

Justification of Criteria—Somatic Symptoms

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Synopsis:

Because the current terminology for somatoform disorders is confusing and because Somatoform Disorders, Psychological Factors Affecting Medical Condition (PFAMC), and Factitious Disorders all involve presentation of physical symptoms and/or concern about medical illness, the workgroup suggests renaming this group of disorders as “Somatic Symptom Disorders.” Because of the implicit mind-body dualism and the unreliability of assessments of “medically unexplained symptoms,” these symptoms are no longer emphasized as core features of many of these disorders. Because somatization disorder, hypochondriasis, undifferentiated somatoform disorder, and pain disorder share certain common features, namely somatic symptoms and cognitive distortions, these disorders are grouped under a common rubric of “Complex Somatic Symptom Disorder.”

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Introduction and Rationale:

The Somatic Symptoms group was charged with viewing those DSM diagnoses where somatic issues predominate. While somatic symptoms are present in virtually every psychiatric diagnosis, they are clearest in the various somatoform disorders and in psychological factors affecting medical condition (PFAMC).

Contemporary criteria for somatoform disorders give heavy emphasis to the concept of “medically unexplained symptoms.” Such terminology enforces a dualism between psychiatric and medical conditions. It bases a diagnosis on a negative—the absence of something, and, as such, runs the risk of misdiagnosis (Kroenke et al, 2007). With such criteria, these disorders are very common, particularly in primary care settings where they are present in 1 out of 6 consultations (Fink, 1999). High levels of presenting somatic symptoms that are below the diagnostic threshold of somatization disorder are quite common and disabling in primary care and medical settings and tend to be associated with both depression and anxiety disorders (Bridges and Goldberg 1985; Barsky et al 1999; Kirmayer and Robbins 1992; Escobar et al, 1998; Gureje et al, 1999). Similarly, psychological factors which complicate underlying medical disorders constitute the essence of PFAMC and are also very common in medical settings (Levenson 2008; Dimatteo 2004).

Despite their prominence in primary care settings, these diagnostic codes are rarely used. In 2008, among 28 million Wellpoint/Anthem Blue Cross Blue Shield members, only 0.04% of the members had a clinical encounter for which the primary diagnosis was any of the somatoform disorders or PFAMC. Similarly, among patients within the Veterans Administration during the years 2002-2008, only 0.18% of inpatient encounters and 0.25% of outpatient encounters had as a primary diagnosis any of the

somatoform disorders or PFAMC (Levenson, unpublished). With the possible exception of pain disorders, these disorders are uncommonly encountered in psychiatric practice. There is considerable confusion about the criteria for the disorders and the terms themselves are intensely disliked by patients. A 2009 survey of physicians revealed that somatoform NOS was regarded as unclear by 45%, not particularly useful by 51%, and was regarded as a useful diagnosis by only 6% of patients (Dimsdale, Sharma, & Sharpe, unpublished).

Place of prominence in the group of somatoform disorders is given to somatization disorder, which is relatively rare, using the existing criteria (Escobar et al, 1987). In a systematic review of somatization disorder in population-based samples (10 studies) the median prevalence was 0.4% (range 0.03% to 0.84%) (Creed, Barsky J Psychosom Res 2004). As a result, the majority of patients with somatoform disorders are given a residual category diagnosis (undifferentiated somatoform disorder, or somatoform disorder NOS) (Kumabara et al 2007). There have been very few population studies of DSM-IV somatization disorder, but the most recent in China found a prevalence of 0.03% (Phillips et al, 2009). The number of cases of somatization disorder is so small that these data cannot be used to identify the risk factors or associated features reliably.

Researchers therefore have largely abandoned DSM IV criteria of somatization disorder and developed their own criteria, of which “abridged 4/6,” and “multisomatoform” have been the most widely studied (Escobar, Kroenke). The low prevalence of somatization disorder, combined with the difficulty of measurement of all of the somatoform disorders has meant that these disorders have not even been included in most national surveys of mental health (see table below). Even liberalizing the criteria in terms of symptom count, fails to reveal a natural ‘cut point’ in diagnosing the disorder (Creed, unpublished).

