Specific Somatoform Disorder in the General Population

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The authors assessed the validity of the recently proposed diagnosis for specific somatoform disorder in the general population. German versions of the DSM-IV adapted Composite International Diagnostic Interview were administered to a representative sample of 4,075 individuals. Multivariate analyses were used to compare impairment, life satisfaction, and use of health care. A total of 803 of 4,075 subjects (19.7%) with undifferentiated somatization disorder were identified, which included 51 subjects (1.3%) who met criteria for specific somatoform disorder. Subjects with specific somatoform disorder were more impaired, had lower life satisfaction, and had higher use of health care than subjects with undifferentiated somatization disorder only. The proposed diagnosis of specific somatoform disorder demonstrated a high validity independent of comorbid depressive and anxiety disorders. (Psychosomatics 2003; 44:304–311)

Somatoform symptoms are among the most common reasons for seeking medical help. Escobar et al.[1] and Schwartz et al.[2] reported a lifetime prevalence of somatoform disorders of 4%–5% in the general population. Despite the clinical and economic importance of somatoform disorders, there is still a major need for an empirical evaluation of current classification criteria. Because of the rather restrictive diagnostic criteria of somatization disorder, according to DSM-III-R[3] and DSM-IV,[4] most patients with somatoform symptoms fall into the category of undifferentiated somatoform disorder, which is defined as residual. To overcome this unsatisfactory situation, Escobar and colleagues[1,5] proposed an abridged diagnosis of somatization disorder that requires four symptoms in men and six symptoms from the list of 35 DSM-III-R somatization symptoms. Main critical points of this concept are that the Somatic Severity Index 4/6 criteria are based on the DSM-III symptom list, which was not empirically validated, that it has been used mainly in epidemiological research, and that the Somatic Severity Index 4/6 criteria may be overinclusive in clinical groups. Other approaches investigating the Somatic Symptom Index have found good discrimination between mild and severe forms of somatization with a cutoff point of eight symptoms of 35.[6] Rief and Hiller[7] presented an empirical analysis, selecting 32 symptoms with satisfying psychometric performance from DSM-IV and ICD-10 criteria; 21 somatic symptoms were omitted. A cutoff point of seven or more symptoms yielded the best discrimination between low and high disability. Moreover, the need for a new classification of somatization disorder was emphasized—not mainly based on number of symptoms but to include cognitive factors, illness behavior, and psychosocial impairment.[7–9] One promising approach to this problem was introduced by Kroenke et al.[10,11] with the concept of multisomatoform disorder, which focuses

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on current somatoform symptoms. On the basis of their clinical and empirical work, Rief and Hiller[7,8] proposed and defined three new diagnoses for the classification of somatoform disorders:

1. A polysymptomatic somatoform disorder with a duration of at least 2 years, the presence of at least seven unexplained physical symptoms, characteristic psychological features, and significant distress or impairment.
2. A specific somatoform disorder, requiring at least one unexplained physical symptom and a substantial impairment in more than one life area.
3. A health anxiety disorder, corresponding to the DSM-IV criterion of hypochondriasis.

In the present study, we aimed to do the following:

1. To assess the prevalence of undifferentiated somatization disorder according to DSM-IV and of specific somatoform disorder in the general population.
2. To investigate whether the proposed diagnosis of specific somatoform disorder, which requires at least one unexplained physical symptom and significant impairment, identifies a subgroup of subjects with a lower quality of life, more days of impairment in activities of daily living, more use of health care, and a higher number of hospitalizations.
3. To investigate the relationship between the diagnosis of specific somatoform disorder and the Somatic Severity Index 4/6 criteria standard.

METHOD

Sample

The data came from a baseline cross-section of a longitudinal study that was part of the project Transitions in Alcohol Consumption and Smoking. The survey was based on individuals living in the northern German city of Lübeck or in one of 46 surrounding communities that constituted the catchment area of Lübeck. The aim of the community selection was precise representation with regard to settlement structure. The total population living in this area consisted of 325,107 individuals. Consideration of the inclusion criteria by age (range = 18–64) and nationality (to avoid problems with language, only Germans were included), 193,452 citizens were the target population. A random sample of 6,447 addresses was drawn from all registration office files. A total of 619 (9.6%) of these turned out to not fulfill the inclusion criteria (the subject had moved out of the sampling area, the subject was not known under the registered address, the subject was of non-German nationality, the subject was deceased, lived in prison, or resided in other institutions). Of the remaining 5,829 individuals, a total of 4,093 completed the interview, which corresponded to a response rate of 70.2%. Reasons for nonresponse were refusal (N = 979), no contact with the sampled individual (N = 668), nonparticipation because of illness (N = 80), or incomplete interview or interview obtained by phone (N = 9). An analysis of the reasons for nonresponse revealed that older subjects refused more often, and younger ones more frequently moved out of the sampling area or could not be reached. Because of these compensatory effects, a small amount of deviation from the target population and the final sample resulted, which would not justify the methodological problems inherent in weighting. Eighteen of the 4,093 interviews could not be analyzed because of nonsystematic reasons.

Diagnostic Assessment

The diagnostic interview was performed in face-to-face interviews with the fully structured and standardized Munich Composite International Diagnostic Interview,[12,13] the most recent German version of the World Health Organization (WHO) Composite International Diagnostic Interview[14] adapted for DSM-IV. The responses of the participants were directly entered into a laptop computer. The interviews were performed by trained freelancers, interviewing both as a chief occupation and as a sideline; however, all were experienced in conducting health surveys. To control for a possible interviewer bias, a heterogeneous interviewer crew was selected that consisted of 56 individuals of all age groups (mean = 36.1, SD = 11.2, range = 21–69) and both sexes (46.3% women). After 5 days of initial interviewer training, continuous individual brush-up sessions were administered by WHO Composite International Diagnostic Interview trainers. A complete hard copy of all interviews was edited by a WHO Composite International Diagnostic Interview trainer with regard to consistency and clinical relevance of the symptoms. In regular meetings attended by experts, uncertain cases were clarified by consensus, and homogeneous work was guaranteed. Weekly contact and feedback made it possible to add missing information by immediate inquiry and continuous monitoring of interviewer activities. In the applied diagnostic algorithm for undifferentiated somatization disorder, we