

Per Fink – Selected references

Fink, P. & Schroder, A. (2010). One single diagnosis, bodily distress syndrome, succeeded to capture 10 diagnostic categories of functional somatic syndromes and somatoform disorders. *Journal of Psychosomatic Research*, 68, 415-426.

Notes: BACKGROUND: In order to clarify the classification of physical complaints not attributable to verifiable, conventionally defined diseases, a new diagnosis of bodily distress syndrome was introduced. The aim of this study was to test if patients diagnosed with one of six different functional somatic syndromes or a DSM-IV somatoform disorder characterized by physical symptoms were captured by the new diagnosis. METHOD: A stratified sample of 978 consecutive patients from neurological (n=120) and medical (n=157) departments and from primary care (n=701) was examined applying post-hoc diagnoses based on the Schedules for Clinical Assessment in Neuropsychiatry diagnostic instrument. Diagnoses were assigned only to clinically relevant cases, i.e., patients with impairing illness. RESULTS: Bodily distress syndrome included all patients with fibromyalgia (n=58); chronic fatigue syndrome (n=54) and hyperventilation syndrome (n=49); 98% of those with irritable bowel syndrome (n=43); and at least 90% of patients with noncardiac chest pain (n=129), pain syndrome (n=130), or any somatoform disorder (n=178). The overall agreement of bodily distress syndrome with any of these diagnostic categories was 95% (95% CI 93.1-96.0; kappa 0.86, P<.0001). Symptom profiles of bodily distress syndrome organ subtypes were similar to those of the corresponding functional somatic syndromes with diagnostic agreement ranging from 90% to 95%. CONCLUSION: Bodily distress syndrome seem to cover most of the relevant "somatoform" or "functional" syndromes presenting with physical symptoms, not explained by well-recognized medical illness, thereby offering a common ground for the understanding of functional somatic symptoms. This may help unifying research efforts across medical disciplines and facilitate delivery of evidence-based care

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Fink, P., Rosendal, M., Dam, M. L., & Schroder, A. (2010). Ny fælles diagnose for de funktionelle tilstande. *Ugeskrift for Læger*, 172, 1835-1838.

Notes: Functional somatic symptoms are prevalent in all medical settings, but their management is hampered by an obsolete theoretical framework and inadequate classification systems. Epidemiological and neurobiological studies suggest that the functional somatic syndromes, e.g. fibromyalgia, chronic fatigue syndrome, irritable bowel syndrome and somatoform disorders belong to the same family of disorders. An empirically based diagnosis including different subtypes and severities is proposed as a unifying diagnostic construct: bodily distress syndrome. This construct provides a common language for functional disorders across medical specialties

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Fink, P. & Rosendal, M. (2008). Recent developments in the understanding and management of functional somatic symptoms in primary care. *Curr.Opin.Psychiatry*, 21, 182-188.

Notes: PURPOSE OF REVIEW: Medically unexplained or functional somatic symptoms

are prevalent in primary care, but general practitioners commonly find them difficult to treat. We focus on the conceptual issues and treatment from a primary care perspective, although the field is difficult to review because of the inconsistency and multiplicity of terminology used by different authors and specialties. RECENT FINDINGS: The training of general practitioners in management techniques has been hampered by an obsolete theoretical framework and outdated diagnostic systems. Epidemiological studies, however, indicate that valid, empirically based diagnostic criteria for functional disorders may be developed. Management studies in primary care have shown disappointing effects on patient outcome, but a lot may be gained by making the training programmes more sophisticated. Recently, stepped care approaches have been introduced but they need scientific evaluation. SUMMARY: There is an immediate need for a common language and a theoretical framework of understanding of functional symptoms and disorders across medical specialties, clinically and scientifically. Any names that presuppose a mind-body dualism (such as somatization, medically unexplained) ought to be abolished. The overall ambition for treatment is to offer patients with functional somatic symptoms the same quality of professional healthcare as we offer any other patient
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Fink, P., Toft, T., Hansen, M. S., Ornbol, E., & Olesen, F. (2007). Symptoms and syndromes of bodily distress: an exploratory study of 978 internal medical, neurological, and primary care patients. *Psychosomatic Medicine*, 69, 30-39.
Notes: OBJECTIVE: Physical complaints not attributable to verifiable, conventionally defined diseases, i.e., medically unexplained or functional somatic symptoms, are prevalent in all medical settings, but their classification is contested as numerous overlapping diagnoses and syndrome labels have been introduced. This study aims to determine whether functional somatic symptoms cluster into distinct syndromes and diagnostic entities. METHODS: The 978 consecutively admitted patients from a neurological department (n = 120), a medical department (n = 157), and from primary care (n = 701) were interviewed using the Schedules for Clinical Assessment in Neuropsychiatry (SCAN) diagnostic instrument. RESULTS: Patients complained of a median of five functional somatic symptoms; women of six, men of four ($p < .0001$). No single symptoms stood out as distinctive for patients with multiple symptoms. Principal component factor analysis identified a cardiopulmonary including autonomic (CP), a musculoskeletal (MS), and a gastrointestinal (GI) symptom group explaining 36.9% of the variance. Latent class analysis showed that the symptom groups are likely to materialize in the same patients, suggesting that they are different manifestations of a common latent phenomenon. Inclusion of a group of five additional general, unspecific symptoms in latent class analysis allowed construction of clinical diagnostic criteria for 'bodily distress disorder' dividing patients into three classes: nonbodily distress (n = 589), modest bodily distress (n = 329, prevalence 25.3%, men 20.4%, women 25.6%), and severe bodily distress (n = 60, prevalence 3.3%, men 1.2%, women 4.8%). CONCLUSION: The study suggests that bodily distress disorder as defined here may unite many of the functional somatic syndromes and some somatoform disorder diagnoses. Bodily distress may be triggered by stress rather than being distinct diseases of noncerebral pathology

