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Is there a better term than "Medically unexplained symptoms"?

Introduction

The European Association of Consultation Liaison Psychiatry and Psychosomatics (EACLPP) is preparing a document aimed at improving the quality of care received by patients who have "medically unexplained symptoms" or "somatisation" [1]. Part of this document identifies barriers to improved care and it has become apparent that the term "medically unexplained symptoms" is itself a barrier to improved care. This is because the term is not acceptable to some patients and doctors. It defines the patient's symptoms by what they are not, rather than by what they are, and it reflects dualistic thinking – regarding symptoms as either "organic" or "non-organic"/"psychological".

The authors of this paper met in Manchester in May 2009 to review thoroughly this problem of terminology and make recommendations for a better term.. The deliberations of the group form the basis of this paper. Our discussion concerned terminology applicable to the more severe and persistent common symptoms of unknown aetiology, so often seen in primary care, and the recognised disorders, which present with symptoms that escape orthodox medical or surgical disease explanations. The latter include the disorders currently listed in the Somatoform disorders chapters of the American Diagnostic and Statistical Manual of Mental Disorders (DSM) and the WHO International Classification of Diseases (ICD). Our priority was to identify a term or terms that would facilitate management – that is it would encourage joint medical psychiatric/psychological assessment and treatment and be acceptable to physicians, patients, psychiatrists and psychologists.

In the first step, we reviewed why the term "medically unexplained symptoms" is so often unhelpful. In the second step we established a set of criteria which may be used to judge any alternative term. In the third step we applied these criteria to the various terms which have been used to describe this group of complaints.

"Medically unexplained symptoms" – one advantage, but many reasons to discontinue use of the term

The term "medically unexplained symptoms" has gained some popularity during recent years among general practitioners and others to describe the bodily complaints of their patients when the aetiology is unclear. The term implies that the complaints cannot be fully explained by structural bodily pathology. Used in this way, the term "medically unexplained symptoms" is like a pre-diagnostic statement: it implies that currently there is no "organic cause" for the problem but it leaves open the potential aetiology of the problem.

Unfortunately, any advantage of using this term in a purely descriptive diagnostically noncommittal way is outweighed by a number of disadvantages which, in our opinion, and in that of many others, discredits further use of the term "medically unexplained symptoms".

From a clinical point of view the phrase "medically unexplained" is a negative statement, withholding from the patient that which he or she usually seeks most - a positive explanation for their symptom(s) and support [2,3].

Conceptually, referring to a symptom as "medically unexplained" is ambiguous in at least two senses:

a) it is not sufficiently clear what counts as a medical explanation of a symptom. This might refer to a good correlation between the nature of the symptom and proven organic pathology, described in functional anatomical and pathophysiological terms. Alternatively it might refer to a description of central nervous system dysfunctions associated with a subjective symptom, such as pain, even though this may not implicate the CNS in direct causation.
b) It is not clear whether describing a symptom as "medically" unexplained implies that medicine has nothing to offer the patient who has such a symptom. By labelling the symptom in this way it may appear that the doctor is dismissing the patient because s/he is unable to help. Even if this is not what the doctor intends, it may be understood by patients in this way [4].

A more fundamental problem with the concept underlying "medically unexplained symptoms" is the dualism it fosters. A patient's symptom is seen either as an organic one ("medically explained") or, medically "unexplained", which may be taken to imply a psychological cause. This dualism

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is still enshrined in our classifications of diseases (ICD has a separate chapter for "mental " disorders and DSM is only concerned with mental disorders) despite the fact that we know now that human illness is determined by a mixture of biological, psychological and social factors.

To overcome this problem of dualism there are several possible alternatives. One requires that we describe, in every patient, relevant factors on all three dimensions (biological, psychological and social) contributing to his or her suffering [5,6]. However, such an approach across the whole range of medical problems might be difficult to realise in practise.

Secondly, if we accept the existing division of disorders into primarily physical/organic or mental/psychological categories, then a third category of overlapping or "interface" disorders becomes necessary. The disorders which are captured with a term like "medically unexplained symptoms" are neither predominantly organic nor predominantly psychological; they bridge the organic – psychological divide so they belong to an interface category of disorders, where both dimensions are of diagnostic and therapeutic relevance. There is a serious problem with this latter approach as, for many of us, it is confusing and seems obsolete to use "organic" and "psychological" as separate concepts, with an "interface" between them as all symptoms are manifestations of CNS activity and thus have a biological or "organic" basis.

