Somatic Symptom Disorders

Introduction

This group of disorders is characterized predominantly by somatic symptoms or concerns that are associated with significant distress and/or dysfunction. Somatic symptoms are common in every day life and medical practice. Such symptoms may be initiated, exacerbated or maintained by combinations of biological, psychological and social factors. The diagnostic criteria are applicable across the lifespan, even though developmental differences in the presentation and phenomenology of somatic symptom disorders may exist.

These disorders typically present first in non-psychiatric settings and somatic symptom disorders can accompany diverse general medical as well as psychiatric diagnoses. Having somatic symptoms of unclear etiology is not in itself sufficient to make this diagnosis. Some patients, for instance with irritable bowel syndrome or fibromyalgia would not necessarily qualify for a somatic symptom disorder diagnosis.

When criteria are met for two disorders such as major affective disorder and complex somatic symptom disorder, both diagnoses should be coded (i.e. there is no implicit hierarchy of diagnoses). There are other psychiatric disorders which may present with prominent somatic symptoms such as depression or panic; therefore, not all presentations with somatic symptoms would qualify for this diagnosis.

I. **Psychological factors affecting medical condition** (#316).

The essential feature of this disorder is the presence of one or more clinically significant psychological or behavioral factor that adversely affects a somatic symptom or medical condition by increasing risk for suffering, death, or disability. These factors can adversely affect the medical illness by influencing its course or treatment, by constituting an additional health risk factor, or by exacerbating the physiology that is related to the medical illness.

Psychological or behavioral factors include psychological distress, patterns of interpersonal interaction, coping styles and maladaptive health behaviors such as denial of symptoms or poor adherence to medical recommendations. Common clinical examples are: anxiety exacerbating asthma, denial of need for treatment for acute chest pain, manipulating insulin in order to lose weight.

This diagnosis should be reserved for situations where the effect of the psychological factor on the medical condition is evident, and the psychological factor has clinically significant effects on the course or outcome of the medical condition. Abnormal psychological or behavioral symptoms which develop in response to a medical condition are more properly coded as an adjustment disorder (a clinically significant psychological response to an identifiable stressor).

To meet criteria for Psychological Factors Affecting Medical Condition, both criteria A and B are necessary.

A. A general medical condition is present.
B. Psychological or behavioral factors adversely affect the general medical condition in one of the following ways:
    1. the factors have influenced the course of the general medical condition as shown by a close temporal association between the psychological factors and the development or exacerbation of, or delayed recovery from, the general medical condition
    2. the factors (e.g. poor adherence) interfere with the treatment of the general medical condition
    3. the factors constitute additional health risks for the individual
    4. the factors influence physiology to precipitate or exacerbate symptoms of the general medical condition

II. Complex Somatic symptom disorder (CSSD) (#XXX)

The hallmark of this disorder is disproportionate or maladaptive response to somatic symptoms or concerns. Patients typically experience distress and a high level of functional impairment. In severe cases, they may adopt a sick role. Sometimes the symptoms accompany diagnosed general medical disorders or psychiatric disorders, and sometimes the disorder occurs alone. There may be a high level of health care utilization, which rarely alleviates the patient's concerns. From the clinician's point of view, many of these patients seem unresponsive to therapies, and new interventions or therapies may only exacerbate the presenting symptoms or lead to new side effects and complications. Some patients feel that their medical assessment and treatment have been inadequate.

Patients with this diagnosis typically have multiple, current, somatic symptoms that are distressing; rarely, they may have only one severe symptom. The symptoms may or may not be associated with a known medical condition. Symptoms may be specific (such as localized pain) or relatively non-specific (e.g. fatigue or multiple symptoms). The symptoms sometimes represent normal bodily sensations (e.g., orthostatic dizziness), or discomfort that does not generally signify serious disease (e.g., bad taste in one's mouth) or are incompatible with known pathophysiology (e.g. seeing double with one eye closed). Such patients often manifest a poorer health-related quality of life than patients with other medical disorders and comparable symptoms.

Patients with this diagnosis tend to have heightened levels of health-related anxiety and a low threshold for alarm about the presence of illness. They appraise their bodily symptoms as particularly threatening, harmful, or troublesome and have a tendency to assume the worst about their health. They believe in the medical seriousness of their symptoms despite evidence to the contrary. Health concerns are diffuse and may assume a central role in their lives, becoming a feature of their identity, a way of responding to stressful events, a topic of interpersonal communication, or a basis for interpersonal relationships

Complex somatic symptom disorder (includes previous diagnoses of somatization disorder DSM IV code 300.81, undifferentiated somatoform disorder DSM IV code 300.81, hypochondriasis DSM IV code 300.7, as well as some presentations of pain disorder DSM IV code 307). To meet criteria for CSSD, criteria A, B, and C are necessary.

