# The need to distinguish between bodily distress disorder and somatic symptom disorder

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Letter to the editor

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Comment on:

Henningsen P, Zipfel S, Sattel H, Creed F: Management of Functional Somatic Syndromes and Bodily Distress. Psychother Psychosom 2018;87:12-31.

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Dear Editor,

We read the article entitled Management of Functional Somatic Syndromes and Bodily Distress by Henningsen et al. [1] with great interest. The authors state that they intend to develop a unifying perspective on the understanding and management of functional somatic syndromes and bodily distress, while also providing an update on current concepts and their aetiologies as well as evidence-based recommendations for treatment, thereby concentrating on developments in the last decade. However, we feel that, for several reasons, rather than offering clarification, the paper creates conceptual confusion.

Firstly, it is important to differentiate between functional somatic syndromes (FSS) or bodily distress disorder (BDD) (both mainly characterized by medically unexplained symptoms) on the one hand and somatic symptom disorder (SSD) on the other. In their "terminology, classification and overlap" section, the authors refer to SSD as an arbitrary DSM-5 alternative to FSS (or BDD), thus sharing the view Fink takes [2]. Although this may seem understandable from a historical perspective, considering the poor conceptualisation of somatoform disorders in the DSM-IV, we would like to point out that in the DSM-5 the criteria for SSD are based on a very different conceptualisation and incorporate an important change[3]. More precisely, the persistent, explained or unexplained, somatic symptoms have to be associated with disproportionate thoughts, feelings and behaviours related to these symptoms. In our view, future DSM editions should adopt a more dimensional approach to the diagnosis of SSD, placing less emphasis on health anxiety and incorporating the Diagnostic Criteria for Psychosomatic Research (DCPR) [4]. The DCPR system has merit as it showed its clinical utility in predicting treatment outcomes. Also, it takes subthreshold syndromes and the heterogeneity of psychological problems affecting a sizable number of patients suffering from a medical illness into account [5], such as: allostatic overload and demoralization. In DSM-5, these conditions are too vaguely being described as "Psychological factors affecting other medical conditions".

Second, regarding the differentiation between FSS/BDD and SSD, empirical research has shown that not all patients with FSS fulfil the criteria of SSD. In their study of patients with fibromyalgia, Haüsser et al. [6] find that merely 25.6% of a sample of 156 patients met the SDD criteria. Furthermore, a recent latent-class analysis of chronic fatigue syndrome (CFS) revealed important differences in between-group scores on the Cognitive Behavioural Responses Questionnaire [7]. More precisely, the largest subgroup (33%) mainly reported features associated with FSS, showing the lower scores, and the smallest subgroup (11%) showed high scores particularly on behaviour avoidance and damage beliefs. In keeping with this, the latter group was also more likely to believe that their symptoms were physical in nature. Hence, only

a proportion of patients with FSS show characteristics of SSD. Moreover, as Henningsen et al. [1] mention themselves, the number of bodily symptoms is a strong predictor of disability and healthcare use, but with health anxiety being an additional and independent predictor.

Third, in their schematic model of the aetiology of bodily distress, the authors mainly adopt insights from cognitive and behavioural theories and do not include evidence on physiological disturbances in FSS. For instance, CFS has been associated with hypothalamic–pituitary–adrenal axis dysfunction, which seems clinically relevant as it is linked to more severe symptoms and/or disability and poorer outcomes to standard treatments [8]. As to irritable bowel syndrome, the evidence strongly suggests that it is a systems disease that not only involves complex individual systems (i.e. the nervous, immune, digestive, and microbiota systems and the environment), but also their complex reciprocal interactions [9]. Moreover, it has been pointed out earlier that the so-called unexplained symptoms will eventually stop being unexplained once the underlying pathogenic mechanisms are unveiled [10]. Adhering to the concept of FSS or BDS as a concept excluding somatic explanations does not help research and clinical practice further, as it hampers taking such developments into account. Thus, an approach that continues to focus on so-called unexplained symptoms misses the opportunity to advance research and clinical care in this domain.

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