Perhaps as a reaction to the measurement problems with somatization disorder, the low rates, and the reliance on “medically unexplained symptoms,” this area of psychiatric diagnosis is understudied, and psychiatrists and health service planners have been accused of neglecting an important group of disorders associated with considerable distress and disability (Saxena 2005, Creed 2006). The absence of somatoform disorders from population-based disorders has been described by a German group, which did include somatoform disorders, as “astonishing considering that these disorders are the third most frequent in the general population” (Baumeister, 2007).

There is thus a paucity of epidemiological data on somatization disorder as defined by DSM IV, and the impression is that this disorder is extremely rare. When different criteria are adopted to assess prevalence, one finds very different prevalence estimates. In 119 primary care patients, Lynch (1999) reports that Abridged somatization (4m/6f) was present in 6%, Multisomatoform disorder in 24%, DSM IV somatization disorder <1%, and DSM IV Undifferentiated somatoform disorder in 79%.

Table 1: Sampling of major psychiatric epidemiology studies — none of which assessed somatization disorder

Country	Survey	Author
USA -	National Comorbidity Survey.	Kessler RC et al 1994
USA -	National Comorbidity Survey replication.	Kessler RC 2005
UK -	National Psychiatric Morbidity survey	Jenkins R. 1997.
Australia -	National Mental Health Survey.	Andrews G. 2001
Netherlands –	NEMESIS.	Bijl RV. 1998
World	World Mental Health Surveys:	Kessler RC. JAMA 2004

Given that (a) the reliance on medically unexplained symptoms as a key factor for such diagnoses is intensely problematic, (b) the diagnoses are not used by clinicians, (c) patients find them very objectionable, (d) clinicians find these diagnoses unclear; and (e) there are highly discrepant prevalence estimates using various criteria, the workgroup proposes a number of changes in this important area of psychiatric diagnosis.

Recommendations:

The work group proposes 4 major changes and 1 minor change to the nomenclature, as summarized below.

Major change #1: Rename Somatoform disorders to Somatic Symptom Disorders and combine with PFAMC and Factitious Disorders

The workgroup suggests combining Somatoform Disorders, Psychological Factors Affecting Medical Condition (PFAMC), and Factitious Disorders into one group entitled “Somatic Symptom Disorders” because the common feature of these disorders is the central place in the clinical presentation of physical symptoms and/or concerns about medical illness. The grouping of these disorders in a single section is based on clinical utility (these patients are mainly encountered in general medical settings), rather than assumptions regarding shared etiology or mechanism.

Major change #2: De-emphasize medically unexplained symptoms

Remove the language concerning medically unexplained symptoms for reasons specified above. The reliability of such judgments is low (Rief, 2007). In addition, it is clear that many of these patients do in fact have considerable medical co-morbidity (Creed, Ng). Medically unexplained symptoms are 3 times as common in patients with general medical illnesses, including cancer, cardiovascular and respiratory disease

compared to the general population (OR=3.0 [95%CI: 2.1 to 4.2] (Harter et al 2007). This de-emphasis of medically unexplained symptoms would pertain to somatization disorder, hypochondriasis, undifferentiated somatoform disorder, and pain disorder. We now focus on the extent to which such symptoms result in subjective distress, disturbance, diminished quality of life, and impaired role functioning.

Major change #3: Combine somatization disorder, hypochondriasis, undifferentiated somatoform disorder, and pain disorder into a new category entitled “Complex Somatic Symptom Disorder” (CSSD)

Combine somatization disorder, hypochondriasis, undifferentiated somatoform disorder, and pain disorder into a new category entitled “Complex Somatic Symptom Disorder” (CSSD) which emphasizes the symptoms plus the patients’ abnormal cognitions (Barsky, Lowe, Rief). The term “complex” is intended to denote that in order for this diagnosis to be made, the symptoms must be persistent and must include both somatic symptoms (criterion A) as well as cognitive distortions (criterion B).

This is a major change in the diagnostic nomenclature, and it will likely have a major impact on diagnosis. It clarifies that a diagnosis of CSSD is inappropriate in the presence of only unexplained medical symptoms. Similarly, in conditions such as irritable bowel syndrome, CSSD should not be coded unless the other criterion (criterion B—attributions, etc) is present.

