Somatic Symptom Disorder

Diagnostic Criteria **300.82 (F45.1)**

A. One or more somatic symptoms that are distressing or result in significant disruption of daily life.

B. Excessive thoughts, feelings, or behaviors related to the somatic symptoms or associated health concerns as manifested by at least one of the following:

1. Disproportionate and persistent thoughts about the seriousness of one's symptoms.
2. Persistently high level of anxiety about health or symptoms.
3. Excessive time and energy devoted to these symptoms or health concerns.

C. Although any one somatic symptom may not be continuously present, the state of being symptomatic is persistent (typically more than 6 months).

Specify if:

With predominant pain (previously pain disorder): This specifier is for individuals whose somatic symptoms predominantly involve pain.

Specify if:

Persistent: A persistent course is characterized by severe symptoms, marked impairment, and long duration (more than 6 months).

Specify current severity:

Mild: Only one of the symptoms specified in Criterion B is fulfilled.

Moderate: Two or more of the symptoms specified in Criterion B are fulfilled.

Severe: Two or more of the symptoms specified in Criterion B are fulfilled, plus there are multiple somatic complaints (or one very severe somatic symptom).

Diagnostic Features

Individuals with somatic symptom disorder typically have multiple, current, somatic symptoms that are distressing or result in significant disruption of daily life (Criterion A), although sometimes only one severe symptom, most commonly pain, is present. Symptoms may be specific (e.g., localized pain) or relatively nonspecific (e.g., fatigue). The symptoms sometimes represent normal bodily sensations or discomfort that does not generally signify serious disease. Somatic symptoms without an evident medical explanation are not sufficient to make this diagnosis. The individual's suffering is authentic, whether or not it is medically explained.

The symptoms may or may not be associated with another medical condition. The diagnoses of somatic symptom disorder and a concurrent medical illness are not mutually exclusive, and these frequently occur together. For example, an individual may become seriously disabled by symptoms of somatic symptom disorder after an uncomplicated myocardial infarction even if the myocardial infarction itself did not result in any disability. If another medical condition or high risk for developing one is present (e.g., strong family history), the thoughts, feelings, and behaviors associated with this condition are excessive (Criterion B).

Individuals with somatic symptom disorder tend to have very high levels of worry about illness (Criterion B). They appraise their bodily symptoms as unduly threatening, harmful, or troublesome and often think the worst about their health. Even when there is evidence to the contrary, some patients still fear the medical seriousness of their symptoms. In severe somatic symptom disorder, health concerns may assume a central role in the individual's life, becoming a feature of his or her identity and dominating interpersonal relationships.

Individuals typically experience distress that is principally focused on somatic symptoms and their significance. When asked directly about their distress, some individuals describe it in relation to other aspects of their lives, while others deny any source of distress other than the somatic symptoms. Health-related quality of life is often impaired, both physically and mentally. In severe somatic symptom disorder, the impairment is marked, and when persistent, the disorder can lead to invalidism.

There is often a high level of medical care utilization, which rarely alleviates the individual's concerns. Consequently, the patient may seek care from multiple doctors for the same symptoms. These individuals often seem unresponsive to medical interventions, and new interventions may only exacerbate the presenting symptoms. Some individuals with the disorder seem unusually sensitive to medication side effects. Some feel that their medical assessment and treatment have been inadequate.

Associated Features Supporting Diagnosis

Cognitive features include attention focused on somatic symptoms, attribution of normal bodily sensations to physical illness (possibly with catastrophic interpretations), worry about illness, and fear that any physical activity may damage the body. The relevant associated behavioral features may include repeated bodily checking for abnormalities, repeated seeking of medical help and reassurance, and avoidance of physical activity. These behavioral features are most pronounced in severe, persistent somatic symptom disorder. These features are usually associated with frequent requests for medical help for different somatic symptoms. This may lead to medical consultations in which individuals are so focused on their concerns about somatic symptom(s) that they cannot be redirected to other matters. Any reassurance by the doctor that the symptoms are not indicative of serious physical illness tends to be short-lived and/or is experienced by the individuals as the doctor not taking their symptoms with due seriousness. As the focus on somatic symptoms is a primary feature of the disorder, individuals with somatic symptom disorder typically present to general medical health services rather than mental health services. The suggestion of referral to a mental health specialist may be met with surprise or even frank refusal by individuals with somatic symptom disorder.

