Psychosomatic Diagnosis: a literature review.

Summary: Structural, epidemiological and medical biases tend to restrict the application of a proper diagnostic procedure in clinical practice. The aim of this review is to discuss factors affecting the occurrence, nature and presentation of psychosomatic diagnoses and their connotation with pejorative overtones. This paper investigated the multifactorial causes for these occurrences and revealed their implications for clinical management and medical research. It is suggested that psychological assessment should be provided in the early stages of the clinical investigation and some diagnoses should be reintroduced in current psychiatric classifications. Pejorative overtone has also been attributed to several diagnoses, particularly those related to somatisation. The use of moral remarks added to medical diagnosis should be banned from literature since it has distorted both practice and statistical results.

Introduction

Physical symptoms in the absence of an identifiable organic correlation are common in medical practice (Shepherd *et al.*, 1966; Von Korff *et al.*, 1988; Kroenke & Magelsdorff, 1989; Mayou, 1991). Many complaints of chronic pain, dyspepsia, headache, dyspnea, joint pain, chest pain, causalgia, dizziness, loss of function, palpitations and fatigue fall into this category. About 30% of these symptoms were attributed by the attending physician to "psychiatric disturbance" (Bain & Spaulding, 1967; Lipowski, 1988).

The medical profession finds these conditions difficult to describe with a satisfactory term. Those that have been used included non-specific, non-organic, functional, dysfunctional and idiopathic somatic symptoms. These "diagnostic puzzles" are difficult to treat. They are usually accompanied by over-investigation and consume considerable medical resources to little benefit. Independent of physical findings or excessive preoccupation with normal physiological signs, the progression of this expensive investigative process leads these initial unexplained medical symptoms to be later classified as functional or as psychological overlay. At other times these symptoms are categorized as psychogenic, psychosomatic, conversion, somatisation, somatoform disorder and hysteria. Usually, these labels are accompanied by the absence of physiological correlates, obvious pathological explanation or physical and laboratory findings. Applied to patients with a similar clinical picture, the term hypochondriasis emphasizes beliefs concerning illness rather than symptoms (Kellner, 1985). Other terms, like atypical or non-specific and functional somatic symptoms, are concerned with somatic symptoms that do not result from physical disease, but often originates from normal bodily sensations or some sort of autonomic dysfunction in its association with cognitive distortion. The majority of these labels have been seen by the medical profession as having a "pejorative overtone" (Sharpe *et al.*, 1992; Mayou 1975; 1976; 1991). The aim of this paper is to review the basis for these medical diagnoses and

to investigate why they became associated with such a depreciative adjective.

Historical perspective

For centuries, physicians have recognized somatising patients. They have given a variety of overlapping labels that were some times inter-changeable. This was particularly true to the terms "hysteria" and "hypochondriasis" (Veith, 1965; Fisher-Homberger, 1972; Boss, 1979) which originated from the Greek language.

Sydenham's Dissertation of 1682 represents a landmark in the evolution of medical thought about these diagnoses. He provided a description of the physical and mental symptoms of these disorders. Hysteria often exhibited a single symptom and was viewed as a malady of women. Hypochondriasis included a wide range of symptoms, which could imitate many diseases and prevailed in males. They were both considered a disturbance of the mind and an inconsistency of the body due to disorders of "animal spirits".

In 1733, Cheyne pointed out the difficulties in giving this diagnosis for patients in medical settings and how his colleagues attributed to them and to him "pejorative overtones"

Nervous distempers are under some kind of disgrace and imputations in the opinion of the Vulgar and Unlearned. They pass among the multitude for a lower degree lunacy. Often when I have been consulted in a case, and found it to be what is commonly called "nervous". I have been in the utmost difficulty when desired to define or name the distemper. If I called the case glandular with nervous symptoms (actual psychological overlay), they concluded I thought them pox'd or had the King's Evil. If I said it was vapour, hysteric or hypochondriacal disorders (actual somatisation), they thought I called them mad or fantastical (symptom in their minds) and was thought as rude, a fool, a weak and ignorant coxcomb, and perhaps dismissed in scorn form seeming to impeach their courage. Notwithstanding all this, the disease is as much a bodily distemper as the smallpox or a fever and I think never happens to any but those of the liveliest and quickest natural parts and particularly where there is the most delicate sensation and taste, both of pleasure and pain (p13).

Of course, it could be argued that words like hysteria and hypochondriasis do not in fact have the same meaning in today’s terminology. However, no matter what one calls these symptoms, the point to be stressed is that they were not explained physically and possibly had a psychological origin.

In 1799, Sims explicitly distinguished hysteria from hypochondriasis by pointing out the new feature of disease conviction. In hypochondriasis, patients had their mind "almost entirely taken up with the state of their health, which they imagine to be infinitely worse that it is and believed themselves afflicted with almost every disorder they have ever seen, read or heard of" (Lipowski, 1988). Hysteria was associated with changeable mood, while hypochondriasis resembled melancholia. Therefore, Sims described in these clinical pictures symptoms that we now associate with those of anxiety and depression.

Although described in obsolete words, the clinical cases reported above can easily be recognized in the actual medical practice. This suggests that culture, sociofamily factors and behavior can change over the centuries, but the influence of mental mechanisms on psychosomatic illness remains essential.