It is unclear how these changes would affect the base rate of disorders now recognized as somatoform disorders. One might conclude that the rate of diagnosis of CSSD would fall, particularly if some disorders previously diagnosed as somatoform were now diagnosed elsewhere (such as adjustment disorder). On the other hand, there are also considerable data to suggest that physicians actively avoid using the older diagnoses because they find them confusing or pejorative. So, with the CSSD classification, there may be an increase in diagnosis.

The proposal is to group together these heretofore separately recognized disorders because in fact, there are 3 diverse sources suggesting considerable overlap among them.

1. A 2009 study found that 52% of physicians surveyed indicated that there was “a lot of overlap” and an additional 38% thought that there was “some overlap” across these disorders. In contrast, less than 2% of physician respondents felt that these were “distinctly different disorders (Dimsdale, Sharma, & Sharpe, unpublished).

2. There are limited data regarding overlap in clinical settings. One primary care study, for instance, found that 20% of somatization disorder patients also had hypochondriasis (Escobar, 1998). In primary care patients, somatization disorder was 5 times (Fink et al 2004) to 20 times (Barsky et al 1992) more common in hypochondriasis patients as compared to primary care patients without hypochondriasis.

3. Treatment interventions are similar in this group of disorders. Cognitive behavior therapy (CBT) and antidepressant medications appear to be the most promising therapeutic approaches for hypochondriasis, somatization disorder, and pain disorder (Kroenke 2007; Sumathipala 2007). Although several variations of CBT have been

employed, they share many elements in common. These include the identification and modification of dysfunctional and maladaptive beliefs about symptoms and disease, and behavioral techniques to alter illness and sick role behaviors and promote more effective coping. The literature on the use of antidepressants is more limited, but it too does not suggest any major distinctions in therapeutic response across these different disorders. In addition to these patient centered commonalities of treatment, all of these disorders benefit from specific interventions with the patient's non-psychiatric physician (e.g. scheduling regular appointments as opposed to prn appointments, limiting testing and procedures unless clearly indicated) (Allen 2002).

A key issue is whether the guidelines for CSSD describe a valid construct and can be used reliably. A recent systematic review (Lowe, submitted for publication) shows that of all diagnostic proposals, only Somatic Symptom Disorder reflects all dimensions of current biopsychosocial models of somatization (construct validity) and goes beyond somatic symptom counts by including psychological and behavioral symptoms that are specific to somatization (descriptive validity). Predictive validity of most of the diagnostic proposals has not yet been investigated.

Major change #4: Modify criteria for conversion disorder

Changes are made in an effort to simplify the criteria for conversion disorder. First, we suggest removing the requirement that the clinician actively establish that the patient is not feigning. This is because (a) it is probably clinically impossible to prove that a patient is not feigning (Sharpe, 2003) and (b) there is no evidence that feigning of conversion symptoms is more common than feigning of other mental disorders. However as with other disorders positive evidence of feigning remains an exclusion, thereby differentiating conversion from factitious disorder and malingering.

Second, we suggest removing the requirement that the clinician has to establish that there are associated psychological factors. This is because (a) as with feigning, it is very difficult to reliably establish that relevant psychological factors are present in all cases and (b) the research evidence suggests that psychological factors can often be found but are not specific and have only a weak association with the diagnosis (Roelofs, 2005). The association with psychological factors has therefore been relegated to accompanying text rather than remaining a clinical requirement for diagnosis.

Third, we emphasize the importance of obtaining positive evidence of the diagnosis from appropriate neurological assessment and testing. Current diagnostic criteria require that the symptom, after appropriate medical assessment, is found not to be due to a general medical condition. In contrast to most other somatic symptoms, it can be usually be reliably determined whether neurological symptoms are due to an organic disease (Stone et al 2009). Additionally there are also findings on neurological assessment and investigation that positively suggest the symptoms are those of conversion (such as Hoovers sign for motor weakness or absence of seizure activity on an EEG during apparent seizures for seizures) (Hallett 2005; Reuber 2004; Stone 2005).

We suggest retaining Conversion Disorder in the Somatic Symptom Disorders section of the DSM. Conversion remains a condition defined by a somatic symptom that

causes disability or distress and therefore sits comfortably in the new Somatic Symptom Disorders category that replaces somatoform disorders on grounds of utility. The alternative placement of this diagnosis is with dissociative disorders. The argument for moving conversion there is that the mental mechanisms involved are similar. However dissociation is a hypothetical process and moving conversion would (a) risk making an unjustified assumption about cause (b) lose the utility of grouping with other conditions that present with a somatic symptom.

