

Overlap, Comorbidity, and Stability of Somatoform Disorders and the Use of Current Versus Lifetime Criteria

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The authors examined disorder overlap, comorbidity, stability, and predictors of somatoform disorders (SDs) by “lifetime” and “current” symptom criteria in a general population sample of 421 respondents interviewed with the Composite International Diagnostic Interview in 1990 and 2001. Disorder overlap and comorbidity were considerable. “Current” SDs were four times more likely to occur among respondents with depression. Diagnostic stability was highest for “current” SDs (retrospective consistency: 42%). Young women were more prone to a stable (chronic) course over time. Previous depression and physical disease were risk factors for “current” but not for “lifetime” SDs; diagnostic criteria should therefore be based on current symptoms.

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Somatoform disorders (SDs), as described in *The Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (DSM–IV)*¹ and the *International Classification of Diseases, 10th Edition (ICD–10)*,² are characterized by one or more medically unexplained symptoms (MUSs). The greater the number of MUSs, the more severe the condition is considered to be. For each individual patient, the nature and number of symptoms may change over time. Most diagnostic criteria will therefore include references to the number of clinically significant MUSs and the symptom timeline (time of onset, duration, and status as current or previously present). Because individual symptoms change over time, but SDs are considered to be stable and long-lasting conditions, core diagnostic criteria are built on the number of lifetime symptoms, rather than current symptoms. The justification for this practice is that counting only current symptoms might omit outpatients who of-

ten report MUSs but who fail to meet current occurrence criteria at a given point in time.

Although symptom variability over time has been demonstrated^{3,4} and the counting of diverse MUSs from symptom lists has been argued to be insufficient and not empirically based,^{5–7} the symptom-counting issue of SDs still remains a contentious one. A criticism of existing SD criteria has also been that they are either too broad and or too narrow.⁸ Since the introduction of the SD category in the DSM–III,⁹ a reduction in required MUS criteria for “somatization disorder (SDz)” has taken place in both DSM–IV and ICD–10. Numerous alternative diagnostic scales have also been put forth. An example is the Abridged Somatoform Disorder scale (SSI–4/6), which utilizes the Somatoform Symptom Index (SSI)^{10,11} symptom list and consists of four lifetime MUSs for men and six for women. Later, it was recommended that this symptom complex be reduced to the abridged three/five (men/women) (SSI–3/5) equivalent of DSM–IV.¹² Other constructs have also been launched, such as the polysymptomatic somatoform,⁷ undifferentiated visceral somatoform,¹³ and multisomatoform disorder (MSD).¹⁴ The last consists of three current MUSs combined with one lifetime MUS. Recently, a further modification of this construct has been suggested, to “physical

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symptom disorder (PSD),”¹⁵ consisting of only one (or more) current MUSs. The ongoing reclassification and nomenclological debate about SDs,^{16–21} supports the grouping together of SDs and suggests the designation “psychosomatic distress syndromes” as the new collective and common term for SDs.²²

A major challenge to future SD diagnosis is the substantial overlap between existing individual functional syndromes, with similarities outweighing the differences between them.^{23,24} Another challenge is the comorbidity issue^{25–27} and, as pointed out earlier, a high risk of comorbid anxiety and depression.^{28,29} The importance of probing for or ruling out concomitant physical disease^{23,27} is yet another issue. In order not to miss any coexistent physical disease, when dealing with chronic physical symptoms, it has been recommended that clinicians examine for physical disease first, before evaluating the patient for anxiety and/or depression.¹³

In spite of this, SDs are considered by DSM–IV and ICD–10 to be stable and long-lasting conditions, even though the stability of the whole SD category over a 3½-year period has been reported to be as low as 48%.³⁰ Predictors of a stable course were female gender, previous substance abuse, and anxiety disorder.³⁰ The importance of diagnostic utility (usefulness), meaning the essence of what the diagnosis conveys in course, outcome, and etiology, has been advocated in psychiatric diagnoses.³¹ Also, it has been suggested that one regard syndromes as discrete only if they have been shown to have distinct natural boundaries or “zones of rarity.”³ Diagnostic changes purporting to improve clinical utility in future revisions of DSM have been recommended.³² Advancing classification toward coherent medical etiological explanations³³ and basing all future criteria of SDs on empirically-based research⁷ is also urged. Even though serotonergic amino acids have been found as biological correlates of multiple unexplained symptoms,³⁴ psychopathology and etiological mechanisms are, nonetheless, still not well understood. Because of the paucity of longitudinal follow-up studies,³⁵ existing knowledge concerning the discreteness, course, and prognosis of SDs is still sparse.^{4,29,30,35–37}

Against this background, this article presents three central diagnostic issues: 1) category discreteness and “zones of rarity;” that is, the degree of overlap between SD subtypes and co-occurrence with anxiety and depression; 2) stability of SDs over time; and 3) differences in SD diagnoses based on “current” versus “lifetime” symptom criteria. More specifically, we pose the following research questions: 1) To what extent do disorders of the SD cate-

gory overlap at a given time-point? What is the comorbidity of SDs with anxiety and depression? 2) What is the stability of SDs over time? What is the likelihood that those diagnosed with an SD (“lifetime” or “current”) in 1990 would receive the same diagnosis in 2001? What proportion of respondents with SDs, including the MSD and SSI–3/5 at baseline, retained the same or received another SD diagnosis at follow-up? 3) What baseline sociodemographic and morbidity variables (age, gender, anxiety, depression, physical morbidity, psychiatric diagnoses) predict having a) any “lifetime” SD; and b) any “current” SD at follow-up?

METHOD

Sample

Participants in the Norwegian general population (Oslo, Norway-Lofoten cohort),³⁸ age 18 or older, who had been interviewed in 1989/1990 (hereafter referred to as baseline or 1990) with the Composite International Diagnostic Interview (CIDI), Version 1.0,³⁹ were reinterviewed 10–11 years later, in 2000/2001 (hereafter referred to as follow-up or 2001) with the computerized M–CIDI, Version 1.2.⁴⁰ The baseline population consisted of a random sample drawn from Statistics Norway (Norway’s central institution for official statistics), out of which 2,727 persons responding to the Hopkins Symptoms Checklist 25-item scale questionnaire (HSCL–25)⁴¹ were further selected for the CIDI interview.^{42,43} All those with HSCL scores ≥ 1.55 were selected for CIDI interview, in addition to a random sample of those with HSCL–25 scores ≤ 1.55 . Details of the initial sampling have been described previously.^{3,38,42–44}

In all, 605 respondents were interviewed with the CIDI Somatoform Section at baseline, and 421 persons (242 women and 179 men; 57.5% and 42.5%, respectively) were re-interviewed in 2001 (response rate: 69.6%). Only data pertaining to follow-up respondents interviewed at both time-points (N = 421) are reported in this article. The CIDI-trained interviewers at both time-points were nurses, social workers, and medical and psychology students, as well as the psychiatrists participating in the research project. All interviewers were trained according to the CIDI training program, by the study’s leading psychiatrist. Good inter-rater reliability has previously been demonstrated for the CIDI,⁴⁵ and, similarly, no interviewer outliers were found in our data.

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