Hysteria and hypochondriasis may be viewed nowadays as the prototypes of somatoform disorders, which the DSM-III stated as "physical symptoms suggesting physical disorders". Moreover these entities represent prime examples of an abnormal body experience (somatisation) and of an abnormal cognitive disturbance (obsessional thoughts), respectively.

Epidemiology

The frequency of the somatisation may increase with the increase of medical care (White, 1961; Lipowski, 1988). Population surveys (Wadsworth *et al,* 1972) demonstrate that minor bodily symptoms are very common and that only a small proportion of them are reported to doctors. Studies in primary practice are particularly important. The 1980-81 National Ambulatory Medical Care survey in the US looked at about 90 000 visits to physicians and found that 72% of the patients who received psychiatric diagnosis had one or more physical symptoms for their complaints (Shurman *et al.*, 1985). In general practice, one fifth of all attendees present with physical symptoms of minor emotional disorder (Shepherd *et al,* 1966; Mayou, 1976, 1991). Psychiatrist who work in general hospitals consistently report hysterical symptoms as being more common than do their colleagues with more limited specialist experience (Mayou, 1975). At the secondary level of medical care the frequency of somatisation may be even higher. For example, in the UK during 1985 there were 330,000 hospital referrals for back pain, and 63,000 hospital in-patient treatments averaging 2 weeks. Of these patients, 60% had non-specific backache. The etiology of these cases were still not diagnosed by discharge.(Lipton & Jones, 1987). The problem

for diagnosing these cases is related in part to the delay in obtaining results from investigations and to the lack of training in psychological medicine. However, it may also be related to the intrinsic difficulty of providing a psychiatric diagnosis to patients who communicate their psychological distress through physical symptoms. This way of describing somatisation has been criticized for failing to reveal the crucial point that somatisers actually experience and communicate primarily somatic, not psychological, distress and this is the main feature that characterizes them. It is important to examine why this became so.

Somatisation in epidemiological research

Several authors have pointed out the influence of culture in the presentation of somatisation (Slater 1965, Carter 1972, Hare, 1974, Mayou, 1975). Others reported on social and cultural differences on the prevalence of mental illness and alcoholism at specific locations (Bebbington *et al*, 1981, Goodman, 1981, Cooper, 1987). Yet the influence of sociofamilial and cultural factors are directly related to the level of care in which the research is conducted. This may be particularly relevant since somatisation varies from culture to culture.

There is growing evidence that the prevalence of illnesses in the general population differs from primary and secondary care (Mayou, 1975, 1976, Lipowski, 1988). Thus in *general populations* there are individuals who seek care and those who do not, even with the same sort of diagnosis.

Those who reach *primary care* are more concerned with their symptoms, which they perceive as serious and they may insist in having further investigations. Usually, at this level an organic diagnosis is given, distinguishing cases from non-cases. Patients with organic pathology or functional somatic symptoms are likely to be identified as such, and they normally disclose functional illness behavior by accepting the doctor's guidance and reassurance. Investigations and proper counseling often remove the patient's psychological concern and any tendency towards unreasonable illness behavior. However, in some non-diagnosable cases, a mixture of organic and non-organic factors are usually present.

These patients are often referred to specialized services for further investigations, either in general hospitals or specialized clinics e.g. rheumatology or orthopedics. Thus, in *secondary care level*, psychological overlay remains frequent. Some patients, most of who lack a conclusive diagnosis and show dysfunctional illness behavior, become persistent attendees and are often

referred to *tertiary care*.

These cases are usually characterized by previous negative investigations and repeated failure to respond to treatment in previous levels of care. They are often seen in highly specialized services and the distinction made in this level is between somatisers and non-somatisers. The possible higher frequency of somatisation in these patients is often misinterpreted as bias in their referrals and study results are eventually dismissed because of "selected patient samples" (Mayou, 1976, 1994, 1996). Nevertheless, the presence of somatisation in tertiary level of care (e.g. Pain Clinics, Neurologic Clinics, Psychiatry) might be expected to be higher than in primary care, and certainly higher than in the general population. It is this process of psychological escalation that possibly reduces differences in rates of somatisation between samples from different cultures. Psychological enhancement is relevant to epidemiological research because psychosocial and family factors may be investigated on persistent chronic attendees. It is likely that the influence of psychological factors is indeed greater in tertiary than in previous levels of care. This would explain the different results from studies in those levels in which organic pathology and minor problems are likely to be identified and treated (Barker & Mayou, 1992, Mayou *et al*, 1993, Mayou, 1993, 1995).

Social and medical problems in assigning a psychosomatic diagnosis

The reluctance of patients to verbalize their psychological distress to doctors or to communicate them through physical complaints probably results from a multifactorial interaction that includes personal, medical, sociofamily and cultural aspects. This psychosomatic language of distress appears to be prevalent in cultures (e.g. Western societies) where expression of emotional distress in psychological terms is socially unacceptable or family inhibited (Kirmayer, 1984; Lipowski, 1988) or where communication of emotional distress in a somatic form is encouraged (Zborowsky, 1956). The latter examined the degree of mother over protection and concern in Italian and Jewish communities in New York.

