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Commentary

Persistent-postural perceptual dizziness (PPPD): Yes, it is a psychosomatic condition!

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Abstract. The Barany society published recently the consensus document for the diagnostic criteria of persistent postural perceptual dizziness (PPPD). In this commentary we highlight the benefits of this new diagnosis and possible problems that can arise during the use of the criteria in day to day clinical practice at a University Clinic for Psychosomatic Medicine. The diagnostic criteria of PPPD are compared to those of somatic symptom disorder and bodily distress disorder. We think that a discussion from a psychosomatic point of view is important to improve the understanding between different specialties and how PPPD fits into the broader framework of psychosomatic medicine.

Recently, the Barany society published diagnostic criteria for concept of persistent postural perceptual dizziness (PPPD) [1]. The diagnostic guidelines describe very helpful criteria which can be used to characterize a specific population of individuals with vertigo/dizziness/imbalance due to a psychosomatic, or as titled in the original document, functional cause. This will in the future be helpful to gain insight into epidemiologic aspects of the condition and evaluate treatment options. Additionally, it gives neurologists/otolaryngologists or general medicine physicians who might not be so experienced with psychosomatic disease concepts, something at hand to categorize and label patients. This is important to avoid unnecessary diagnostic workup or uncertainty for the patients. The PPPD concept can be helpful, just as the concept and Rome diagnostic criteria of irritable bowel syndrome (IBS) have helped many patients and internists deal with their psychosomatic bowel problems [2].

The diagnostic criteria of PPD have some weaknesses especially from a psychosomatic perspective which we would like to comment on and discuss:

- The abstract of the guidelines states that PPPD "*is not a psychiatric condition*", but a "*functional disorder*" [1]. From our experience in working with patients and teaching on psychosomatic vertigo syndromes this wording has led to considerable confusion, since many view psychiatry and psychosomatic medicine as "sister disciplines" with partly overlapping competences, which might also stem from the fact that in ICD 11 [3] as in DSM 5 [4] psychiatric and psychosomatic conditions are grouped together.
- "*Clinicians may encounter patients who describe persistent vestibular symptoms that do not fit the diagnostic criteria of either PPPD . . . . . In many patients, these functional forms of vestibular symptoms are accompanied by other chronic physical complaints such as fatigue and pain, raising the possibility that*

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they are but one manifestation of a broader somatic symptom disorder or bodily distress disorder" *[1].* In essence, PPPD is described as being a distinct entity separate from a somatic symptom disorder (SSD) or bodily distress disorder (BDD). We would like to point out that according to the official diagnostic criteria only a single somatic symptom is sufficient to diagnose SSD ([4] alongside other criteria see Table 1) and even for BDD the presence of multiple somatic symptoms is not required although they are described to be common [3]. A high number of patients with PPPD will therefore fulfill the SSD or the BDD criteria, although absolute numbers are not available [5]. This discussion is not new: 20 years ago it was debated if the existing definitions of specific functional somatic symptoms such as IBS and chronic fatigue syndrome are of limited value; instead a dimensional classification was proposed [6]. Fo*r* patients with only a single, specific functional somatic symptom, like PPPD, and without excessive psychobehavioral features the specific diagnosis of this functional somatic symptom may in certain settings be helpful [5]. For those patients who have numerous bodily symptoms, who are given more than one diagnosis of a functional somatic symptom (e.g. comorbidity of PPPD and fibromyalgia) and/or who show accompanying psychobehavioral features, the diagnosis of SSD, a somatoform disorder or, in the future BDD, is more appropriate [5].

- According to the PPPD diagnostic criteria triggering factors for PPPD can be a *neurological or medical condition or psychological distress [1].* While this is certainly correct, it is very unspecific and thus of limited diagnostic value. On the other hand one criterion of the PPPD diagnostic criteria (criterion B, see Table 1) is quite narrow since patients can only be diagnosed with PPPD if their vertigo is aggravated by all three factors: "*upright posture, active or passive motion and visual stimuli*" [1]. From our experience at a clinic specialized in psychosomatic vertigo syndromes this is often not the case and the limiting factor why a diagnosis cannot be made in an individual patient despite this patient clearly displaying psychosomatic vertigo symptoms. Interestingly this "AND" between the aggravating factors was replaced by an "OR" in the ICD 11 beta version [3]. The Barany guidelines [1] as well as the ICD 11 [3] note that not all situations might be equally provocative.
- The anxiety aspect was removed from the PPPD concept, although it has been an integral part of the concept of psychosomatic vertigo syndromes for many years [7] and psychobehavioral alterations are also present in the concept of SSD "*Excessive thoughts, feelings and behaviors related to these somatic symptoms or associated health concerns*" (SSD criterion B and BDD (Table 1).
- "*Symptoms are not better accounted for by another disease or disorder*" [1]. While the SSD and BDD criteria both got rid of this point to allow for a positive diagnosis and not one of exclusion this point is retained in PPPD. The mind body dualism is emphasized by this statement instead of focusing on modern, holistic disease concepts [8].
- "*Functional conditions are considered as . . . . . disorders* "*arising from a change in the mode of action of an organ*"*, unrelated to structural or cellular deficits.. . . . In this connotation, functional is not a synonym for psychogenic or psychosomatic . . . . . and, therefore, does not reflect a presumption of psychopathological abnormalities*". We agree that psychosomatic diseases are not characterized by severe psychopathological abnormalities such as thought disorders or neurocognitive deficits. Mild alterations in psychopathological status such as increased health anxiety (anxiety as a symptom was present in the initial description of "phobic vertigo" [9]) or continuous rumination about the somatic symptoms are found in the majority of patients. We do not agree that functional or psychosomatic disorders are "*unrelated to structural or cellular deficits*". It has now been well investigated that hormonal, neurobiological and immune alterations, changes in muscle tone, heart rate variability or breathing pattern, can be caused by chronic stress, one of the major players in psychosomatic disorders. And such alterations have also been shown for PPPD [10].

Yes, it is a psychosomatic condition! We think that PPPD is a prototypical example of a psychosomatic condition, in the sense that it requires a comprehensive interdisciplinary and holistic approach to the patient and that psychosocial factors, above all chronic stress, play an important role in the vulnerability, course, and outcome of the disease [11].

Table 1
Comparisons of abbreviated Criteria for PPPD, SSD and BDD

PPPD (Barany Criteria)	Somatic symptom disorder (DSM V)	Bodily distress disorder (ICD 11)
One or more symptoms of dizziness, unsteadiness, or non-spinning vertigo	One or more somatic symptoms	The presence of typically multiple bodily symptoms that may vary over time. Occasionally there is a single symptom—usually pain or fatigue
Present on most days for 3 months or more	The disorder is persistent (usually more than six months).	Bodily symptoms are persistent, being present on most days for at least several months
Persistent symptoms occur without specific provocation, but are exacerbated by three factors (or avoidance of these situations)		
The disorder is precipitated by conditions that cause vertigo, or medical illnesses, or psychological distress		
Symptoms cause significant distress or functional impairment	Symptoms cause distress or psychosocial impairment	Symptoms are distressing to the individual
	Excessive thoughts, feelings, or behaviors associated with the somatic symptoms	Excessive attention directed toward the symptoms, which may be manifest by repeated contact with health care providers
Symptoms are not better accounted for by another disease or disorder		

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