Syndrome Shift – revisited

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Syndrome Shift in psychosomatics describes the phenomenon that, after treating a disease, new symptoms or even a second diseases show up when underlying conflicts or structural deficits stayed untackled during treatment. Without the "removal of the cause" of a disorder, syndrome shift seems probable. The concept almost forgotten since the nineties is revisited under aspects of Operationalized psychodynamic Diagnosis OPD.

Keywords: Syndrome shift, psychosomatics, operationalized psychodynamic diagnosis, prerequisites of therapy, structure, conflict

Historical aspects

The concept of Syndrome Shift[1] stems from the psychosomatic medicine of last century's 50s up to the 1990s. Treating patients with somatic procedures like surgery or medication medical doctors faced the fact that outcomes sometimes were disappointing – for example when other diseases showed up, or the patient even deteriorated. While going deeper into such phenomena, the term "Syndrome Shift" was formed in times when psychotherapy had not yet developed our current concepts. These concepts contrast conflict versus structure, and describe modern trauma therapy, which was only developed in the 1990s. Even behavioural therapy was only at the beginning of its deepened development (Jacobi 1999).

While psychotherapy worked out new concepts, psychosomatic medicine was more and more taken over by psychotherapists from somatic doctors.[2] Unfortunately, psychotherapists usually lack direct contact with

[1] Syndrome Shift should be translated into German as "Symptomwandel", a term common in psychodynamic publications. "Symptomverschiebung" is sometimes used by behavioural authors.

[2] The new medical specialty in "Psychosomatics and Psychotherapy" was created in Germany during the nineties, with an emphasis on psychotherapy, but not on somatic medicine. In present, medical doctors in Germany specialized in internal medicine are no longer eligible to train and graduate in psychoanalysis, except they hold a second specialist title in Psychosomatics and/or Psychiatry. – Psychiatric medical societies have added psychosomatics to their title: the German Society for Child and Adolescent Psychiatry, Psychosomatic Medicine and Psychotherapy (DGKJP), and the German Society for Psychiatry and Psychotherapy, Psychosomatics and Neurology (DGPPN) which proves the takeover of psychosomatics by psychiatrists.

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the somatic patient during somatic treatment, and therefore don't get into timely and direct contact with the patients' complaints and features at somatic hospitals or at general practitioner's office. They see the patient when psychic aspects are already accepted and therapy should start. At the same time when somatic medicine developed more and more elaborated methods of treatment, psychosomatic medicine went independent ways of more "psychic" interventions as, at least in Germany, psychosomatics became a specialization of its own with specialized in and outpatient treatment.

Parikh et al. (1984) put an emphasis on that "only symptomatic relief, rather than a cure by removal of the cause" could bring about recurrence or syndrome shift (Parikh M. et al. 1984). We could state that in former times psychosomatics advocated by somatic doctors with an interest in "psycho" had a more holistic background than today.

In present times, Syndrome Shift seems to be a forgotten term. On PubPsych, there are 6 items with the term in the title, the "youngest" dating from 1996, and on PsychInfo, there is no relevant publication to be found.[3] Even in the English Wikipedia there is no entry named "Syndrome Shift" or "Symptom Shift".[4]

Definition

A psychosomatic disease could be understood either as a dysfunctional as well as an unconscious attempt to master a conflict, or as a narcissistic reparation, or as an adaption-effort, or even as an unconscious self-harm or self-destruction (Klußmann 1999). Thus, psychodynamic needs are served by somatic symptoms. Syndrome Shift can be defined when a second and new disease shows up after a first psychosomatic illness was (sufficiently) treated (Kröber & Kämmerer 1987), and that the second disease serves more or less equal needs like the first. Using this definition, there would be no differentiation whether the second disease may be somatic or psychiatric.

[3] Inquiry 2022-08-27 on APA Psychinfo; besides, no relevant results on "syndrome change".

[4] Inquiry 2022-08-28 on en.wikipedia.org.

Findings

Some findings from last century's publications should illustrate the phenomenology of Syndrome Shift. Sinclair-Gieben et al. (1962) described psychiatric symptoms after gastric surgery in 86 %, mostly depressive with or without suicidal ideations or acts. Ely & Johnson (1966) found new symptoms in patients with gastrectomy in 87 %, naming that new symptoms occurred when conflicts as well as anxiety were not sufficiently tackled. They stated that new symptoms work towards a "psychosomatic homeostasis" in case that psychologic problems persist. Zauner (1967) describes a sample of operated ulcer patients. A subgroup developed vegetative symptoms after an interval, alongside with similar conflicts prevailing at the beginning of the gastric disease. Klußmann (1984) compared patients with Ulcerative Colitis with or without operation. New symptoms in patients after surgical intervention were attributed to the attempt to overcome psychic fragmentation and psychic emptiness. Surgical intervention in patients with a non-psychosomatic illness, such as polyposis, showed better results that in diseases like ulcerative Colitis, Crohn's disease, usually associated with psychosomatic aspects (Klußmann et al. 1987). Eckhof (1991) reported as case of anorexia nervosa being sufficiently treated changing to hypochondria, discussing that the Syndrome Shift goes along with certain changes in structural aspects.

Psychiatrists and psychotherapists know about Syndrome Shift from anorexia to bulimia to be observed in a number of cases. There might even be a shift over several disorders: The author saw a patient with an obsessive-compulsive disorder, then changing to anorexia, changing to bulimia, both with a remission of obsessive symptoms, then changing to an anxiety disorder combined with depression and again obsessive-compulsive symptoms.

Discussion

Findings not only from case reports or personal experience show that the phenomenon of Syndrome Shift exists, psychotherapists may hold oneself back from discussing Syndrome Shift, as it will occur when underlying conflicts and structural deficits – or even traumata – are insufficiently treated. Insufficient treatment is deplorable and endangers the narcisstic self of the treating therapist. On the other hand, looking on phenomenology might be conceived as trivial and shallow – although it would be a confrontation

with reality. Abstaining from phenomenology can avert deeper understanding of underlying circumstances, structural deficits or unconscious conflicts. The patient might thus be let alone when going into symptoms and regression.

Using current theory, Syndrome Shift will be more comprehensible, especially when applying Operationalized psychodynamic Diagnosis (OPD2) with its view on a) prerequisites of treatment (Axis I), b) conflicts (Axis III) and c) structural deficits (Axis IV). Psychosomatic as well as psychiatric diseases should be evaluated on all three axes. Especially in psychosomatic patients, prerequisites of treatment as psychosocial circumstances are of great importance – as their impact is crucial on putting conflicts and structural deficits into effect. Furthermore, psychosomatic patients quite often show structural deficits in anticipation, in affect perception, affect tolerance and affect mentalization. Such personality traits are found in the alexithymia concept, applied to psychosomatic patients in former days. In summary, therapy planning should therefore take into account present psychosocial circumstances, structural deficits and present and/or ongoing, biographically based conflicts, each individually viewed on its own axis.

The concept of Syndrome Shift could help us find blind spots when new symptoms show up. When facing Syndrome Shift, therapists should be aware of whether there is a progression – be it in conflict or structure – or a regression. The latter might be caused by psychosocial circumstances as prerequisites of treatment, or by some kind of malignant regression due to unresolved conflicts and/or deficits.

Sometimes, just being aware of what actually happens might lead to a kind of therapeutic containment that will pave the way for the therapist's alpha-function in order to better reach the patient's unconscious.

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