Crying in complaint is responded to by parents with sympathy, concern and help. By their over-protective and worried attitude they foster complaining and tears. The child learns to pay attention to each painful experience and to look for help and sympathy which is readily given to him. In Jewish families, where not only a slight sensation of pain but also each deviation from

the child's normal behavior is looked upon as a sign of illness, the child is prone to acquire anxieties with regard to the meaning and significance of these manifestations (p. 28).
Zborowsky presents something of a caricature. However, his view of somatic complaints as inherent in the familial response to the child's health and illness is an important insight.

Other factors operate in doctor-patient relationships. These may explain why so many patients are discharged from hospital without proper diagnosis and treatment. The way care is provided associated with medical biases usually interferes with the mechanism of providing an adequate diagnosis. Few specialists are really concerned with careful diagnostic discrimination between organic and non-organic illness (Campero *et al.*, 1993; Verdugo & Ochoa, 1992,1994; Ochoa *et al.*, 1993, 1995, 1997).

In structural terms, the physician first sees the patient without a psychological and social assessment. At the beginning of the clinical investigation, there is a tendency to provide an organic label however tenuous. Although a psychologist or psychiatrist usually provides a diagnosis of somatisation, patients are only referred to them after receiving a provisional diagnosis. This way of referring not only crystallizes the idea of an organic illness but the psychiatrist is then unable to exclude it. The mental health professional only *adds* a psychological component, thus suggesting functional overlay instead of a more refined diagnosis indicating the type of somatisation. This is reinforced by the fact that most patients are obviously not mentally ill and do not fit into major psychiatric diagnostic categories. Finally, when patients ‘ crystallize’ the idea of an organic illness they tend to become much less tolerant of psychological assessment and reluctant to consider a psychological origin for their unexplained symptoms. As a result, we end up with a false impression that conversion and somatoform disorders are very rare.

The term *crystallization* can be employed to qualify a specific interaction between doctor and patient. In this relationship the doctor induces the patient to think he or she has a physical illness by the overuse of physical investigations or by suggesting the possibility of an organic illness by using medical terminology to explain findings which are not strictly related to the cause of the symptoms. The usual way to reinforce *crystallization* is to provide invasive treatment (e.g. nerve block, injection, and denervation) without a proper psychological assessment. This reinforcement also occurs with unnecessary drug prescription (Mayou, 1991, 1993) and unnecessary surgical intervention (Barker & Mayou, 1992). These authors found that patients who had normal

appendices removed had a worse prognosis than comparisons. In the year following admission, those patients presented recurrent and disabling pain associated with continued psychiatric symptoms.

The consequence of this medical bias, whereby the idea of an organic illness is made concrete to the patient, leads to several problems. Firstly, inducing misdiagnosis. This includes prevention of a proper organic diagnosis, bias in psychiatric assessment away from somatoform categories and invalid research results. The impediment of a correct psychiatric diagnosis and its subsequent treatment leads to poor clinical response and increases patient dissatisfaction with staff. Secondly, it increases long lasting and unrealistic treatments and an expansion in the take-up of social benefits. Chronic undiagnosed somatisers with an organic label are now more commonly seen than misdiagnosed hysteria with real organic pathology (Quill, 1985; Ron, 1994; De Lemos, 1997).

Diagnoses that are not objectively verifiable often condemn patients to chronicity and iatrogenesis (Ochoa, 1993, 1997). It seems that doctors' abnormal diagnostic behavior leads to patients' abnormal illness behavior that is compounded by abnormal treatment behavior (Awerbuch, 1985; Ochoa, 1997). To prevent these problems, psychological assessment should be provided much earlier in the clinical investigation, preferably before the allocation of a provisional organic diagnosis.

Professional bias

In clinical practice, the act of diagnosis is a professional process by which signs and symptoms inform a diagnostic dimension or category. If patients do not respond to treatment, the diagnosis is reconsidered and so is the treatment. In this way, after some time, the doctor can be close to the clinical reality of the patient, considering the physical, psychological, somatopsychic or psychosomatic pain.

The value of a diagnosis is that if the theory underlying it is scientifically sound, it implies the course the doctor is to follow. Thus it should provide a useful prediction for the course of the disease. This will imply its etiology, and perhaps most importantly of all, will suggest the most appropriate treatment. However, somatisation poses serious problems for diagnosis. The complexities of mechanisms involved in the production of a clinical symptom lead to a great

variety of characteristics that may not always be fully attributable. To understand somatisation and classify the symptom rationally, the physician must be aware of a range of clinical and psychological factors.

In terms of secondary and tertiary levels of care, a doctor's specialty may also introduce some bias on his or her conclusions about diagnostic adequacy, allowing room for idiosyncrasy. Twycross (1990) trying to understand pain in cancer patients, proposed the concept of *informed imagination*, whereby a symptom that is not readily classified will still be understood as part of a system of medical knowledge, and an attempt will be made to establish a diagnosis, however conjectural. To this concept can be added the complimentary notion of *concept extension* which describes an attitude whereby the diagnostic concept is extended to encompass symptoms that do not fit the classification.

