Somatization Disorder

Briquet's Syndrome, Somatization Disorder, and Co-Occurring Psychiatric Disorders

By BARRY LISKOW, MD

The diagnosis of somatization disorder described in the DSM-III-R is derived from research in the 1960s and 1970s on Briquet's syndrome. Briquet's syndrome occurs predominantly in women and is defined as presenting with a complicated and dramatic medical history beginning before the age of 30 and consisting of a minimum of 25 of 59 medically unexplained symptoms in at least nine of 10 symptom groups. This compares with the DSM-III-R's definition of somatization disorder which requires a minimum of 13 of 37 medically unexplained symptoms and in which the grouping of symptoms plays no part in the diagnosis. Apart from a single study, little work has been done in determining the comparability of Briquet's syndrome and somatization disorder. Although only sparse research has been done regarding somatization disorder, much has been accomplished regarding Briquet's syndrome. However, recent findings have called into question notions of how this diagnosis should be approached and treated.

The manner in which co-occurring diagnoses were addressed in the studies made it difficult to ascertain how these additional syndromes related to the illness.

For example, schizophrenia is not an excluding diagnosis in some studies, but is in others. In addition, the diagnostic rules utilized in most studies of Briquet's syndrome prevent the diagnosis of anxiety neurosis (approximately equivalent to panic disorder) from being made if another psychiatric illness occurred prior to the onset of this disorder.

Because Briquet's syndrome usually has an early onset, anxiety neurosis could seldom be acknowledged as occurring with it. Furthermore, in these original diagnostic criteria, certain diagnoses such as phobic neurosis cannot be made in "patients with another definable psychiatric illness." Hence, the research diag-

---

Dr. Liskow is Chief of Staff, Columbus VA OPC and Professor of Psychiatry, Ohio State University.
Address reprint requests to Barry Liskow, MD, 2090 Kenny Road, Columbus, OH 43221.

350
nostic criteria used in most studies of Briquet's syndrome do not allow phobic disorder and Briquet's syndrome to be diagnosed concurrently. Finally, depressive symptoms constitute such a large number of the symptoms of Briquet's syndrome that the depressive disorder diagnoses (e.g., major depressive disorder, dysthmic disorder, etc.) are seldom noted as co-occurring diagnoses in Briquet's syndrome studies.

Despite the confusion regarding how to regard certain psychiatric disorders co-occurring with Briquet's, other syndromes have been consistently reported to co-occur with Briquet's syndrome including antisocial personality, drug and alcohol dependence, and, on occasion, secondary depression. In addition, recent studies which have considered all syndromes co-occurring with Briquet's without regard to overt or covert exclusionary rules have indicated high rates of schizophrenia, mania, obsessive-compulsive disorder, and panic disorder with agoraphobia occurring with Briquet's syndrome. The Table shows the co-occurrence of psychiatric disorders in Briquet's patients found in these recent studies of inpatient and outpatient psychiatric populations. There are a number of possible explanations for the co-occurrence of such a large number of syndromes with Briquet's. For example, Briquet's syndrome patients may simply report a great number of all types of psychiatric symptoms, just as they report a great number of all types of medical symptoms, and thus appear to have a multitude of psychiatric syndromes. The course of these concomitant syndromes would be expected to follow that of Briquet's and not of the individual syndromes. Studies indicating the stability of the diagnosis of Briquet's syndrome, its predictable natural history and its specific family history lend support to this interpretation.

Several studies have suggested that Briquet's syndrome can occur as a consequence of another disorder. The course of Briquet's syndrome would be expected to follow the course of the concomitant illness. However, because no studies have divided Briquet's syndrome patients by their concomitant diagnoses and followed the course of these illnesses or response to treatment, no data support or refute this concept. Briquet's syndrome might be both a primary illness and a syndrome occurring in the context of other disorders. Hypochondriasis would be such an example, occurring as a primary disorder and as a consequence of others such as affective disorder or schizophrenia.

