoms, the "abridged somatization disorder," or SSI-4/6. To reach the criteria for this class, male patients must have 4 and female patients must have 6 somatoform symptoms out of the list of 35 symptoms for somatization disorder. This new concept has already been used in some newer studies, which found a diagnostic class between somatization disorder and undifferentiated somatoform disorder to be useful, because patients with SSI-4/6 have nearly the same comorbidity patterns and reductions of life quality as patients with somatization disorder.[6,7]

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In the past, many authors have warned against misdiagnosing organic disorders with labels such as hysteria or conversion.[8–10] These authors usually refer to a well-known study of Slater and Glithero,[11] who reassessed 85 patients with the diagnosis of hysteria 9 years later. In their study, the diagnosis of hysteria was abandoned for 33% of the patients because organic explanations of the somatic complaints were later found. Although the results of some other studies imply that the rates of misdiagnoses found by Slater and Glithero[11] are not representative,[12–17] their work is important because it stresses the necessity of intensive search for possible organic causes of "hysterical symptoms."

None of the follow-up studies cited earlier used either the operationalized approach of somatoform disorders, according to DSM-III (or DSM-III-R), or structured interviews for the diagnostic process. Therefore, it is questionable how stable the diagnosis of somatoform disorder, according to DSM-III-R, was. There is a lack of information about the course of disorders with multiple somatoform symptoms, but which do not fulfill the criteria of somatization disorder. A second point of interest concerns the stability of comorbidity patterns of patients with somatoform disorders. Following these topics, we examined the course of patients who had been diagnosed by structured clinical interviews as "somatoform disordered." This interview was repeated 2 years later, and questionnaires were also used at the second assessment.

METHODS

The study took place at a psychosomatic hospital in Germany. These kinds of hospitals for mental and psychosomatic disorders are part of the general health care system. Public and private coverages are accepted. As a result, a wide spectrum of patients from all socioeconomic classes is represented. In 1991, 1,300 persons were hospital inpatients, with a median age of 41 years and a gender ratio of 71% female:29% male. Forty-three percent of all inpatients had not attended high school, 43% had a history of another inpatient treatment, and 49% had a history of outpatient psychotherapy. Most patients were referred by their family physicians (70%), but some were referred by their psychiatrists (27%) or internists (2%).

Psychodiagnostic Instruments

Mental disorders were assessed with the Structured Clinical Interview for DSM-III-R (SCID).[18] This interview covers most psychiatric diagnoses by specific questions concerning the diagnostic criteria. By use of this instrument, reliable and valid diagnoses can be reached.

For the present study, an important self-rating scale was used: the Screening for Somatoform Symptoms (SOMS)[19] (Appendix). This instrument checks for the presence of the 35 somatic symptoms relevant for somatization disorder, according to DSM-III-R. Items 36–42 concern further somatic symptoms, which may also be present in anxiety disorders or affective disorders (e.g., trembling, loss of appetite, or chronic fatigue). All symptoms without organic pathologies that have been present for the last 2 years should be marked. Further items (43–52) represent inclusion and exclusion criteria for subgroups of somatoform disorders. As possible variables, the positive symptom scores for items 1–35 (somatization index) and for items 1–42 (symptoms total) were computed. Earlier studies demonstrated good internal consistency for the scale (Cronbach's α 0.85; for men 0.87; for women 0.84 for the somatization index). Also, an investigation of the self-rating scale with a group of inpatients ($n = 51$) shows a good 72-hour retest reliability for this score ($R_{tt} = 0.85$). As already published,[20] the SCID confirmed a diagnosis of somatoform disorders for 30 of 41 patients with elevated scores on the SOMS (73%). Six of the 11 "misdiagnosed" patients had multiple somatic symptoms that were attributable to anxiety disorders; this points to a possible weakness of the instrument in differentiating somatic symptoms of somatoform disorders and somatic symptoms of anxiety disorders.

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