Searching for a Gastrointestinal Subgroup Within the Somatoform Disorders

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The authors examined whether patients suffering from functional gastrointestinal symptoms constitute a separate group within the broader concept of the somatoform disorders. The authors compared 103 patients with a severe gastrointestinal syndrome, 220 patients with a somatization syndrome according to DSM-IV, and 250 clinical control subjects with nonsomatoform mental disorders. The gastrointestinal group showed more catastrophizing thinking, complained more about autonomic sensations, felt bodily weaker, was less tolerant towards bodily discomfort, had developed more hypochondriacal fears and behaviors, was more depressed, and was more severely disabled in different areas of psychosocial functioning than the other groups. These differences, however, disappeared when general somatization was controlled for by analysis of covariance. Only a small effect related to dysfunctional cognitions remained specific to the gastrointestinal syndrome. Because these results do not confirm the idea of an independent gastrointestinal syndrome, general mechanisms of somatization seem to play the dominant role.

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There is broad scientific and clinical agreement about the somatoform disorders as a well-defined and valid clinical group. Somatizing patients present with physical symptoms for which no sufficient organic pathology can be found. Recent research has identified additional characteristics that distinguish somatoform disorders from other psychopathologies such as affective or anxiety disorders. Somatizing patients are more concerned with hypochondriacal fears of suffering from a serious illness,[1] tend to frequently visit doctors and other health specialists,[2] and perceive themselves as weak and disabled.[3] Serious psychosocial disabilities were also demonstrated for several subgroups of the somatoform disorders, especially when combined with major depression.[4]

Despite such common features, it is unclear whether the somatoform disorders should be seen as a homogeneous category or whether specific subforms must be differentiated. Traditional viewpoints are reflected by our current classification systems. The DSM-IV[5] differentiates between one polysymptomatic and two monosymptomatic disorders. Somatization disorder is the polysymptomatic condition because multiple physical symptoms from different sites of the body are required for this diagnosis. The monosymptomatic disorders are pain disorder for syndromes with pain as the dominant clinical feature, and conversion disorder for patients whose complaints are restricted to medically unexplained neurological symptoms. A similar approach has been taken by the ICD-10.[6] Other distinguishable syndromes such as functional gastrointestinal disorder and irritable bowel syndrome,[7] noncardiac chest pain,[8] tinnitus,[9] chronic fatigue syndrome,[10] or multiple chemical sensitivities[11] are potential candidates for

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further subgroups of the somatoform disorders in the future, but empirical findings about the relationship among these specific syndromes and the general framework of the somatoform disorders are still needed. Hypochondriacal disorder is somewhat different from the disorders mentioned above because it primarily refers to anxious beliefs and inappropriate convictions of being seriously ill.

Therefore, we evaluated the role of functional gastrointestinal symptoms from the perspective of the somatoform disorders. Most researchers consider medically unclear gastrointestinal dysfunctions as a more or less isolated disorder and interpret associations with symptoms of mental disorders as a problem of comorbidity.[12] Several studies have demonstrated that gastrointestinal dysfunctions such as irritable bowel syndrome are related to increased visceral sensitivity and altered bowel motility,[7] high levels of emotional distress,[13,14] and psychosocial impairments.[15] Similar results were found for patients with somatoform disorders. In addition, Rief et al.[3] reported in a recent study that somatizing patients tend to catastrophize benign bodily sensations as harmful and threatening, leading to inadequate beliefs about one's own physical functioning and health. It is not known whether this pattern of negative cognitions is typical also for functional gastrointestinal disorders.

We address the following questions in our study. How close are functional gastrointestinal symptoms associated with other medically unexplained symptoms? Do gastrointestinal patients show similar patterns of dysfunctional cognitions concerning bodily functioning and health beliefs than patients with a more general somatization syndrome? Are differences in psychopathology and psychosocial impairment better predicted by gastrointestinal symptoms or by general somatization?

METHODS

The Patient Sample

We collected data on gastrointestinal and general somatoform symptomatology from a sample of 751 patients who were selected from consecutive first contacts of treatment candidates at a center for behavioral medicine. Of those selected, 480 (63.9%) were women and 271 (36.1%) men. The sample's mean ± SD age was 45.7 ± 10.7 years, with a range from 17 to 76 years. Of these, 554 patients (72.5%) reported bodily symptoms for which their doctors had not found evidence of organic causes. Of these 554 patients, 348 (62.8%) were women and 206 (37.2%) were men, with a mean ± SD age of 44.9 ± 10.5 years within the range from 18 to 74 years. All patients gave their written informed consent to participate in our study.

The Center for Behavioral Medicine

All patients had been referred to the Roseneck Center of Behavioral Medicine. This research-oriented inpatient unit is affiliated with the medical faculty of the University of Munich. It is open to patients of all social and vocational levels. Indications for treatment are all mental and psychophysiological disorders except schizophrenia and related psychotic disorders, acute manic episodes, and severe disorders due to psychoactive substances. The Roseneck Center is typically chosen in Germany for cases with comorbidity of psychological and physiological symptoms, cases of chronic syndromes, and when appropriate outpatient treatment facilities are regionally lacking. The patients represent a high-risk group for somatization syndromes and serious physical conditions that could explain the somatic symptoms in the long-term course are extremely rare.

Procedure and Instruments

After the patients had contacted us for the first time in order to get registered for admission, they received a set of questionnaires by mail that included the following measures.

Screening for Somatoform Symptoms (SOMS). The SOMS is a questionnaire that includes all items relevant to diagnose somatoform disorders according to the criteria of DSM-IV and ICD-10. Among these items are 10 symptoms of the upper and lower gastrointestinal tract. Patients were instructed to report symptoms that were present during the past 2 years, when doctors did not find a sufficient explanation for the symptoms, and when the symptoms bothered the patients a lot. The SOMS assesses all physical symptoms from the DSM-IV and ICD-10 symptom lists of somatization disorder and from the ICD-10 category of somatoform autonomic dysfunction. The SOMS consists of 53 somatization symptoms plus 15 inclusion and exclusion criteria (such as duration of the disorder or frequency of doctor visits). The number of positive symptoms are added to the somatization index DSM-IV with 1 point for each of the 33 symptoms listed for DSM-IV somatization disorder. The correlation between this index, according to interview and questionnaire, is 0.71; further validation data are reported in the manual of the SOMS.[16]

Cognitions About Body and Health Questionnaire