

Justification of Criteria—Somatic Symptoms

DRAFT 1/31/11

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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 studies 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 (Creed et al 2010). 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 unpublished, Escobar in press). 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). The criteria listed in “B” can be assessed through clinical observation or via direct inquiry of the patient.

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.

When the patient’s presentation is characterized by a predominance of certain clinical features, optional specifiers may be employed to denote a predominance of somatic complaints (previously somatization disorder), predominant health anxiety (previously hypochondriasis), or predominant pain (previously pain disorder).

Extensive analyses of patients with prominent health complaints suggest that what was heretofore labeled as hypochondriasis is heterogeneous. Such studies suggest that >75% of such patients would meet criteria for CSSD but that there are a sizeable minority of patients who have high illness anxiety but who have minimal somatic complaints. This condition is referred to as Illness Anxiety Disorder in DSM V. It straddles both the Somatic Symptom Disorders and the OCD Spectrum group of disorders but is listed herein for convenience in making a differential diagnosis where somatic symptoms are a focus of diagnosis and treatment.

There can be comorbidities with other psychiatric diagnoses as well as other medical diagnoses. In such cases, it is best to code all diagnoses rather than assume one is primary. The presence of CSSD complicates management of all disorders and must be addressed in the treatment plan.

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 B-type criteria are crucial for a diagnosis of CSSD. These criteria in essence reflect disturbance in thoughts, feelings, and/or behaviors in conjunction with long standing distressing somatic symptoms. Whilst an exact threshold is perhaps arbitrary, considerable work suggests that the degree of functional impairment is associated with the number of such criteria. Using a threshold of 2 or more such criteria results in prevalence estimates of XXXX in the general population, XXXX in patients with known medical illnesses, and XXXX in patients who may previously have been considered to suffer from a somatoform illness. {text in development concerning impact of different thresholds for criteria B- from Francis}

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

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).

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.

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: Simple or abridged somatic symptom disorder

The diagnosis of Somatoform Disorder Not Otherwise Specified has been criticized for its vagueness (Dimsdale, Sharma, and Sharpe, 2011). On the other hand, it is readily recognized that more specific diagnoses such as those now included in CSSD, excluded patients with substantial somatic distress and who responded to psychiatric treatment. In an effort to be more specific about the criteria than merely “Not Otherwise Specified,” DSM V introduces a new diagnosis entitled Simple Somatic Symptom Disorder. The principal differences between CSSD and SSSD are the time course and the number of B-type criteria. CSSD requires a time course of >6 months; whereas SSSD requires symptoms for >1 month. CSSD requires at least two B-type criteria reflecting thoughts, feelings, and behaviors; whereas SSSD requires only 1 such criterion. Whereas SSSD can be construed to be a more minor or acute presentation than CSSD, the symptoms can be quite protracted (viz, for instance, various pain disorders).

Recognizing that there can be utility in specifically coding single symptoms when they predominate, there is the option of specifying (“e.g. SSSD.pain”).

Major change #5: Functional Neurological Symptoms

This disorder was previously known as Conversion Disorder. The name has been changed to adopt a name that has fewer theoretical implications and that is more accepted by neurologists and patients. We propose the term ‘functional neurological symptoms’, as a diagnosis for symptoms such as ‘functional weakness’, as both theoretically appropriate and practically useful (Stone et al, 2010).

Other 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.

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) and (c) relevant psychological factors may be difficult to discover at the time of initial evaluation. 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. FNS are usually diagnosed after a neurologist has found the symptoms to be incongruous with disease or internally inconsistent(6). For example, functional leg weakness can be demonstrated objectively when weakness of hip extension disappears during contralateral hip flexion against resistance (Hoover’s sign) (Stone 2005, Stone 2010). Functional arm tremor may be suspected when a tremor disappears during voluntary rhythmical movement of the unaffected arm. Tunnel vision {need definition} is inconsistent with optical kinetics.

Non-epileptic attacks are suspected when there is a seizure-like event with simultaneous normal video EEG. The DSM-IV criteria currently require the exclusion of disease but do not refer to these useful procedures. We suggest that incorporating physical diagnostic features observed in FNS into the criteria would improve confidence in the diagnosis.

We suggest retaining FNS in the Somatic Symptom Disorders section of the DSM. FNS 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 (Brown 2007). The argument for moving FNS there is that the mental mechanisms involved are similar. However dissociation is a hypothetical process and moving FNS would (a) risk making an unjustified assumption about cause (b) lose the utility of grouping with other conditions that present with a somatic symptom.

{Michael, these are left over references. It isn't clear that these are needed in the above section. Please evaluate and advise where they should be cited or whether they may be dropped}

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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 imposed on another."

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.

{Mike Irwin: text in development concerning differentiation between factitious disorder, malingering, and conversion disorder}

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 PHQ15, Kroenke 2002) and for the cognitive distortions and misattributions associated with CSSD (viz Whiteley Index, Pilowsky. 1967, Fink 1999). The Whiteley scale may be used to assist the clinician in assessing the severity of some of the cognitions listed in Criterion B. The mean score in primary care outpatients and community non-patient volunteers is typically <1.60. On the other hand, DSM IV hypochondriacs have typically scored >3.15, using the 14-item Whiteley with Likert scores from 1 to 5/item. {need ref from Barsky}. Alternate severity metrics would grade levels as “1”= mild somatic symptoms/concerns that are intermittent and not incapacitating; “2” =moderate somatic symptoms/concerns that are persistent/recurrent and minimally incapacitating; “3” = severe symptoms/concerns that are persistent/recurrent and moderately incapacitating; “4”= very severe symptoms/concerns that are persistent/recurrent and severely incapacitating.

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 (e.g. “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 persistence of the symptoms and the resulting functioning consequences. These severity scores might range for instance from 1= minor and brief impairment (non-incapacitating symptom such as aphonia lasting <2 days); 2=minor impairment and persistent/recurrent (from 3 days to 3 months); 3=moderate impairment and brief; 4= severe and persistent/recurrent (> 3 months bedbound with contractures and/or muscle wasting).

For PFAMC, severity scoring might range from 1 = increases risk (inconsistent adherence with anti-hypertension treatment); 2= aggravates underlying condition (e.g. anxiety aggravating asthma); 3= results in hospitalization or 4. =Results in likely severe life-threatening risk such as ignoring heart attack symptoms

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{reference list is not verified }

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