Minor Change: Factitious Disorders:

The work group proposes minor modifications to factitious disorders. Most importantly, it eliminates the distinction between factitious disorders involving physical vs psychological symptoms. It clarifies who is the patient in circumstances previously diagnosed as “factitious disorder by proxy.” This is now termed “factitious disorder on other.”

Additional minor changes in the factitious disorder descriptions were made to emphasize objective identification rather than inference about intentionality or possible underlying motivation. "Intentional production or feigning" was thus removed and replaced with "a pattern of falsification". The wording "pattern of falsification" attempts to emphasize that the diagnosis should follow an objective characterization of a set of behaviors, without perceived inference about the intentionality or possible underlying motivation for these behaviors. "...associated with identified deception" was inserted to state that the behaviors showed evidence of deception as identified by the observer. Again, this wording emphasizes behaviors being observed, rather than inference about intent. Finally, item A4 was added to clarify that factitious disorder is not diagnosed when it is accounted for by another mental disorder such as an acute psychosis.

Body dysmorphic disorder (BDD):

BDD is being considered by another workgroup (Anxiety disorders workgroup). Logically, it could be included in the framework of the Somatic Symptom Disorders but conceptually, it might also fit in the Anxiety Disorder group. Criteria and placement of this disorder remain to be determined. However, moving the disorder out of the Somatic Symptom Disorders section would appear to involve more of a change in the nomenclature than retaining it within the Somatic Symptom Group.

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Severity Metrics

Severity metrics are readily available for somatic symptoms (viz PHQ, Kroenke 2002) and for the cognitive distortions and misattributions associated with CSSD (viz Whiteley Index, Pilowsky. 1967, Fink 1999).

There are few widely employed measures of severity in factitious disorder or conversion disorder.

For factitious disorder, one might grade severity levels as “1” when symptoms alone are reported (“bright red blood in stool”), as “2” when a lab test was modified (e.g. introducing blood into a urine sample), as “3” when patients make themselves sick or as “4” when patients’ actions lead to life threatening illness.

For conversion disorder, the severity scoring might best be based on the severity of the associated disability (using a simple rating of mild, moderate and severe)

For PFAMC, severity scoring might include “1” when the psychological factor only increases risk for medical illness, “2” when the symptoms of medical illness are exacerbated, and “3” when the effect is life-threatening.

Reference List

{note, the list is not verified yet}

Allen LA, Escobar JI, Lehrer PM, Gara MA, Woolfolk RL. Psychosocial treatments for multiple unexplained physical symptoms: A review of the literature. *Psychosom Med* 2002; 64:939-950.

Andrews G, Henderson S, Hall W. Prevalence, comorbidity, disability and service utilisation. Overview of the Australian National Mental Health Survey. *Br J Psychiatry*. 2001 Feb;178:145-53.

Barsky AJ, Ettner SL, Horsky J, Bates DW. Resource utilization of patients with hypochondriacal health anxiety and somatization. *Medical Care* 2001;39:705-715.

Barsky AJ, Orav EJ, Bates DW. Somatization increases medical utilization and costs independent of psychiatric and medical comorbidity. *Archives of General Psychiatry* 2005;62:903-910.

Barsky AJ, Borus JF. Functional somatic syndromes. *Ann Intern Med* 1999; 130: 910-921.

Barsky AJ, Wyshak G, Klerman GL. Psychiatric comorbidity in DSM-III-R hypochondriasis. *Arch Gen Psychiatry*. Feb 1992;49(2):101-108.

Baumeister H, Härter M. Prevalence of mental disorders based on general population surveys. *Soc Psychiatry Psychiatr Epidemiol*. 2007 Jul;42(7):537-46.

Bijl RV, Ravelli A, van Zessen G. Prevalence of psychiatric disorder in the general population: results of The Netherlands Mental Health Survey and Incidence Study (NEMESIS). *Soc Psychiatry Psychiatr Epidemiol*. 1998 Dec;33(12):587-95

Bridges KW, Goldberg DP. Somatic presentations of DSM-III psychiatric disorders in primary care. *J Psychosomat Res* 1985; 29: 563-569.