Since somatic symptom disorder is associated with depressive disorders, there is an increased suicide risk. It is not known whether somatic symptom disorder is associated with suicide risk independent of its association with depressive disorders.

Prevalence

The prevalence of somatic symptom disorder is not known. However, the prevalence of somatic symptom disorder is expected to be higher than that of the more restrictive DSM-IV somatization disorder (<1%) but lower than that of undifferentiated somatoform disorder (approximately 19%). The prevalence of somatic symptom disorder in the general adult population may be around 5%–7%. Females tend to report more somatic symptoms than do males, and the prevalence of somatic symptom disorder is consequently likely to be higher in females.

Development and Course

In older individuals, somatic symptoms and concurrent medical illnesses are common, and a focus on Criterion B is crucial for making the diagnosis. Somatic symptom disorder may be underdiagnosed in older adults either because certain somatic symptoms (e.g., pain, fatigue) are considered part of normal aging or because illness worry is considered "understandable" in older adults who have more general medical illnesses and medications than do younger people. Concurrent depressive disorder is common in older people who present with numerous somatic symptoms.

In children, the most common symptoms are recurrent abdominal pain, headache, fatigue, and nausea. A single prominent symptom is more common in children than in adults. While young children may have somatic complaints, they rarely worry about "illness" per se prior to adolescence. The parents' response to the symptom is important, as this may determine the level of associated distress. It is the parent who may determine the interpretation of symptoms and the associated time off school and medical help seeking.

Risk and Prognostic Factors

Temperamental. The personality trait of negative affectivity (neuroticism) has been identified as an independent correlate/risk factor of a high number of somatic symptoms. Comorbid anxiety or depression is common and may exacerbate symptoms and impairment.

Environmental. Somatic symptom disorder is more frequent in individuals with few years of education and low socioeconomic status, and in those who have recently experienced stressful life events.

Course modifiers. Persistent somatic symptoms are associated with demographic features (female sex, older age, fewer years of education, lower socioeconomic status, unemployment), a reported history of sexual abuse or other childhood adversity, concurrent chronic physical illness or psychiatric disorder (depression, anxiety, persistent depressive disorder [dysthymia], panic), social stress, and reinforcing social factors such as illness benefits. Cognitive factors that affect clinical course include sensitization to pain, heightened attention to bodily sensations, and attribution of bodily symptoms to a possible medical illness rather than recognizing them as a normal phenomenon or psychological stress.

Culture-Related Diagnostic Issues

Somatic symptoms are prominent in various "culture-bound syndromes." High numbers of somatic symptoms are found in population-based and primary care studies around the world, with a similar pattern of the most commonly reported somatic symptoms, impairment, and treatment seeking. The relationship between number of somatic symptoms and illness worry is similar in different cultures, and marked illness worry is associated with impairment and greater treatment seeking across cultures. The relationship between numerous somatic symptoms and depression appears to be very similar around the world and between different cultures within one country.

Despite these similarities, there are differences in somatic symptoms among cultures and ethnic groups. The description of somatic symptoms varies with linguistic and other local cultural factors. These somatic presentations have been described as "idioms of distress" because somatic symptoms may have special meanings and shape patient-clinician interactions in the particular cultural contexts. "Burnout," the sensation of heaviness or the complaints of "gas"; too much heat in the body; or burning in the head are examples of symptoms that are common in some cultures or ethnic groups but rare in others. Explanatory models also vary, and somatic symptoms may be attributed variously to particular family, work, or environmental stresses; general medical illness; the suppression of feelings of anger and resentment; or certain culture-specific phenomena, such as semen loss. There may also be differences in medical treatment seeking among cultural groups, in addition to differences due to variable access to medical care services. Seeking treatment for multiple somatic symptoms in general medical clinics is a worldwide phenomenon and occurs at similar rates among ethnic groups in the same country.

Functional Consequences of Somatic Symptom Disorder

The disorder is associated with marked impairment of health status. Many individuals with severe somatic symptom disorder are likely to have impaired health status scores more than 2 standard deviations below population norms.