In multidisciplinary pain clinics, for example, there is a tendency to extend the organic classification to include those patients with some sort of somatisation (e.g. atypical facial pain, pre-trigeminal neuralgia, sympathetic maintained pain) or to create new diagnoses in descriptive terms based almost exclusively on clinical examination (e.g. fybromyalgia, chronic fatigue syndrome, repetitive strain injury). The patient is therefore labeled with a diagnosis, which has no cause, no confirmed physiopathological mechanism and no laboratory findings to measure its progress (Croft *et al.*, 1994). Usually response to treatment does not include placebo comparison, making clinical conclusions rather unreliable (Campero *et al.*, 1993; Verdugo & Ochoa, 1994). The result is a hypothetical organic illness and an ill-formulated management that precludes a proper organic or psychological diagnosis and proper treatment.

The extended concept can be considered as a process of professional distortion, which can lead to specific views about the patient's symptomatology, either considering every symptom as purely physical or as mainly psychological. The psychologist and psychiatrist may be equally guilty when they extend the concept of some psychological illnesses solely because of negative physical findings. Whilst informed imagination is a more neutral, scientific and operational way of thinking, it is still based on medical theories which by and large do not include psychological theories. In any case, the doctor’s aim should be to discover the *clinical reality*, in other words the patient's pathology. However, the diagnostic label depends not only upon the apparent seriousness and nature of the clinical picture, but upon the attitude and behavior of patients and

the demands they makes upon doctors (Mayou, 1976).

Psychosomatic presentation

Difficulty in properly classifying cases with somatisation is an old problem. Several structural, social, medical and professional biases interfere with the appropriateness of medical diagnoses, particularly those related to the psychosomatic encroachment. Doctors may induce *crystallization*. Their choice for a specific theoretical approach may lead to different interpretation of unexplained physical symptoms and would promote changes in diagnostic classification. These factors have also contributed to exclude or to re-include some psychosomatic diagnoses in some of the most used psychiatric classifications (e.g. DSM-III, DSM-III-R and DSM-IV).

Independent of cognitive distortion and its association with psychophysiological mechanisms, as happens to Functional Somatic Symptoms, there may be other explanations for the emergence of unexplained somatic symptoms. It is possible that some of these symptoms arise from mental processes, no matter how these symptoms are labeled (e.g. somatoform, somatisation, psychosomatic, psychogenic or conversion). The inquest on why some individuals somatise more often than others and why somatisation frequently recurs imitating other psychiatric disorders supports the argument in favor of the involvement of mental processes in the genesis of some types of somatisation. This is even more so in cases with psychogenic pain, where these mental processes probably derived from the interaction between traumatic childhood experiences and a variety of other social factors (Roy, 1992; De Lemos, 1997). There are some additional reasons to support the relevance of mental mechanisms in these cases (De Lemos, 1997; Ochoa, 1997).

The former studied the impact of family atmosphere in chronic pain maintenance for 10 years and investigated whether psychogenic pain was a myth or reality. This study (not published in part because it's pejorative overtones) showed that the concept of psychogenic pain is a valid and useful concept. Patients with this type of pain were distinguished formally using discriminant function analysis including *any* or *all* of its phenomenological, behavioral and etiological characteristics. Using *all* the criteria reflects the clinician's ability to make the distinction between non-organic and organic pain. Being able to make it almost as well *on single* grounds also suggests that psychogenic pain is a *useful* category as well as consistent one. The latter was concerned to identify neurological inconsistencies that could be attributable to mental

mechanisms.

Several studies have addressed the issue of co-morbidity of mood disorder and chronic pain (Chaturvedi, 1987; Marshal *et al.*, 1992); Sullivan *et al.*, 1992). However, when a proper distinction between non-organic and organic pain is made (Peyrot *et al.*, 1993; De Lemos, 1997), depression and anxiety do not correlate with pain type. The latter study also showed that depression arises from pain rather than the reverse. Thus, there is weak support for considering psychogenic pain as a process influenced or generated by affective disturbance.

Excessive preoccupation with normal sensations (heart beat), functional bodily manifestations (palpitation) associated with the wrong interpretation of these autonomic symptoms have been considered as being important in the emergence of somatisation (Sharpe *et al.* 1992). This cognitive-behavioral model of etiology distinguishes between predisposing, precipitating and perpetuating factors and great emphasis is given to body surveillance and cognitive distortions as "barriers to recovery". Trying to explain somatisation, Mayou (1993) gives the following example.

A middle aged man with bad family history of heart disease may present with chest wall pain which he has misinterpreted as evidence of heart failure shortly after hearing the death of a close friend from heart attack (p.75).

In this example, in contrast with other descriptions, there is virtually no physiological link between the underlying heart function and chest wall pain, thus the model relies heavily on cognitive distortion. Moreover, it was derived from studies on recurrent acute pain rather than chronic fluctuating pain. In previous descriptions (Mayou, 1976), the model was anchored in an experiential aspect. Cognitive disturbance (chest wall pain) should be preceded by an over concern with a past episode of minor injury/illness (angina) and triggered by an autonomic dysfunction (tachycardia) associated with mood disorder (anxiety) and other complimentary factors (caffeine, nicotine).

