

Redefining (somatoform) pain disorder in ICD-10: a compromise of different interest groups in Germany

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Purpose of review

Pain is one of the most frequent reasons to visit health professionals. Many patients suffering from chronic pain conditions not only need medical treatment but also psychiatric or psychological interventions. This additional treatment need should be underlined using an ICD section F diagnosis. The current ICD-10 diagnosis of somatoform pain disorder requests psychological causation of the pain, which is frequently unclear or difficult to decide.

Recent findings

In Germany, the different interest groups, namely of psychiatry, pain research, psychosomatic medicine and clinical psychology, met to find a consensus on how to re-classify pain disorder under section F of ICD-10. This manuscript summarizes the result.

Summary

A diagnosis of pain disorder is necessary to underline the additional need of psychiatric/psychological interventions in chronic pain conditions. This diagnosis should include psychological features that are relevant for development or maintenance of chronic pain. In contrast to earlier attempts of redefining pain diagnoses, our attempt included representatives of the association for the study of pain.

Keywords

classification, pain, somatoform pain disorder

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Introduction

Many patients with pain symptoms need additional psychiatric or psychological interventions. This should be reflected by using an adequate diagnosis under section F in ICD-10. Current classification approaches, however, have substantial shortcomings, are unreliable, and did not include representatives of pain research in the discussion of classification rules. Therefore, an attempt was made in Germany to include all groups working with patients with pain, and to redefine (somatoform) pain disorder under ICD-10. The results of this consensus could serve as a model to revise pain disorder for ICD-11.

Pain is one of the most frequent reasons to visit health professionals. The prevalence rates of current symptoms like back pain, joint pains, or headache is reported to be in the range of 20–40% of the adult population, and the relative risk of suffering from one of these symptoms during a lifetime is supposed to be more than 0.80 [1,2*]. If symptoms persist longer than 6 months, further symptom persistence, increased numbers of sick leave days,

disability, increased healthcare costs and reduction of quality of life are typical consequences.

For most pain conditions, the symptoms are poorly explained by a defined biomedical condition, the association between medical findings and disability is low, and the cause of many pain symptoms remains unclear. For chronic pain especially, mere biomedical models can hardly explain the multiple consequences mentioned above, and it has been shown that cognitive, affective and behavioural factors play a central role in exacerbation and maintenance of the complaints. Therefore, it is not surprising that pharmacological treatment with analgesics in combination with physiotherapy is frequently not sufficient for symptom relief, but psychological and psychiatric interventions are necessary. (We will use these terms encompassing also psychosomatic or consultation-liaison services.) In fact, psychological interventions such as cognitive-behavioural therapy are one of the empirically best-founded therapies for chronic pain conditions (e.g. [3,4**]).

Comorbidity rates with depression or anxiety disorders are increased in chronic pain [5,6], but the relevance of psychological factors in pain is not limited to comorbidity with these clearly defined mental disorders. Therefore, diagnoses like ‘somatoform pain disorder’ or ‘psychological factors affecting physical conditions’ have been suggested in DSM-IV [7] and ICD-10 [8]. Problems in their definition and the need for revision of these diagnoses and their criteria are under debate [9–11,12**]. This debate, however, did not integrate the view of pain researchers so far, although pain represents the most frequent symptom cluster of somatoform disorders, and (nonpsychiatric) pain research has a long tradition and a powerful scientific network.

In Germany, ICD-10 was chosen as the principal classification system for the healthcare system and health insurances. The relevance of the classification system has tremendously increased since DRG systems (‘diagnosis related groups’) were introduced as the bases for financial reimbursement of treatment costs in nonpsychiatric settings. In general medical settings, financial reimbursement for the hospitals is higher if treatment-relevant comorbid psychiatric disorders are diagnosed. Therefore, the question arises of which diagnoses should be used to underline the need for additional psychiatric or psychological treatment in pain, if full-blown psychiatric disorders like depression or panic are not present, but other psychological factors play a major role in the maintenance or treatment of pain.