Differential Diagnosis

If the somatic symptoms are consistent with another mental disorder (e.g., panic disorder), and the diagnostic criteria for that disorder are fulfilled, then that mental disorder should be considered as an alternative or additional diagnosis. A separate diagnosis of somatic symptom disorder is not made if the somatic symptoms and related thoughts, feelings, or behaviors occur only during major depressive episodes. If, as commonly occurs, the criteria for both somatic symptom disorder and another mental disorder diagnosis are fulfilled, then both should be coded, as both may require treatment.

Other medical conditions. The presence of somatic symptoms of unclear etiology is not in itself sufficient to make the diagnosis of somatic symptom disorder. The symptoms of many individuals with disorders like irritable bowel syndrome or fibromyalgia would not satisfy the criterion necessary to diagnose somatic symptom disorder (Criterion B). Conversely, the presence of somatic symptoms of an established medical disorder (e.g., diabetes or heart disease) does not exclude the diagnosis of somatic symptom disorder if the criteria are otherwise met.

Panic disorder. In panic disorder, somatic symptoms and anxiety about health tend to occur in acute episodes, whereas in somatic symptom disorder, anxiety and somatic symptoms are more persistent.

Generalized anxiety disorder. Individuals with generalized anxiety disorder worry about multiple events, situations, or activities, only one of which may involve their health. The main focus is not usually somatic symptoms or fear of illness as it is in somatic symptom disorder.

Depressive disorders. Depressive disorders are commonly accompanied by somatic symptoms. However, depressive disorders are differentiated from somatic symptom disorder by the core depressive symptoms of low (dysphoric) mood and anhedonia.

Illness anxiety disorder. If the individual has extensive worries about health but no or minimal somatic symptoms, it may be more appropriate to consider illness anxiety disorder.

Conversion disorder (functional neurological symptom disorder). In conversion disorder, the presenting symptom is loss of function (e.g., of a limb), whereas in somatic symptom disorder, the focus is on the distress that particular symptoms cause. The features listed under Criterion B of somatic symptom disorder may be helpful in differentiating the two disorders.

Delusional disorder. In somatic symptom disorder, the individual's beliefs that somatic symptoms might reflect serious underlying physical illness are not held with delusional intensity. Nonetheless, the individual's beliefs concerning the somatic symptoms can be firmly held. In contrast, in delusional disorder, somatic subtype, the somatic symptom beliefs and behavior are stronger than those found in somatic symptom disorder.

Body dysmorphic disorder. In body dysmorphic disorder, the individual is excessively concerned about, and preoccupied by, a perceived defect in his or her physical features. In contrast, in somatic symptom disorder, the concern about somatic symptoms reflects fear of underlying illness, not of a defect in appearance.

Obsessive-compulsive disorder. In somatic symptom disorder, the recurrent ideas about somatic symptoms or illness are less intrusive, and individuals with this disorder do not exhibit the associated repetitive behaviors aimed at reducing anxiety that occur in obsessive-compulsive disorder.

Comorbidity

Somatic symptom disorder is associated with high rates of comorbidity with medical disorders as well as anxiety and depressive disorders. When a concurrent medical illness is

present, the degree of impairment is more marked than would be expected from the physical illness alone. When an individual's symptoms meet diagnostic criteria for somatic symptom disorder, the disorder should be diagnosed; however, in view of the frequent comorbidity, especially with anxiety and depressive disorders, evidence for these concurrent diagnoses should be sought.

Illness Anxiety Disorder

Diagnostic Criteria **300.7 (F45.21)**

A. Preoccupation with having or acquiring a serious illness.
B. Somatic symptoms are not present or, if present, are only mild in intensity. If another medical condition is present or there is a high risk for developing a medical condition (e.g., strong family history is present), the preoccupation is clearly excessive or disproportionate.
C. There is a high level of anxiety about health, and the individual is easily alarmed about personal health status.
D. The individual performs excessive health-related behaviors (e.g., repeatedly checks his or her body for signs of illness) or exhibits maladaptive avoidance (e.g., avoids doctor appointments and hospitals).
E. Illness preoccupation has been present for at least 6 months, but the specific illness that is feared may change over that period of time.
F. The illness-related preoccupation is not better explained by another mental disorder, such as somatic symptom disorder, panic disorder, generalized anxiety disorder, body dysmorphic disorder, obsessive-compulsive disorder, or delusional disorder, somatic type.

Specify whether:

Care-seeking type: Medical care, including physician visits or undergoing tests and procedures, is frequently used.