Surely this model explains the emergence of some conscious (or pre-conscious) functional somatic symptoms. However, it does not explain why in some cases these somatic misinterpretations do not change after proper medical clarification. This reluctance probably indicates an unconscious component. The model also does not explain why some of these somatic complaints follow the pattern of recurrent psychiatric syndromes. Conversely to other non

relenting sensations, pain is not a physiological bodily function and does not have a correlate to be monitorised as happens to other bodily sensations (e.g. digestion, heartbeat or breathing). Thus, the behavioral model may not be applicable for the majority of chronic pain. Particularly in those cases where the onset of pain is followed by mild accidents incapable of accounting for autonomic nerve dysfunction or when it appears for no apparent reason. An observational study (De Lemos, 1997), conducted in a tertiary care level, showed no significant differences in social modeling in patients with psychogenic pain. Again there is little evidence to consider inexplicable pain as a functional somatic symptom or to assume that it is other than an expression of a mental process which may be in part unconscious and for this reason more resistant to clarification.

Psychosomatic diagnosis

Early this century, Freud who attributed the emergence of somatic symptoms to unconscious mental processes accepted the term hysteria. His views were mainly based on the psychiatric approach that prevailed at that time and derived from the hypnotic treatment that was routinely employed on hysterical cases (Freud & Breuer, 1895). Hysterical symptoms were conceived as resulting from the mental mechanism of dissociation and subsequent conversion. Conversion was understood as a displacement of mental energy towards the body to avoid unbearable mental stress. The clinical picture of these cases included personal suggestibility, loss of bodily functions and denial. The psychological sources of the pseudo neurologic hysterical symptoms were demonstrated by the use of hypnotic therapy.

One or two decades later, the term *somatisation* was introduced by one of his followers - Stekel - to described a more transient syndrome characterized by multiple symptomatology whereby a serious neurosis could promote bodily disorder. This new term was slightly different from the concept of conversion. These multiple symptoms were usually treated by dynamic psychotherapy (Hinsie & Campbell, 1960; Lipowski, 1988). Alexander *et al.* (1934) was concerned with the specificity of psychological factors and mental mechanisms in some illnesses regarded as psychosomatic. Following a similar theoretical approach, Menninger (1947) extended the concept of somatisation by defining "somatisation reactions" as the "visceral expressions of the anxiety which is thereby prevented from being conscious". Thus, the somatic symptom was not seen any more as a neurotic trait but as a result of a state of mind. In general terms,

psychoanalysis has used the concept of somatisation to indicate an unconscious defense mechanism and to address certain somatic complaints to a hypothesized psychogenic source. This view is not shared by some psychiatrists and is often regarded as unacceptable for those who are not psychoanalysts. They would favor a more neutral and descriptive approach that does not imply an etiologic mechanism. However, this approach is often conceived in relation to other theoretical approaches (e.g. cognitive-behavioral) and frequently includes some alternative explanation of the genesis of somatic symptoms (Sharpe *et al*, 1992).

Somatisation could be viewed as a tendency to experience and communicate somatic distress by patients that disclosed a specific clinical pattern. Their symptoms are unaccountable by pathological findings; they are attributed to physical illness, and they make patients seek medical help.

Bridges and Goldberg (1985), for example, stipulated that to be considered somatisers patients must meet the following criteria. They must seek medical help for somatic symptoms (and not for psychological manifestations of psychiatric disorders); must attribute their symptoms to physical illness, and must report, when properly interviewed, symptoms that justify psychiatric diagnosis. Although the patient seldom agrees, some physicians usually interpret somatisation as a response to psychosocial stress. Others would rather describe somatisation in terms of somatisation behavior, best seen as a behavioral syndrome (Barker & Mayou, 1992). For these authors, somatisation is understood as a wide concept that includes a wide variety of different physical complaints not normally associated with physical illness.

The general assumption of this approach (Sharpe *et al.*, 1992; Mayou, 1993; 1995) is that the presentation of somatic symptoms is originally related to mild psychophysiological mechanisms or minor physical illnesses, which are later misinterpreted through cognitive disturbance and influenced by concomitant mood disorder. The clinical picture is maintained or perpetuated by a reciprocal interaction between the patient's illness behavior and the reinforcing attitude of those who care for the patient (including doctors). Great emphasis is given to three aspects of the somatisation process: *experiential, cognitive and environmental.* The experiential aspect is what individuals perceive in regard to their bodies. It includes *transient changes in body functioning, non-specific psychological dysfunction* and *persistent physical complaints.* Examples of *transient changes in body functioning* are tachycardia, dyspepsia, dyspnea, headaches, asthenia, and

dizziness. Examples of *non-specific psychological dysfunction* are irritability, insomnia, lethargy, anxiety, depression, and fatigue. Examples of *persistent physical complaints* are chronic pains, such as atypical facial pain, chronic dysfunctions (e.g. irritable bowel syndrome), chronic loss of a function (e.g. vision, voice or hypoalgesia) and changes in appearance (e.g. dysmorphophobia.) These bodily complaints are *all* seen as variants presented in somatisation. However, these complaints are related to different concepts and completely different etiologic mechanisms for each symptom. While transient change and psychological dysfunction can be reasonably attributed to the emergence of functional somatic symptoms, chronic persistent complaints are more likely to be the expression of more serious types of somatisation (e.g. somatoform disorders, conversion) and serious cognitive distortion as sometimes seen in schizophrenia (e.g. dysmorphophobia).