Creed F, Barsky A. A systematic review of the epidemiology of somatisation disorder and hypochondriasis. *Journal of Psychosomatic Research* 2004;56:391-408.

Creed F. Should general psychiatry ignore somatisation and hypochondriasis? *World Psychiatry*. 2006 (Oct): 146-50.

Creed F. Should general psychiatry ignore somatisation and hypochondriasis? *World Psychiatry*. 2006 (Oct): 146-50

Creed F, unpublished Can we now explain "medically unexplained" symptoms? Hackett Award Lecture. Academy of Psychosomatic Medicine Meeting. Las Vegas. Nov 13th 2009

Demyttenaere K, Bruffaerts R, Posada-Villa J, Gasquet I, Kessler RC, et al Prevalence, severity, and unmet need for treatment of mental disorders in the World Health Organization World Mental Health Surveys. *JAMA*. 2004 Jun 2;291(21):2581-90.

DiMatteo MR. Variations in patients' adherence to medical recommendations: a quantitative review of 50 years of research. *Med Care*. 2004;42:200-9.

Dimsdale J & Creed F: The proposed diagnosis of somatic symptom disorders in DSM-V to replace somatoform disorders in DSM-IV—a preliminary report. *J Psychosom Res* 2009 66 (2009) 473–476

Dimsdale J, Sharma N, Sharpe M, What do physicians think about somatoform disorders? unpublished

Escobar JI, Burnam MA, Karno M, Forsythe A, Golding JM. Somatization in the community. *Arch Gen Psychiatry* 1987; 44: 713-718.

Escobar JI, Gara M, Cohen Silver R, Waitzkin H, Holman A, Compton W. Somatization disorder in primary care. *Br J Psychiatry* 1998; 173: 262-266.

Fink P, Ornbel E, Toft T, Sparle KC, Frostholm L, Olesen F. A new, empirically established hypochondriasis diagnosis. *Am J Psychiatry* 2004 2004;161(9):1680-91.

Fink P, Ewald H, Jensen J, Sørensen L, Engberg M, Holm M, Munk-Jørgensen P. Screening for somatization and hypochondriasis in primary care and neurological in-patients: a seven-item scale for hypochondriasis and somatization. *J Psychosom Res*. 1999 Mar;46(3):261-73.

Gureje O, Simon G. The natural history of somatization in primary care. *Psychol Med* 1999; 29: 669-676.

Hallett M, Cloninger CR, Fahn S, Jankovic J, Lang AE, Yudofsky SC. Psychogenic Movement Disorders. Lippincott Williams & Wilkins and the American Academy of Neurology, 2005.

Härter M, Baumeister H, Reuter K, Jacobi F, Höfler M, Bengel J, Wittchen HU. Increased 12-month prevalence rates of mental disorders in patients with chronic somatic diseases. *Psychother Psychosom*. 2007;76(6):354-60.

Jenkins R, Lewis G, Bebbington P, Brugha T, Farrell M, Gill B, Meltzer H. The National Psychiatric Morbidity surveys of Great Britain—initial findings from the household survey. *Psychol Med*. 1997 Jul;27(4):775-89.

Katon W, Von Korff M, Lin E, Lipscomb P, Russo J, Wagner E, Polk E Distressed high utilizers of medical care. DSM-III-R diagnoses and treatment needs. *Gen Hosp Psychiatry*. 1990 Nov;12(6):355-62.

Kessler RC, McGonagle KA, Zhao S, Nelson CB, Hughes M, Eshleman S, Wittchen HU, Kendler KS. Lifetime and 12-month prevalence of DSM-III-R psychiatric disorders in the United States. Results from the National Comorbidity Survey. *Arch Gen Psychiatry*. 1994 Jan;51(1):8-19.

Kessler RC, Chiu WT, Demler O, Merikangas KR, Walters EE. Prevalence, severity, and comorbidity of 12-month DSM-IV disorders in the National Comorbidity Survey Replication. *Arch Gen Psychiatry*. 2005 Jun;62(6):617-27.

Kessler RC, JAMA 2004 Demyttenaere K, Bruffaerts R, Posada-Villa J, Gasquet I, et al.; WHO World Mental Health Survey Consortium. Prevalence, severity, and unmet need for treatment of mental disorders in the World Health Organization World Mental Health Surveys. *JAMA*. 2004 Jun 2;291(21):2581-90

Kirmayer LJ, Robbins JM. Three forms of somatization in primary care. *J Nerv Ment Dis* 1991; 179: 647-655.