Care-avoidant type: Medical care is rarely used.

Diagnostic Features

Most individuals with hypochondriasis are now classified as having somatic symptom disorder; however, in a minority of cases, the diagnosis of illness anxiety disorder applies instead. Illness anxiety disorder entails a preoccupation with having or acquiring a serious, undiagnosed medical illness (Criterion A). Somatic symptoms are not present or, if present, are only mild in intensity (Criterion B). A thorough evaluation fails to identify a serious medical condition that accounts for the individual's concerns. While the concern may be derived from a nonpathological physical sign or sensation, the individual's distress emanates not primarily from the physical complaint itself but rather from his or her anxiety about the meaning, significance, or cause of the complaint (i.e., the suspected medical diagnosis). If a physical sign or symptom is present, it is often a normal physiological sensation (e.g., orthostatic dizziness), a benign and self-limited dysfunction (e.g., transient tinnitus), or a bodily discomfort not generally considered indicative of disease (e.g., belching). If a diagnosable medical condition is present, the individual's anxiety and preoccupation are clearly excessive and disproportionate to the severity of the condition (Criterion B). Empirical evidence and existing literature pertain to previously defined DSM hypochondriasis, and it is unclear to what extent and how precisely they apply to the description of this new diagnosis.

The preoccupation with the idea that one is sick is accompanied by substantial anxiety about health and disease (Criterion C). Individuals with illness anxiety disorder are easily

alarmed about illness, such as by hearing about someone else falling ill or reading a health-related news story. Their concerns about undiagnosed disease do not respond to appropriate medical reassurance, negative diagnostic tests, or benign course. The physician's attempts at reassurance and symptom palliation generally do not alleviate the individual's concerns and may heighten them. Illness concerns assume a prominent place in the individual's life, affecting daily activities, and may even result in invalidism. Illness becomes a central feature of the individual's identity and self-image, a frequent topic of social discourse, and a characteristic response to stressful life events. Individuals with the disorder often examine themselves repeatedly (e.g., examining one's throat in the mirror) (Criterion D). They research their suspected disease excessively (e.g., on the Internet) and repeatedly seek reassurance from family, friends, or physicians. This incessant worrying often becomes frustrating for others and may result in considerable strain within the family. In some cases, the anxiety leads to maladaptive avoidance of situations (e.g., visiting sick family members) or activities (e.g., exercise) that these individuals fear might jeopardize their health.

Associated Features Supporting Diagnosis

Because they believe they are medically ill, individuals with illness anxiety disorder are encountered far more frequently in medical than in mental health settings. The majority of individuals with illness anxiety disorder have extensive yet unsatisfactory medical care, though some may be too anxious to seek medical attention. They generally have elevated rates of medical utilization but do not utilize mental health services more than the general population. They often consult multiple physicians for the same problem and obtain repeatedly negative diagnostic test results. At times, medical attention leads to a paradoxical exacerbation of anxiety or to iatrogenic complications from diagnostic tests and procedures. Individuals with the disorder are generally dissatisfied with their medical care and find it unhelpful, often feeling they are not being taken seriously by physicians. At times, these concerns may be justified, since physicians sometimes are dismissive or respond with frustration or hostility. This response can occasionally result in a failure to diagnose a medical condition that is present.

Prevalence

Prevalence estimates of illness anxiety disorder are based on estimates of the DSM-III and DSM-IV diagnosis *hypochondriasis.* The 1- to 2-year prevalence of health anxiety and/or disease conviction in community surveys and population-based samples ranges from 1.3% to 10%. In ambulatory medical populations, the 6-month/1-year prevalence rates are between 3% and 8%. The prevalence of the disorder is similar in males and females.

Development and Course

The development and course of illness anxiety disorder are unclear. Illness anxiety disorder is generally thought to be a chronic and relapsing condition with an age at onset in early and middle adulthood. In population-based samples, health-related anxiety increases with age, but the ages of individuals with high health anxiety in medical settings do not appear to differ from those of other patients in those settings. In older individuals, health-related anxiety often focuses on memory loss; the disorder is thought to be rare in children.

Risk and Prognostic Factors

Environmental. Illness anxiety disorder may sometimes be precipitated by a major life stress or a serious but ultimately benign threat to the individual's health. A history of child-