A third approach is concerned solely with the description of symptoms or clusters of symptoms. (e.g. fatigue, pain, sleep problems or widespread bodily pain) [7,8]. This approach makes no assumptions about aetiology. It also allows symptoms to be described in patients whether or not they suffer from other, well-recognised organic disease (such as cancer or rheumatoid arthritis).

Criteria to judge the value of alternative terms for "medically unexplained symptoms"

Ten criteria were developed in order to judge the value of potential terms which might be used to describe the group of symptoms currently referred to as medically unexplained symptoms. Obviously, this list of criteria does not claim to be exhaustive, but we believe that it captures the most important aspects. The criteria are that the term:

1. is acceptable to patients
2. is acceptable and usable by doctors and other health care professionals, making it likely that they will use it in daily practice.
3. does not reinforce unhelpful dualistic thinking.
4. can be used readily in patients who also have pathologically established disease
5. can be adequate as a stand alone diagnosis
6. has a clear core theoretical concept
7. will facilitate the possibility of multi-disciplinary (medical and psychological) treatment
8. has similar meaning in different cultures
9. is neutral with regard to aetiology and pathology
10. has a satisfactory acronym.

Terms suggested as alternatives for "medically unexplained symptoms"

The group reviewed terms which are used currently or have been proposed for the future. An extensive list was abbreviated to the following 8 terms or categories:

The terms we reviewed were:

1. Medically unexplained symptoms or medically unexplained physical symptoms
2. Functional disorder or functional somatic syndromes
3. Bodily distress syndrome/disorder or bodily stress syndrome/disorder
4. Somatic symptom disorder
5. Psychophysical / psychophysiological disorder
6. Psychosomatic disorder
7. Symptom defined illness or syndrome
8. Somatoform disorder

As discussed above, the term "medically unexplained symptoms" clearly fails criteria 1, 3 and 6, possibly also 4 and 5. Therefore we recommend that the term not be used in the future.

The term *somatoform disorder* is known to be unacceptable to many patients and doctors and, because the diagnosis relies on "medically unexplained symptoms", it classically endorses the organic/psychological dualism.

The term *Symptom defined illness or syndrome* is unlikely to be widely accepted among patients and doctors alike; it lacks a clear core concept and does not easily fit with a concurrent pathologically established disease.

Somatic symptom disorder is not a term that is likely to be embraced enthusiastically by doctors or patients; it has an uncertain core concept, dubious wide acceptability across cultures and does not promote multidisciplinary treatment.

In our discussion, the terms which fit most closely the criteria we have set out above were the following: bodily distress (or stress) syndrome/ disorder, psychosomatic or psychophysical disorder, functional (somatic) syndrome or disorder.

The term *bodily distress disorder* fulfils most criteria from the list above with the exception of criterion 10 (the acronym BDD is in use already to indicate Body Dysmorphic Disorder). In the discussion it became clear that there is a semantic uncertainty as to the notion of distress: for Danish and German participants of the meeting this term does not necessarily imply a psychological component (there can be distress solely in the form of bodily complaints like pain and dizziness), whereas for the British participants the notion of distress seems to be inextricably linked to a psychological state (pain and

other bodily complaints "causing" distress, not being a form of distress).

The term "*psychosomatic disorder"* also fulfils most criteria of the list. Although it is accurate in describing the problem in terms of both psychological and somatic components, it generally has negative connotations [9] outside of some, especially German- speaking countries. This difference may be due to the fact that in Anglophone countries the term is exclusively linked to the more or less Freudian tradition of psychogenic explanations of disease. In these countries, the term "psychosomatic medicine" does seem to be more generally acceptable and those psychiatrists who offer "psychosomatic medicine" or "psychological medical" clinics find that patients are not put off by these labels. Thus there seems to be a difference according to whether we use the term "psychosomatic" to describe symptoms/ disorder or a type of healthcare.

The term "*psychophysical / psychophysiological disorder"* is similar in its immediate meaning to "psychosomatic disorder". It has the advantage that it is not bound to the tradition of assuming a psychogenic origin. However, "physical" is not a widely used description for bodily complaints.

The term "*functional somatic disorder or syndrome*" fulfils most criteria; it is reasonably widely accepted because it is neutral as to mental or organic backgrounds. There is some confusion regarding its core concept as it may refer to a functional disturbance of the organs implied in the bodily complaints (the traditional understanding) or a functional disturbance of the brain systems underlying symptom experience (the currently favoured view).

