

## Characteristics of oligosymptomatic versus polysymptomatic presentations of somatoform disorders in patients with suspected allergies

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### Abstract

**Objective:** Psychobehavioral characteristics of patients with somatoform disorders (SFDs), are increasingly discussed as possible positive criteria for this diagnostic group. However, little is known about psychobehavioral differences, or similarities, between the different SFD presentations, i.e., polysymptomatic [multisomatoform/somatization disorders (MSD)] versus mono- or oligosymptomatic courses [pain disorder (PD), undifferentiated somatoform disorder (USD)]. **Methods:** This is a cross-sectional study including 268 consecutive allergology inpatients. After an Structured Clinical Interview for *DSM-IV*, patients completed several self-rating questionnaires. Results were compared within the different SFD presentations as well as between patients with versus without SFDs. **Results:** We identified 72 patients with an SFD. There were fewer and smaller psychobehavioral differences within patients with the different SFD presentations (MSD, USDs, PDs) than between patients with undifferentiated versus no SFD. Patients with one of

the three different SFD subdiagnoses scored similarly on many measures referring to psychosocial distress (e.g., psychological distress, mental health-related quality of life, dissatisfaction with care). The number of reported symptoms, somatic symptom severity, a self-concept of bodily weakness, the degree of disease conviction, and physical health-related quality of life discriminated the different SFD presentations not only from patients without SFDs but also from each other. **Conclusions:** Patients diagnosed with one of the different SFD subtypes share many psychobehavioral characteristics, mostly regarding the reporting of psychosocial distress. Perceived somatic symptom severity and physical impairment as indicators of bodily distress could either further define categorical subdivisions of SFD or dimensionally graduate one general SFD category defined by bothering bodily symptoms and disproportionate psychosocial distress.

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**Keywords:** Classification; Dimensional assessment; Distress; Positive criteria; Psychobehavioral characteristics; Somatoform disorders

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### Introduction

The current debate about the classification of somatoform disorders (SFD) in *DSM-V* and *ICD-11* is at a point at which it has become obvious that this disease category has to be

fundamentally changed. General agreement has already become apparent about several important issues:

- SFD have an exceptional position as *interface disorders* between somatic and mental illness [1,2].
- The present classifications are *insufficient* with respect to *criterion and predictive validity* [3].
- A *more inclusive definition of somatization disorder* as the main category of SFD—for example, as “multisomatoform disorder” [4,5]—to unburden the category “undifferentiated somatoform disorder” (USD) is required.
- Instead of focusing on the very questionable core criterion of lacking organic symptom explicability, *positive criteria* for SFD are needed [4,6–8].
- *Bodily and psychosocial distress* play a central role in SFD, suggesting a name change towards “bodily distress disorder” or “complex somatic symptom disorder” [9,10].
- Thus, an SFD could be likewise present in “organically explained” as well as “functional” conditions that are complicated by a disproportional degree of psychosocial affliction [1,10].

Experts disagree, however, on how to deal with the different SFD presentations in the upcoming classifications. Among SFD in a narrower sense (that are—in contrast to hypochondriasis and body dysmorphic disorder—dominated by physical symptoms), it has been suggested to uncouple “pain disorder” (PD) from the SFD category [4], to delete “USD” [4], or, instead, to integrate somatization disorder (or rather its more inclusive re-definition, multisomatoform disorder), USD, and PD in *one* general somatoform category, and only additionally code severity and mono- versus polysymptomatic courses [6].

In accordance with the current approaches of *DSM-IV* and *ICD-10*, new classifications will most likely (and rightfully) maintain a phenomenological approach to diagnoses, and still be based on (physical and psychobehavioral) symptoms rather than etiology or treatment response. Therefore, evidence is needed about phenomenological similarities, or differences, between multisomatoform/somatization disorder (MSD), USD, and PD. In a previous paper we found evidence that there are various *psychobehavioral characteristics* differentiating allergy workup patients with SFD from allergy workup patients without SFD [8]. This former analysis searched for general SFD predictors among workup patients only and did not distinguish between the complex polysymptomatic and the less complex mono- or oligosymptomatic presentations of SFD [8]. Therefore, from that analysis, no conclusions about *general* versus possible *specific* psychobehavioral features of different SFD presentations could be drawn.

Here, we present a descriptive analysis of patient-reported data on psychobehavioral characteristics of the currently defined SFD subcategories (i.e., MSD, PD and USD) from an unselected cohort of allergology inpatients in order to test which characteristics can differentiate between “polysympto-

matic” and “mono- or oligosymptomatic” presentations of somatoform disorders.

## Method

### *Patients, study procedure, and study instruments*

Data were collected from a group of 300 consecutive inpatients of a German university allergy department, which is also a GA2LEN (Global Allergy and Asthma European Network) Excellence Centre. The most common reasons for inpatient admission were (a) that symptoms could not be diagnosed with sufficient certainty in an outpatient setting or (b) because provocation testing was considered fraught with risk. The spectrum of (suspected) allergens was broad; the most commonly mentioned triggers were drugs, foods, additives, or hymenoptera venom, but also other contact or volatile, unrelated, or unknown substances. Details about the spectrum of symptoms and suspected allergens as well as the results of the diagnostic procedures will be reported separately. More details about inclusion and exclusion criteria as well as recruitment and participation have been reported elsewhere [8].

The patients underwent an interview of about 45 minutes duration covering the number of spontaneously reported symptoms, health care utilization, past medical history, and Section G (somatoform disorders) of the Structured Clinical Interview for *DSM-IV* (*SCID-I*) [11], extended by the criteria for multisomatoform disorder [12]. Section G of SCID was applied *without* its skipping rules; all listed symptoms, their onset, course, medical workup/explanation, and impairment were recorded. Afterwards, criteria for multisomatoform disorder were assessed. According to the resulting diagnosis, the patients were allocated to four groups: Patients with MSD, patients with PD, patients with an USD, and patients without any somatoform disorder according to SCID or criteria for multisomatoform disorder. All participants filled out a set of self-rating questionnaires on various psychobehavioral features. In detail, the set covered the Illness Perception Questionnaire, revised version (IPQ-R [13]), the Whiteley-Index, short form (WI-7 [14]), the Cognitions About Body And Health Questionnaire (CABAH [15]), the Scale for the Assessment of Illness Behavior (SAIB [16]), the Reassurance Questionnaire (RQ [17]), large parts of the Health Attitude Survey (HAS [18]), the SF-36 Health Survey [19,20], and four modules of the Patient Health Questionnaire (PHQ [21,22]): the PHQ-15 for somatic symptom severity [23], the PHQ-9 for depression [24], the general anxiety disorder (GAD)-7 for general anxiety [25], and the PHQ stress scale for current life stressors (for details, see Ref. [8]).

### *Statistical analysis*

Statistical analyses were carried out with SPSS (version 17.0). All data were analyzed descriptively reporting

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