A. **Somatic symptoms**:

Multiple somatic symptoms that are distressing, or one severe symptom

B. **Misattributions, excessive concern or preoccupation with symptoms and illness**: At least two of the following are required to meet this criterion:

(1) High level of health-related anxiety.

(2) Normal bodily symptoms are viewed as threatening and harmful

(3) A tendency to assume the worst about their health (catastrophizing).

(4) Belief in the medical seriousness of their symptoms despite evidence to the contrary.

(5) Health concerns assume a central role in their lives

C. Chronicity: Although any one symptom may not be continuously present, the state of being symptomatic is chronic and persistent (at least 6 months).

The following optional specifiers may be applied to a diagnosis of CSSD where one of the following dominates the clinical presentation:

XXX.1 Multiplicity of somatic complaints (previously, somatization disorder)

XXX.2 High health anxiety (previously, hypochondriasis) {If patients present solely with health-related anxiety in the absence of somatic symptoms, they may be more appropriately diagnosed as having an anxiety disorder.}

XXX.3 Pain disorder. This classification is reserved for individuals presenting predominantly with pain complaints who also have many of the features described under criterion B. Patients with other presentations of pain may better fit other psychiatric diagnoses such as major depression or adjustment disorder.

For assessing severity of this disorder, metrics are available for rating degree of somatic symptoms (see for instance PHQ, Kroenke et al, 2002). Scales are also available for assessing severity of the patient's misattributions,

excessive concerns and preoccupations (see for instance Whiteley inventory, Pilowsky , 1967).

III. Conversion disorder (#300.11)

Patients with conversion disorder typically present with neurological symptoms that are found, after appropriate medical assessment, to be incompatible with a general medical condition. These presentations may be acute or chronic. Typical symptoms include weakness, events resembling epilepsy or syncope, abnormal movements, sensory symptoms, dizziness, speech and swallowing difficulties. In addition, the diagnosis will usually be supported by confirmatory physical signs or diagnostic investigations consistent with the diagnosis (such as, Hoover's sign). Psychological factors may be associated with the onset of symptoms, but are not essential for the diagnosis. If there is evidence that the symptoms are intentionally feigned, the condition is not conversion disorder but rather either factitious disorder or malingering.

Criteria A, B, and C must all be fulfilled to make the diagnosis:

A. One or more symptoms are present that affect voluntary motor or sensory function.

B. The symptom, after appropriate medical assessment, is found not to be due to a general medical condition, the direct effects of a substance, or a culturally sanctioned behavior or experience.

C. The symptom causes clinically significant distress or impairment in social, occupational, or other important areas of functioning or warrants medical evaluation.

IV. Factitious disorder #300

Factitious disorders entail long-term, persistent problems related to illness perception and identity. They can be associated with unexpected and/or unexplained symptoms. Individuals with Factitious Disorders falsify medical and/or psychological impairment in themselves and/or others. The diagnosis requires demonstrating that the patient is taking surreptitious actions to cause or simulate illness in the absence of obvious rewards. While an underlying condition may be present, the deceptive behavior associated with this disorder causes others to view such individuals (and/or their proxy) as more ill or impaired than they are and can lead to excessive clinical intervention.

Those with Factitious Disorder by Proxy have been known to falsify illness in children of any age, adults, and pets. The victim (or proxy) is not given the diagnosis of Factitious Disorder by Proxy. When a Factitious Disorder leads to abuse of another or other criminal behavior, V code designations for the victim may be indicated.

Malingering, defined as intentional reporting of symptoms for personal gain (e.g. money, time off work, etc) is not a psychiatric disorder.

IV A. Factitious Disorder on Self (#300.X)- To make this diagnosis, all 4 criteria must be met.

1. A pattern of falsification of physical or psychological signs or symptoms, associated with identified deception.

2. A pattern of presenting oneself to others as ill or impaired.

3. The behavior is evident even in the absence of obvious external rewards.

4. The behavior is not better accounted for by another mental disorder such as delusional belief system or acute psychosis.

IV B. Factitious Disorder on another (#300.X) To make this diagnosis, all 4 criteria must be met. Note that the perpetrator, not the victim, receives this diagnosis.

1. A pattern of falsification of physical or psychological signs or symptoms in another, associated with identified deception.

2. A pattern of presenting another (victim) to others as ill or impaired.

3. The behavior is evident even in the absence of obvious external rewards.

4. The behavior is not better accounted for by another mental disorder such as delusional belief system or acute psychosis.

V. Somatic symptom disorder, NOS (# XXX)

Body dysmorphic disorder

This disorder is being reviewed by the Anxiety Disorders workgroup. Depending upon criteria and evidence, it may be relocated to the Anxiety Disorders section of DSM or may be incorporated into CSSD.