Kroenke K, Spitzer RL, Williams JB, Kroenke K, Spitzer RL, Williams JBW. The PHQ-15: validity of a new measure for evaluating the severity of somatic symptoms. *Psychosomatic Medicine* 2002;64:258-266.

Kroenke K. Efficacy of treatment for somatoform disorders: A review of randomized controlled trials. *Psychosom Med* 2007; 69:881-888.

Kroenke K, Sharpe M, Sykes R, Revising the Classification of Somatoform Disorders: Key Questions and Preliminary recommendations, *Psychosomatics* 2007 48:277-285.

Kuwabara H, Otsuka M, Shindo M, Ono S, Shioiri T, Someya T. Diagnostic classification and demographic features in 283 patients with somatoform disorder.; *Psychiatry Clin Neurosci*. 2007 Jun;61(3):283-9.

Levenson JL: Psychological factors affecting medical condition. In Tasman A, Kay J, Lieberman J, First M, Maj M (eds). *Psychiatry*, 3rd edition. John Wiley & Sons, Chichester, UK, 2008, pp. 1754-1772.

Levenson JL, Prevalence of somatoform disorders as determined from Blue Cross/Blue Shield, Medicare, Medicaid, and Veterans Administration data bases, unpublished

Lowe B, unpublished Validity of current and new somatoform disorder diagnoses: A systematic review and suggestions for classification using positive criteria

Lynch DJ: MANRZC. Somatization in Family Practice: Comparing 5 Methods of Classification. *Prim Care Companion J Clin Psychiatry* 1999;1:85-89.

Ng B, Tomfohr L, Camacho A, Dimsdale J, Prevalence and comorbidities of somatoform disorders in a rural California outpatient psychiatric clinic, unpublished

Noyes R, Jr., Kathol RG, Fisher MM, Phillips BM, Suelzer MT, Woodman CL. Psychiatric comorbidity among patients with hypochondriasis. *Gen Hosp Psychiatry*. Mar 1994;16(2):78-87.

Phillips MR, Zhang J, Shi Q, Song Z, Ding Z, Pang S, Li X, Zhang Y, Wang Z Prevalence, treatment, and associated disability of mental disorders in four provinces in China during 2001-05: an epidemiological survey. *Lancet*. 2009 Jun 13;373(9680):2041-53

Pilowsky I. Dimensions of hypochondriasis. *Br J Psychiatry* 113:89-93, 1967

Reuber M, Elger CE. Psychogenic nonepileptic seizures: a review and update. *Epilepsy and Behaviour* 2003;4:205-16.

Rief W, Isaac M, Are somatoform disorders 'mental disorders'? A contribution to the current debate, *Curr Opinion Psychiatry* 2007; 20:143-146

Rief W, , Rojas G. Stability of somatoform symptoms—implications for classification. *Psychosom Med.* 2007;69:864-9

Roelofs K, Spinhoven P, Sandijck P, Moene FC, Hoogduin KA. The impact of early trauma and recent life-events on symptom severity in patients with conversion disorder. *J.Nerv.Ment.Dis.* 2005;193:508-14.

Saxena S. Somatization and conversion disorders: a forgotten public health agenda? In: Maj M, Akiskal HS, Mezzich JE et al (eds). *Somatoform disorders*. Chichester: Wiley, 2005:42-4

Sharpe M. Distinguishing malingering from psychiatric disorders. In Halligan PW, Bass C, Oakley DA, eds. *Malingering and illness deception*, Oxford: OUP, 2003.

Smith RC, Gardiner JC, Lyles JS et al. Exploration of DSM-IV criteria in primary care patients with medically unexplained symptoms. *Psychosomatic Medicine* 2005 January;67(1):123-9.

Stone J, Carson A, Sharpe M. Functional symptoms and signs in neurology: assessment and diagnosis. *J.Neurol.Neurosurg.Psychiatry* 2005;76 Suppl 1:i2-i12.

Sumathipala A. What is the evidence for the efficacy of treatments for somatoform disorders? A critical review of previous intervention studies. *Psychosom Med* 2007; 69:889-900.