This tendency to encompass a variety of experiential complaints under the rubric of somatisation is shared by most behavioral psychiatrists and it is in part responsible for weakening the frequency of "psychogenic" syndromes in clinical practice, which they regard as "pejorative" (best not being verbalized to patients).

At the end of the last century, however, the diagnosis of hysteria was fashionable and it was dropped from the DSM-III a couple of years ago. Conversely, hypochondriasis was largely displaced by the concept of neurasthenia at that time, but it was reincluded in the DSM-III (Fisher-Homberger, 1972) although considered by some psychiatrists as a *continuum* or as a reaction (Mayou, 1976). Recently, in the DSM-IV the previous diagnosis of Somatoform Pain Disorder was jettisoned and substituted by the diagnosis of Pain Disorder, in which both organic and non-organic aspects of pain should be present. This doubtful approach now makes chronic pain, as an isolated somatisation, impossible to be diagnosed on its own. Thus, "psychogenic" pain should now be included in more restricted categories (e.g. somatoform disorder or conversion), which are difficult to diagnose due to a great number of psychological and physical characteristics that patients must present. The actual diagnostic criteria reduce the prevalence and incidence of “psychogenic pain”.

Nevertheless, several authors still emphasize the importance of the concept of "psychogenic" pain, both in Pain Clinics and neurologic practice (Quill, 1985; Lipowski, 1988; Ron, 1994; Ochoa, 1997). Moreover, the theoretical or terminological reluctance to accept psychogenic diagnoses usually leads to a variety of invasive and surgical treatments with serious iatrogenic

results (Verdugo & Ochoa, 1992; Ochoa, 1995, 1997).

Independent of these "vagaries" of psychiatric nosology and terminology (Lipowski, 1988), changes in medical diagnosis are still very much with us. They raise questions as to what extent we are providing new diagnoses for old diseases (Mayou, 1994; Pearce, 1994). Also to what extent we are altering operational criteria to exclude or include some diagnoses according to underlying medical theories or fashion. It is questionable that these alterations really represent an evolution in the psychological comprehension of unexplained physical symptoms, because they do not take into consideration the meaning of somatisation and its connection with early family disruptive events.

Even accepting the view that favors the use of operational criteria based on symptoms instead of etiology to classify illnesses, new descriptive terminology does not essentially alter the clinical presentation of some ancient illnesses like hysteria or hypochondriasis. Irrespective of the DSM's nomenclature, fashionable diagnoses (and treatments) tend to be transient, while old consistent medical entities are likely to remain. Although some changes in psychiatric classification can be attributed to divergences about the importance given to mental mechanisms involved in somatisation, the great majority of these changes may simply be associated with the way health services and medical care are provided and utilized by patients.

Lets now look how the medical profession and society have enhanced, distorted and applied concepts that were originally developed inside a specific domain, and why this wider use led to the attachment of "pejorative overtones" to some diagnoses.

The pejorative connotation

In the past, pejorative tones attributed to doctors who used certain diagnostic labels could be interpreted in two different ways. It may be related to the insistence of patients to obtain help for disturbance in "animal spirits" or "vapours" in the medical setting, or it may be seen as a reluctance by doctors in accepting the psychological emergency of symptoms in a somatic form.

Today, this dichotomy between diseases regarded as originating from the body versus illnesses mainly attributed to the mind still persists. This controversy is additionally complicated by different psychiatric views towards mental illness and its association with abnormal somatic symptoms. As mentioned before, some psychiatrists tend to disagree with any terminology or

diagnostic label that implies an implicit mental mechanism or etiological assumption.

In the psychological treatment of patients with functional somatic symptoms, Sharpe *et al* 1992 stated.

Existing terms are unsatisfactory because they are used imprecisely, may convey etiological assumptions (such as somatisation), and have a pejorative overtone (p. 516).

However, the decision to assign negative adjectives to a noun is rather subjective. It depends very much on thoughts, beliefs and assumptions of those who employ them. On occasions, these adjectives reflect a moral perspective, other times they reveal the theoretical perspective of the physician or the psychiatrist who use them. There is, however, scarce scientific basis for their use.

The social appropriation of diagnostic concepts

It is well known that psychiatric terminology may spread to outside the medical field and would sometimes be employed with a completely different meaning or connotation. Thus, a label originally developed inside the psychiatric field is often slightly modified by the medical profession, misused at family level and finally applied to a wider sociocultural phenomenon. The concepts of hysteria and hypochondriasis will be regarded as paramount to exemplify the effects of this social dimension on diagnostic conceptualization.

Although both hysteria and hypochondriasis are persistent clinical entities, they have not been immune to the influence of fashionable medical theories. Psychoanalysis conceived hysteria as a result of a mental process characterized by the presence of specific mechanisms. First, conversion that meant the displacement of mental energy towards the body. Second, dissociation implying in a mental mechanism that prevents an association with a past memory. Third, the presence of psychological denial related to the origin of the symptom. Thus, a psychosomatic diagnosis was interpreted as a difficulty to communicate psychological distress (Balint, 1957).

