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Editorial

Somatic symptoms: beyond 'medically unexplained'†

Michael Sharpe

Summary
Somatic symptoms may be classified as either 'medically explained' or 'medically unexplained' – the former being considered medical and the latter psychiatric. In healthcare systems focused on disease, this distinction has pragmatic value. However, new scientific evidence and psychiatric classification urge a more integrated approach with important implications for psychiatry.

Declaration of interest
M.S. was a member of the Somatic Symptoms Disorders Work Group for DSM-5.

Michael Sharpe is Professor of Psychological Medicine at the University of Oxford, UK.

People come to see doctors for help with symptoms. Somatic symptoms are perceived abnormalities of bodily structure or function that the individual finds bothersome or concerning. The doctor usually sees his or her primary role as determining whether the symptoms indicate serious bodily disease. If disease is found, the symptoms are regarded as 'medically explained' and subsequent management focuses on treating that disease; if pathological changes are not found, the symptoms are commonly regarded as 'medically unexplained', and if any management is offered it focuses on treating the symptoms. Following a frequently challenged but nonetheless surprisingly resilient dualistic perspective, the former is deemed to be a medical problem and the latter often a psychiatric one.[1] In other words, if no disease is found in the body, it is assumed that the disease is 'all in the mind' and that symptoms that are medically unexplained are considered, by default, to be 'psychiatrically explained'. The DSM-IV classification reflects this view; the so-called 'somatoform disorders' (literally mental disorders in somatic form) have as their central concept 'medically unexplained symptoms' and the key somatoform diagnosis 'somatisation disorder' is based on counting the total number of medically unexplained symptoms.[2]

Medically unexplained symptoms

Is the concept of a medically unexplained symptom a useful one? A paper in this issue of the journal by Tomenson *et al* asks how well the number of medically unexplained symptoms predicts important clinical outcomes when compared with a simple total of all symptoms.[3] Their findings, from the analysis of multiple clinical data-sets, strongly suggest that it is the total number or 'burden' of somatic symptoms and the patient's concerns about those symptoms, rather than the number of medically unexplained symptoms, that best predicts both disability and future healthcare use. Furthermore, this remains the case even when depression and anxiety are controlled for. So should the concept of 'medically unexplained' now be abandoned? On the one hand, the term clearly is useful as a pragmatic clinical label, to indicate whether a symptom is associated with a serious disease or not and consequently how likely it is to be relieved by treatment of that disease. This is a reason for retaining it. On the other hand, the scientific evidence for the validity of categorising symptoms as either medically explained or medically unexplained is weak. Several studies have found that in patients with chronic medical conditions, whose somatic symptoms would usually be considered as medically explained, there is surprisingly little relationship between severity of the disease and the severity of the symptoms.[1] Conversely, studies of patients with no disease, whose somatic symptoms such as pain could be considered to be medically unexplained, are finding increasing evidence for 'neurological' mechanisms in their aetiology.[4]

Beyond medically unexplained

An alternative view is that all somatic symptoms are both medically explained and medically unexplained to some degree; they are typically neither mere reflections of bodily pathology, nor simply manifestations of mental processes. Rather they are multiply determined and reflect the output of the brain's integration of biological, psychological and social aetiological factors. Signals from the body are processed and interpreted by the brain according to their psychological salience, which in turn is influenced by the symptom's socially communicated meaning.[5] For an example of how psychological and social factors may modulate bodily sensations, consider the differential response to back pain and chest pain; one may be ignored as trivial, whereas the other may result in fear of death, severe anxiety and the urgent seeking of medical care.

So should we replace the idea of medically unexplained symptoms with the simpler and non-dualistic concept of symptom burden; that is, how much patients are bothered by their symptoms, as indicated by the number, severity and psychological reaction to them? Such a paradigm shift would have major implications for both psychiatric diagnosis and clinical practice. The new DSM-5 proposes just this. A new diagnosis of Somatic Symptom Disorder is included based not on medically unexplained symptoms, but rather on the reporting of bothersome and persistent somatic symptoms accompanied by an excessive psychological response.[6] It is possible to give this new psychiatric diagnosis both for medically unexplained symptoms and for somatic symptoms that are 'explained' by a medical condition such as cancer. This new diagnosis means that patients are no longer simply divisible into those with disease and

†See pp. 373–380, this issue.

those with somatoform disorder. There are simply some more in need of psychiatric help with their somatic symptoms than others. Although some of these patients will have depression or anxiety disorders, others will not. This is a profound change from DSM-IV and it will take time for it to be fully appreciated by the clinical community: early indications are that it is likely to be applauded on the one hand for legitimising psychiatric and psychological interventions that will reduce suffering, and criticised on the other for adding what is sadly still seen (even by some psychiatrists) as the stigma of a psychiatric diagnosis to patients who previously had only a medical one.

What does this paradigm shift mean for clinical practice? The traditional view was that the psychiatrist's role was restricted to patients whose somatic symptoms were regarded as a manifestation of mental illness. The described change in conceptualisation means that psychiatrists are now seen to have a wider role in the management of patients, to include those with severely troublesome symptoms of any cause. Supporting this idea is increasing evidence that psychological interventions for severe and disabling somatic symptoms work, irrespective of whether the symptom is medically unexplained or not. For example, there is evidence that cognitive–behavioural therapy reduces not only the fatigue of chronic fatigue syndrome,[7] but also the fatigue associated with diseases such as multiple sclerosis.[8]

Challenges and opportunities

A change in how we think about somatic symptoms offers both challenges and opportunities for psychiatry. The challenges include a change in familiar ways of thinking and a re-examining of old ideas such as somatisation.[9] The opportunities include closer collaboration with physicians in both research and clinical practice to achieve a better understanding of – and more effective treatments for – severe and disabling somatic symptoms and ultimately more effective and integrated medical and psychiatric care for our patients.

Michael Sharpe, FRCPsych, Department of Psychiatry, University of Oxford, Warneford Hospital, Oxford OX3 7JX, UK. Email: michael.sharpe@psych.ox.ac.uk

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