The dissatisfaction with ICD-10 section F diagnoses for pain

ICD-10 defines somatoform pain disorder, but no other principal pain disorder, in section F (mental disorders). Contrary to DSM-V, this diagnosis can only be used in ICD-10 if clear causal psychological factors triggered the pain symptoms. For some chronic pain patients, however, the exacerbation of pain was characterized by organic factors (e.g. herniated disc syndrome), or by an unclear mixture of organic and stress-related factors (e.g. migraine, back pain of musculoskeletal origin), and it is obvious that a monocausal psychological causality is as insufficient as a monocausal biomedical model. Accordingly, the combination of somatic and psychological methods (interdisciplinary pain management) proved to be superior to simple medical or psychological treatments in many chronic pain conditions. Somatoform pain disorder according to ICD-10 cannot be used for those patients with well known organic factors contributing to the process of symptom development, although this is a large subgroup of pain patients.

ICD-10 section F also offers the diagnoses ‘Psychological and behavioural factors associated with disorders or

diseases classified elsewhere’. It is specified, however, that this diagnosis should be used to describe subthreshold states of negative affect, demoralization or health anxiety that occur in the context of a medical condition. The mental disturbances are considered to be mild, and do not justify specific treatment. Therefore, this diagnosis is not considered to be a DRG-relevant disorder, because the severity is supposed to be subthreshold [8]. Furthermore, the criteria for this disorder are completely unspecific, again not justifying considering it as a serious condition necessarily requesting additional treatment. Therefore, this diagnosis is only rarely used in Germany, and, worldwide, this diagnosis is more or less neglected.

The new proposal

The major need for redefining a diagnosis of pain disorder was seen within the pain societies, because most pain hospitals and clinics were subject to DRG regulations, while psychiatric hospitals and psychosomatic hospitals are not. ICD-10 allows the definition of national modifications of the classification system, which, in Germany, are supervised by DIMDI (‘Deutsches Institut für medizinische Dokumentation und Information’). Therefore, the German pain society DGSS (a member of the International Association for the Study of Pain; IASP) asked for an additional diagnosis to categorize pain patients with a special need for additional psychological or psychiatric treatment. This new diagnosis was defined in a consensus process of the societies mentioned in Table 1.

Most participants agreed that the best solution would be to redefine (somatoform) pain disorder, but the rules for national adaptation of classification systems do not allow abolishing ICD-10 diagnoses and replacing them with other diagnoses, but only to add or extend existing WHO diagnoses. Therefore, it was decided that, for the current situation, an additional pain diagnosis should be added under section F of ICD-10, while hoping that future revisions would allow merging of the two section F pain diagnoses into one. In this article, we will focus on the consensual proposal for the future, while, for the present, an additional diagnosis of ‘pain disorder with somatic and psychological factors’ was suggested. The consensual position of major pain societies, psychiatric associations, psychosomatic medicine societies, behavioural and rehabilitation medicine, and clinical psychologists is described in Table 2.

Pain is still the major feature of this diagnosis. We also agreed on a time criterion highlighting that this diagnosis is very relevant for chronic pain (minimum duration: 6 months), although we are aware that many factors relevant for symptom persistence can occur as early as

Table 1 List of contributing societies

German name	English translation of society names	Contact person
Deutsche Gesellschaft zum Studium des Schmerzes DGSS	German Pain Society	Zenz, Nilges
Deutsche Gesellschaft für Psychiatrie, Psychotherapie und Nervenheilkunde DGPPN	German Society for Psychiatry, Psychotherapy, and Neuroscience	Schweiger
Fachgruppe Klinische Psychologie und Psychotherapie der DGPs	Division of Clinical Psychology and Psychological Intervention, German Society of Psychology	Rief
Deutsche Gesellschaft für klinische Psychotherapie und psychosomatische Rehabilitation DGPPR	German Society for Clinical Psychotherapy and Psychosomatic Rehabilitation	Rüddel
Deutsche Gesellschaft für Psychotherapeutische Medizin DGPM	German Society for Psychotherapeutic Medicine	Henningsen
Deutsche Gesellschaft für Verhaltensmedizin und Verhaltensmodifikation DGVM	German Society for Behavioural Medicine and Behaviour Modification	Rief
Deutsches Kollegium für psychosomatische Medizin DKPM	German Collegium for Psychosomatic Medicine	Henningsen

in the very first days of symptom development. Moreover, the definition of the time criteria is according to typical descriptions used in ICD-10 and DSM-IV. Second, the group agreed that such a diagnosis requests psychological features to justify the classification of pain disorder as a 'mental' disorder. If full-blown anxiety or depressive disorders exist, these conditions should be classified using existing diagnoses. To avoid too much overlap between classical mental disorders and the new pain diagnosis, any clear symptoms of depression or anxiety were rejected from inclusion in the classification rules for pain disorder, but we focused on psychological features that have been shown to be more specific in chronic pain conditions.