Psychiatric appropriation followed and hysteria was then postulated as a psychiatric syndrome and later as a reaction, only to be recently dropped from psychiatric classifications and understood as a form of somatisation. The original diagnosis of hysteria suffered several changes. At medical level, the expression was applied to a variety of unexplained somatic symptoms, particularly those in which a dysfunction (e.g. hysterical cough) or a loss of function (e.g. hysterical paralysis) was involved. At family level, the term hysteria acquired a different

connotation either to describe one's tantrums accompanied by unreasonable complaints, or the angry behavior of a child. As shown, there was a substantial change in its conceptualization. At a sociocultural level, hysteria has also been identified with a variety of cultural phenomena, including "possession experience", collective panic, witchcraft and collective suggestibility (e.g. mesmerism). However, there is almost no connection between these social appropriations of the term and the original concept designed to explain non-neurological bodily symptoms. For example, one could have been accused of witchcraft simply because he/she had not agreed with the prevailing religious views even in the absence of any physical symptomatology. The same is valid to the possession experience and to collective panic. Once a psychiatric term has been displaced from its original context and socially relocated, the term loses its original meaning. It then does not retain its prime application and becomes easily tarnished with "pejorative" overtones.

The same course observed in hysteria can also be elicited in the meanders imposed to the diagnosis of hypochondriasis. Psychoanalytically, it was regarded as resulting from obsessional thoughts towards somatic symptoms that were understood as a result of a disease conviction resistant to medical clarification. Psychiatry utilized the concept of hypochondriasis as a syndrome, which disappeared from early classifications to return one century latter in the DSM-III (Fisher-Homberger, 1972). The medical appropriation of the expression was applied to multiple non-specific somatic complaints sometimes accompanied by low mood. At family level, the expression was used to denote one's seeking attention through illness behavior, associated with unreasonable recurrent malaise. Modifications of the original conceptualization can be easily recognized. At medical level, the susceptibility of medical students to imitate some organic diagnosis has been considered as an indication of hypochondriasis. At the social level, the term has also been applied to medication addiction or to the recurrent pursuit of surgical intervention. Again there is little connection between these new uses of the term and the original concept.

As happened to hypochondriasis, the term phobia followed a similar trajectory. In psychoanalysis it was used to indicate a defense mechanism against separation anxiety. At psychiatric level it was associated to obsessional thoughts in anxious patients. In its usual form, it was seen as a psychiatric syndrome, mainly related to avoidance of open spaces or crowds (e.g. agoraphobia). The management of neurotic problems in medical practice used the expression in

relation to cases characterized by the association of somatic symptoms with fear, either in terms of recurrent non-specific complaints (e.g. fear of disease), persistent specific complaints (e.g. dysmorphophobia) or in terms of treatment fear (e.g. needlephobia). The concept of disease fear can be seen as the reverse of disease conviction, while fear of treatment can be interpreted as a "barrier to recovery". At social levels, phobia acquired a variety of meanings including fear of work (e.g. workphobia), homosexuals (e.g. homophobia) and religious fears that led to mystical rituals. The majority of them have acquired pejorative connotations.

The social appropriation of these three diagnostic categories, and the conceptual distortion that followed, has made it hard for doctors to communicate them to patients, either because of the medical setting in which these psychiatric terms were provided or the superinposed "pejorative" overtones that they socially acquired.

In general terms, diagnoses should be given based on scientific accuracy and not on moral grounds. Is calling patients schizophrenic less pejorative than saying they have a somatoform disorder? Let’s examine what is essentially pejorative.

The problem of assigning an acceptable psychosomatic diagnosis in medical practice is complex. In structural terms, services provided in the medical setting do not include early psychological assessment. This makes the task of assigning the diagnosis and explaining the reasons for the patient's somatisation more difficult. Doctors tend to consider all patients as medical cases when in fact some of them are not, although they would like to be. Frequently, the diagnosis of hysteria and hypochondriasis may be misdirected because doctors instead of mental health professionals see the great majority of somatisers. Moreover, doctors tend to undermine the scientific validity and clinical reliability of diagnoses placed in the limit of the psychosomatic boundary (Ron, 1994; Ochoa, 1997). There is also a tendency to consider any non-organic diagnosis as "pejorative". Even though doctors have the intention to respect or to please patients, *any* diagnosis that does not describe an organic cause they would find unsatisfactory. Doctors assume that these diagnoses imply labeling reasonable patients mad. To prevent the maintenance of this problem, psychological examination should be considered essential in health care and multidisciplinary clinics should be extended to the majority of medical subspecialties. Such a policy would promote more rational distribution of existent resources and greater financial benefit for health care.

A further complication in assigning the right diagnosis is posed by family and social appropriation of psychiatric terminology, particularly when these terms have been consistently attributed to child behavior. This appropriation reinforces the impact of a "pejorative" tone in psychosomatic diagnoses, which make it extremely difficult to employ terms like hysterical or hypochondriac in the medical setting.

In addition, the indiscriminate acceptance of "pejorative tones" in relation to some psychosomatic diagnoses has created serious problems in conducting clinical investigation and interpreting statistical results. Psychosomatic categories tend to be regarded with suspicion. Research projects to investigate these diagnoses may be refused by ethical committees on the same basis. If the investigation is eventually approved, results showing prevalence of "psychogenic" illnesses in tertiary care (e.g. Pain Clinics) would not be easily accepted for publication.