Multiple assessment instruments, family history studies, and follow-up studies of the course of Briquet's syndrome and any coexisting illnesses will be required before it can be determined which or how many of the above possibilities are accurate. A recent finding indicated that the group Minnesota Multiphasic Personality Inventory (MMPI) profile of schizophrenic Briquet's patients could not be distinguished from the group MMPI profile of non-schizophrenic Briquet's patients. A similar finding indicated that the MMPI profiles of anxiety disordered (i.e., those with panic, phobic, and/or obsessive-compulsive disorders) and non-anxiety disordered Briquet's syndrome patients could not be distinguished. Although these findings suggest that Briquet's patients are homogeneous, the study had a small number of patients and the possibility exists that the lack of a difference might indicate that other disorders are actually present but masked by Briquet's syndrome. It will take additional assessment instruments in a variety of domains to resolve this question.

As complex and unsettled as the issue of coexisting disorders in Briquet's syndrome is, the situation regarding somatization disorder and coexisting disorders is even more uncertain. Although a recent study found a concurrence rate of 90% between Briquet's syndrome and somatization disorder, this remains the only such study and it relates to

---

**TABLE**

**Lifetime Prevalence of Additional Psychiatric Syndromes in Briquet's Syndrome Patients**

<table>
<thead>
<tr>
<th>Psychiatric Syndrome</th>
<th>Inpatient N=16 (%)</th>
<th>Outpatient N=78 (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organic mental disorder</td>
<td>1(6.2)</td>
<td>1(1.3)</td>
</tr>
<tr>
<td>Alcohol dependence</td>
<td>5(31.2)</td>
<td>13(16.7)</td>
</tr>
<tr>
<td>Drug dependence</td>
<td>5(31.2)</td>
<td>18(23.1)</td>
</tr>
<tr>
<td>Mania</td>
<td>6(37.5)</td>
<td>31(39.7)</td>
</tr>
<tr>
<td>Major depressive disorder</td>
<td>15(93.8)</td>
<td>68(87.2)</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>6(37.5)</td>
<td>21(26.9)</td>
</tr>
<tr>
<td>Antisocial personality</td>
<td>4(25.0)</td>
<td>13(16.7)</td>
</tr>
<tr>
<td>Anorexia nervosa</td>
<td>0(0)</td>
<td>5(6.4)</td>
</tr>
<tr>
<td>Obsessive-compulsive disorder</td>
<td>8(50.0)</td>
<td>21(26.9)</td>
</tr>
<tr>
<td>Phobic disorder</td>
<td>4(25.0)</td>
<td>30(38.5)</td>
</tr>
<tr>
<td>Panic disorder</td>
<td>5(31.2)</td>
<td>35(44.9)</td>
</tr>
<tr>
<td>Mental retardation</td>
<td>0(0)</td>
<td>1(1.3)</td>
</tr>
<tr>
<td>Ego-dystonic homosexuality</td>
<td>0(0)</td>
<td>3(3.8)</td>
</tr>
<tr>
<td>Transsexualism</td>
<td>1(6.2)</td>
<td>0(0)</td>
</tr>
<tr>
<td>Mean number syndromes positive (including Briquet's)</td>
<td>4.7±2.3</td>
<td>4.3±1.9</td>
</tr>
</tbody>
</table>
the DSM-III, not the DSM-III-R. The DSM-III definition of somatization disorder was utilized in a recent large scale psychiatric epidemiological study. This study found a large number of co-occurring psychiatric disorders (including schizophrenia, obsessive-compulsive disorder, and mania) in somatization disorder patients, although a very low incidence (less than 0.1%) of somatization disorder was found in the community (personal communication). Attempts to modify the definition of somatization disorder to capture a larger population are underway, but the relationship of this new definition to Briquet's syndrome, somatization disorder, and co-occurring disorders is yet to be clarified.

There are currently no systematic treatment studies of Briquet's syndrome and no systematic studies of the treatment of co-occurring psychiatric disorders in Briquet's syndrome patients. There have been recent reports regarding the treatment of patients with somatization disorder, but co-occurring diagnoses are not addressed. There have been frequent suggestions in the past several years that non-psychiatric physicians be taught to recognize and manage Briquet's syndrome and somatization disorder patients. These suggestions were based on the belief that Briquet's syndrome and somatization disorder are unitary diagnoses with few clinically significant co-occurring disorders. It is no longer clear that such an assumption can be applied to Briquet's syndrome or to somatization disordered patients. Until such time as the meaning and extent of co-occurring psychiatric disorders becomes clear, patients with these disorders will be best assessed and treated by psychiatrists for their somatoform and other psychiatric disorders.

REFERENCES