Criterion C in Table 2 is a tribute to the existing somatoform pain disorder, and should be rejected in future

Table 2 German criteria for the classification of pain disorder

For the diagnosis of 'Pain disorder', the following four criteria are required:

- (1) The existence of persistent, intense pain leading to clinically significant distress or impairment in social, occupational, or other important areas of functioning
- (2) Psychological factors can be identified that contribute to the course, treatment response or consequences of the pain condition, e.g.
 - attention focusing on pain perception
 - over-interpretation of pain perception and pain consequences, catastrophizing
 - mental rumination about pain-associated factors
 - unflexible monocausal attribution of pain to organic causes
 - avoidance behaviour, fear of pain-causing situations, physical deconditioning
- (3) If biomedical factors or relevant physiological aspects can be defined, a diagnosis of 'pain disorder with somatic and psychological factors' should be considered; if no biomedical or relevant physiological aspects can be defined, a diagnosis of 'somatoform pain disorder' should be considered^a
- (4) The diagnoses should not be used if the pain symptoms are exclusively present in the context of depressive or schizophrenic disorders

^a It is suggested that this differentiation (criterion C) is omitted in future revisions. As long as ICD-10 defines a psychologically caused somatoform pain disorder, however, it is necessary.

revisions. It has been shown that the reliability of such a (psychiatric) pain diagnosis is unnecessarily reduced if the diagnostician has to rate whether biomedical or psychological factors were more prominent during development of the pain condition [13,14^{*}]. The cause of chronic pain is not only sometimes hard to define, but also less relevant for the suffering of the patient and for the maintenance of the pain condition.

Conclusion

Within the ICD-10 system of classification, we present a new proposal for the classification of chronic pain conditions which need additional psychological or psychiatric interventions. This proposal has relevance not only for pain researchers, but also for researchers in the area of irritable bowel syndrome, chronic fatigue, fibromyalgia, noncardiac chest pain, and many others. For the first time, this compromise was developed on the basis of the participation of pain experts and experts from mental and psychosocial health. Therefore, this proposal might serve as a model for future developments of classification revisions of the current somatoform disorder category. As definitions of classification criteria are always driven (and limited) by the specific interests of the professional group developing them, it seems to be more desirable to define all-embracing compromises, especially for the diagnoses overlapping different specialties of medicine.

Our proposal overcomes the distinction of mainly biomedical pain (classified under the organ-specific sections) and psychologically caused pain (section F) in ICD-10; this is a major advantage because this distinction is frequently invalid and unreliable. Also, in comparison with DSM-IV, our proposal has some advantages, because it defines more clearly what the psychological features are that contribute to the pain condition. This is necessary to justify why pain should be (additionally) diagnosed under section F. Therefore, this proposal can serve as a model for the revision of other 'interface

disorders' requesting both medical and psychological approaches for understanding and treatment.

References and recommended reading

Papers of particular interest, published within the annual period of review, have been highlighted as:

- of special interest
- of outstanding interest

Additional references related to this topic can also be found in the Current World Literature section in this issue (pp. 226–227).

- 1 Elliott AM, Smith BH, Penny KI, *et al.* The epidemiology of chronic pain in the community. *The Lancet* 1999; 354:1248–1252.
- 2 Hiller W, Rief W, Brähler E. Somatization in the population: from mild bodily misperceptions to disabling symptoms. *Soc Psychiatry Psychiatr Epidemiol* 2006; 41:704–712.
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This study summarizes key questions around the classification issues of somatoform disorders resulting from three scientific meetings. For pain disorders, it is suggested that they should be classified exclusively as nonpsychiatric disorders, although the question of additional psychiatric or psychological treatment needs is not addressed, and representatives of pain research were not included. The formulation of key questions, however, is helpful for further discussions of classification issues.
- 13 Fink P, Rosendal M, Olesen F. Classification of somatization and functional somatic symptoms in primary care. *Aust N Z J Psychiatry* 2005; 39:772–781.
- 14 Rief W, Rojas G. Stability of somatoform symptoms: implications for classification. *Psychosom Med* 2007; 69:864–869.
This article provides a summary of study results addressing stability of symptoms. It is shown that, in patients with multiple complaints, symptoms tend to persist. Sources of instability are analysed, and implications for classification are outlined.