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Fink, P., Steen, H. M., & Sondergaard, L. (2005). Somatoform disorders among first-time referrals to a neurology service. *Psychosomatics*, *46*, 540-548.

Notes: Consecutive new neurology inpatients and outpatients (N=198) were assessed for somatoform disorders by using the Schedules for Clinical Assessment in Neuropsychiatry. Sixty-one percent of the patients (59% of the female patients and 63% of the male patients) had at least one medically unexplained symptom, and 34.9% fulfilled the diagnostic criteria for an ICD-10 somatoform disorder (27.7% of the male patients, 41.3% of the female patients, 20.5% of the inpatients, and 43.2% of the outpatients). The prevalence figures were about the same when DSM-IV criteria for somatoform disorders were used. Of the patients with a somatoform disorder, 60.5% also had another mental disorder. Somatization disorder, somatoform autonomic dysfunction, pain disorder, and neurasthenia were equally prevalent (6%-7%); dissociative (conversion) disorders and undifferentiated somatoform disorders were found in 2-3% of the patients. Fifty percent of the patients with somatoform disorders were identified by the neurologists

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Fink, P., Ornbol, E., Toft, T., Sparle, K. C., Frostholm, L., & Olesen, F. (2004). A new, empirically established hypochondriasis diagnosis. *American Journal of Psychiatry*, *161*, 1680-1691.

Notes: OBJECTIVE: The narrow ICD-10 and DSM-IV definition of hypochondriasis makes it rarely used yet does not prevent extensive diagnosis overlap. This study identified a distinct hypochondriasis symptom cluster and defined diagnostic criteria. METHOD: Consecutive patients (N=1,785) consulting primary care physicians for new illness were screened for somatization, anxiety, depression, and alcohol abuse. A stratified subgroup of 701 patients were interviewed with the Schedules for Clinical Assessment in Neuropsychiatry and questions addressing common hypochondriasis symptoms. Symptom patterns were analyzed by latent class analysis. RESULTS: Patients fell into three classes based on six symptoms: preoccupation with the idea of harboring an illness or with bodily function, rumination about illness, suggestibility, unrealistic fear of infection, fascination with medical information, and fear of prescribed medication. All symptoms, particularly rumination, were frequent in one of the classes. Classification allowed definition of new diagnostic criteria for hypochondriasis and division of the cases into "mild" and "severe." The weighted prevalence of severe cases was 9.5% versus 5.8% for DSM-IV hypochondriasis. Compared with DSM-IV hypochondriasis, this approach produced less overlap with other somatoform disorders, similar overlap with nonsomatoform psychiatric disorders, and similar assessments by primary care physicians. Severe cases of the new hypochondriasis lasted 2 or more years in 54.3% of the subjects and 1 month or less in 27.2%. CONCLUSIONS: These results suggest that rumination about illness plus at least one of five other symptoms form a distinct diagnostic entity performing better than the current DSM-IV hypochondriasis diagnosis. However, these criteria are preliminary, awaiting cross-validation in other subject groups

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