Refusal for publication is also common where experimental studies obtain negative results. Prof. Everitt, professor of statistics of the Institute of Psychiatry in the Maudsley Hospital, is aware of this selective effect and its impact on research results, particularly those from metanalysis.

Clinical trials which fail to show any (treatment) differences are less likely to be published owing to investigators not writing up the results or to journals declining the paper. Conclusions of the therapeutic effectiveness based on reviews of only the published papers may consequently be seriously misleading. (p. 51).

Assessment of reviews on "medicine-based-evidence" about the prevalence of “psychogenic” entities would often be equally misleading. Therefore, the overall impression obtained from literature may become detached from actual medical practice. This gap could lead to distortions of health strategies. Although claiming to be on behalf of patients, a silent non-scientific censorship that in part relies on medical prejudice leads to lack of information and would continue to demean some consistent diagnostic categories because of their "pejorative" tones.

Conclusion

Taking into account data on prevalence, its relation to how diagnoses are conceived or allocated combined with the way health services are provided, we are now in a position to understand better the process of somatisation and to draw reasonable conclusions about it. As happens in depression

and anxiety, somatisation should be understood as a "continuum". In the general population there is a higher proportion of transient non-specific physical symptoms (indigestion, constipation, bloating stomach, cough, palpitation, headaches, asthenia, dizziness), while in primary care they tend to be more persistent and are usually associated with autonomic dysfunction (e.g. dyspepsia, dyspnea, tachycardia, insomnia). For those who seek medical attention in these levels, the cognitive-behavioral treatment seems appropriate for these syndromes because severe cognitive dysfunction is unlikely to be present unless patients become persistent attendees.

As patients progress to higher levels of care, somatic complaints overlap with non-specific psychological dysfunction (e.g. irritability, insomnia, lethargy, anxiety, depression, fatigue) and are accompanied by higher levels of abnormal illness behavior. The implication here is that a serious cognitive distortion is in operation often co-existing with mood disorder that commonly derives from a primary somatic complaint. A more refined categorical distinction in the dimension of disease conviction should be considered to diagnose cases with somatisation in secondary level of care. Hypochondriasis is probably the term that best describes the majority of these cases.

The tertiary level of care, however, is characterized by the existence of more persistent chronic complaints (e.g. low back pain, atypical facial pain, chronic dysfunction or chronic loss of a function e.g. vision, voice or hypoalgesia) associated with specific psychological dysfunction (e.g. psychogenic pain, somatoform disorder or conversion). Complaints of pain in this somatic domain may be due to primary psychopathology (Derbyshire *et al.*, 1994). This process implies a more serious type of somatisation, which usually presents a poor response to treatment. These somatic complaints probably result from a variety of mental mechanisms, some of which are probably unconscious, triggered by family factors and usually expressed by specific psychological symptomatology (previous psychosomatic illness) or recurrent and persistent psychiatric illnesses (somatoform disorders).

In summary, somatisation should be regarded as a "continuum" and its clinical presentation probably progress in a *crescendo*. In the *general population*, there are non-specific symptoms associated with physical complaints. In *primary care,* the emergence of functional somatic symptoms associated with autonomic dysfunction is frequent. In *secondary levels of care,* clinical overlap between psychological and organic factors prevails and is often associated with cognitive distortions (e.g. degree of disease conviction). Finally in *tertiary care*, there is the presence of

persistent somatisation often associated with somatoform disorders and conversion.

Studies on prevalence show that functional somatic symptoms originating from minor injuries and organic pathology are higher in general population and primary care (Sharpe *et al*, 1992; Mayou, 1993). On the other hand, the association of somatisation with a higher degree of dysfunctional illness behaviors leads to a higher proportion of hypochondriacs and hysterics in secondary and tertiary levels of care (De Lemos, 1997). Possibly, some terms, such as hysteria and somatoform *pain* disorder, should be reinstated in the DSM to indicate those unexplained neurological cases associated with recurrent and persistent somatisation in tertiary level of care. These diagnoses should be considered as a discrete psychiatric entity. They would help to reestablish a common language among doctors and common sense in medical practice.

The attachment of "pejorative overtones" to psychogenic diagnostic categories is multifactorial. It frequently results from the interaction between moral, theoretical and social factors. The widespread appropriation of specific psychiatric labels has influenced and distorted the way diagnoses are verbalized in clinical practice and sanctioned in psychiatric classifications. It has generated vagaries in diagnostic conceptualization, although some of these psychiatric categories, such as hysteria and hypochondriasis, have consistently resisted the test of time without major changes in their clinical presentations.

On the other hand, the use of depreciative appraisal in relation to many unexplained somatic diagnoses has serious implications for the medical practice and the interpretation of statistical results. To date, bias in accepting papers for publication has distorted what is generally considered "medicine based evidence". To justify the use of "pejorative overtones" based on conclusions obtained from the current available literature is, therefore, flawed. To promote a realistic balance, the author supports the view that negative results and negative overtones (or its synonyms) superimposed to some psychosomatic diagnoses should not be regarded as a deterrent for publication. Moreover, pejorative connotations should be viewed as misleading and should be avoided in medical and psychiatric practice. They do not assist diagnosis or management of patients with unexplained somatic symptoms and their use will greatly distort the interpretation of results described in published papers.

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