Implications for treatment

The driving force for improving terminology should be primarily one of improving the quality of care received by patients who suffer from these conditions. All too often, these patients receive one-sided, mostly purely biomedical, but sometimes also purely psychological treatments [10]. A more balanced approach requires developing specific treatment facilities which address the needs of these patients, including those with more severe disorders. In German-speaking countries these facilities already exist within the specialty of Psychosomatic Medicine but such specific treatments are rare in other healthcare systems. Although some existing treatment facilities include both biomedical and psychological therapies (eg in some rehabilitation units) they are not appropriate for, or acceptable to, the majority of patients with the type of symptoms with which we are concerned here. Therefore some specific treatment facilities have been developed (eg Chronic Fatigue clinics in UK) but there is a need for specific treatment facilities that are suitable for a wide range of bodily complaints, such as the Functional Disorders clinic in Denmark [7].

In the light of this overarching criterion of enabling optimal treatment none of the suggested terms are ideal. The terms "bodily distress syndrome (or disorder)" and "psychosomatic" or "psychophysical/psychophysiological" are helpful in providing a positive explanation of the symptoms in terms of both organic and psychological aspects. This may be important since the first step of treatment is usually a positive explanation to the patient of the likely origin of the symptoms and the need for appropriate treatment. Alternatively, the term "functional somatic syndrome" allows explanation in terms of altered brain functioning (linking to the term functional imaging) demonstrating that the symptoms are 'real' and yet changeable by alteration in thinking and behaviour as well as by a psychotropic drug [11].

On the other hand, "bodily distress syndrome/disorder" and "functional somatic syndrome" both open the door to concurrent general medical and psychological treatment because they can be understood both in terms of psychological or organic aspects or restoring normal functioning of the neurological system [11]. The term "psychosomatic" suffers from the close association with one-sided, psychological treatments.

It will probably be necessary, in a process of consultation with representatives of all relevant stakeholders in the field, to find out which of these or any other suggested terms lends itself most readily to the type of evidence based integrative treatment approach which we think is necessary for this type of disorder.

Implications for DSM-V and ICD-11

There is overlap between the discussion reported here and the discussion currently under way towards the creation of DSM-V. Two of the authors (FC, MS) are also members of the working group on Somatic Distress Disorders of the American Psychiatric Association (APA), which is proposing a new classification to replace the DSM-IV "somatoform" and related disorders. In this working group, similar concerns about the use of the term and concept of "medically unexplained symptoms" have been raised [12]. The current suggestion by the DSM-V work group to use the term "Complex somatic symptom disorder" must be seen as step in a process and not as a final proposal. Unfortunately this term does not appear to meet many of the criteria listed above.

One major problem for reforming the classification relates to the fact that the DSM system includes only "mental" disorders whereas what we have described above is the necessity of not trying to force these disorders into either a "mental" or "physical" classification. The ICD-10 system has a similar problem as it has mental disorders separated from the rest of medical disorders.

The solution of "interface disorders", suggested by DSM IV, is a compromise but it is unsatisfactory as it is based on the dualistic separation of organic and psychological disorders and prevents the integration of the disorders with which we are concerned here.

This lack of integration affects the ICD classification also. For example functional somatic syndromes (e.g. irritable bowel syndrome) would be classified within the "physical" classification of ICD or Axis III in DSM (gastrointestinal disorders) and omitted from the mental and behavioural chapter entirely [13].

Conclusion

It is not easy to reach a consensus about the term that should replace "medically unexplained symptoms". There are difficulties with concept, acceptability and language.

With regard to the concept, the choice seems to be between a purely descriptive term – eg symptom-defined disorder - or one which implies an aetiology that encompasses both organic and psychological elements. Acceptability is paramount as any term that is not acceptable to patients and doctors will be an obstacle to improved care. Difficulties with language means that a term that is acceptable in one language may not be in another; in addition one term also can oscillate between different meanings within one language.

What is the best way forward? The processes leading to the preparation of the EACLPP document and to DSM-V is a mixture of well established expert- and evidence-based approaches. To come forward with a good term after dismissing "medically unexplained symptoms" (and somatoform disorders), necessitates the collecting of opinions from a broad range of stakeholders in the field (doctors in specialist somatic care including pain clinics, primary care, mental health; patients, healthcare planners, managers etc.) in order to maximise the likelihood that the new term will be accepted and used widely across all fields of medicine, not only psychiatry or psychosomatic medicine. However, good linkage of these efforts with the DSM- and ICD-processes will be crucial in order to maximize the likelihood that any new term will be used broadly and promote, not hinder, appropriate physical and psychological treatments.

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