Somatic symptom disorder: Epidemiology and clinical presentation

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INTRODUCTION

Somatic symptom disorder is characterized by one or more somatic symptoms that are accompanied by excessive thoughts, feelings, and/or behaviors related to the somatic symptoms [1,2]. In addition, the symptoms cause significant distress and/or dysfunction. The somatic symptoms may or may not be explained by a recognized general medical condition.

The diagnosis of somatic symptom disorder was introduced with publication of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) in 2013 [1,2]. In addition, DSM-5 eliminated the diagnoses of somatization disorder, undifferentiated somatoform disorder, hypochondriasis, and pain disorder; most of the patients who previously received these diagnoses are now diagnosed in DSM-5 with somatic symptom disorder.

This topic reviews the epidemiology, pathogenesis, clinical presentation, and course of illness in somatic symptom disorder. The assessment, diagnosis, differential diagnosis, and treatment of somatic symptom disorder are discussed elsewhere. (See "Somatic symptom disorder: Assessment and diagnosis" and "Somatic symptom disorder: Treatment".)

TERMINOLOGY AND DSM-5

Somatic symptom disorder is a diagnosis that was introduced with publication of the DSM-5 in 2013 [1-3]. The clinical features and diagnostic criteria are discussed elsewhere in this topic. (See 'Clinical presentation' below and "Somatic symptom disorder: Assessment and diagnosis", section on 'Diagnostic criteria'.)

The DSM-5 diagnosis of somatic symptom disorder has largely consolidated and supplanted the diagnoses of somatization disorder, undifferentiated somatoform disorder, hypochondriasis, and pain disorder, which were included in the prior edition of the Diagnostic and Statistical Manual, Fourth Edition, Text Revision (DSM-IV-TR) and were collectively referred to as somatoform disorders [1-4]. The somatoform disorders were eliminated in DSM-5.

Most of the patients who previously received the DSM-IV-TR somatoform diagnoses are now diagnosed in DSM-5 with somatic symptom disorder [1,3]. As an example, the term hypochondriasis (table 1) in DSM-IV-TR described patients who misinterpreted one or more bodily symptoms and believed that they had a serious disease or were preoccupied with fear of a disease, despite appropriate medical evaluation and reassurance [4]. Among patients previously diagnosed with hypochondriasis, it appears that most are subsumed under the DSM-5 diagnosis of somatic symptom disorder (if physical complaints are prominent) and fewer under the DSM-5 diagnosis of illness anxiety disorder (if physical complaints are minimal or nonexistent) [1]:

- A retrospective study identified patients who initially received a DSM-IV diagnosis of hypochondriasis (n = 58); post-hoc application of DSM-5 criteria found that 76 percent met criteria for somatic symptom disorder and 24 percent met criteria for illness anxiety disorder [5].

- A prospective study of 59 patients who met DSM-IV criteria for hypochondriasis found that somatic symptom disorder was present in 56 percent, illness anxiety disorder in 36 percent, and comorbid somatic symptom disorder plus illness anxiety disorder in 8 percent [6].

Additional information about illness anxiety disorder, including its diagnostic criteria (table 2), is discussed separately. (See "Illness anxiety disorder: Epidemiology, clinical presentation, assessment, and diagnosis".)

A review by the workgroup that developed the DSM-5 diagnosis of somatic symptom disorder found that the construct, descriptive, and predictive validity of somatic symptom disorder were superior to the validity of the DSM-IV somatoform disorders [3]. In addition, inter-rater and test-retest reliability for somatic symptom disorder are good to very good [2,6,7].

Although the diagnosis of somatic symptom disorder has been criticized as overinclusive and fraught with the potential for false positives [8], it appears that somatic symptom disorder may be a more restrictive diagnosis than the DSM-IV-TR somatoform diagnoses that it replaced. A study of patients with symptoms that were deemed "medically unexplained" (n = 325) found that twice as many patients fulfilled diagnostic criteria for a somatoform disorder than for somatic symptom disorder (93 versus 46 percent) [9]. In addition, the diagnosis of somatic symptom disorder requires that patients exhibit excessive thoughts, feelings, or behaviors related to the somatic symptoms, and thus identifies a group with greater mental impairment, compared with somatoform disorders [10].

The DSM-IV-TR somatoform disorders included the criterion that somatic symptoms were medically unexplained. However, the reliability for medically unexplained symptoms is poor [3,11] because it is difficult to prove that a symptom is medically unexplained (prove a negative) [1]. By contrast, DSM-5 somatic symptom disorder can be diagnosed in patients with known general medical disorders [1,2].

DSM-5 includes somatic symptom disorder in the category called somatic symptom and related disorders, which are diagnoses characterized by prominent somatic concerns, distress, and impaired functioning [1]. Patients with somatic symptom and related disorders typically present to primary care clinicians and general medical specialists rather than psychiatrists.

The World Health Organization's International Classification of Diseases – 10th Revision (ICD-10) still retains the term "somatoform disorders" as a category, as well as the specific diagnoses of somatization disorder, undifferentiated somatoform disorder, hypochondriacal disorder, and persistent somatoform pain disorder [12].

EPIDEMIOLOGY

Prevalence — The prevalence of somatic symptom disorder is unclear because it was introduced as a diagnosis in the DSM-5, which was published in 2013 [1]. Somatic symptom disorder was derived in part from the somatoform disorders (diagnoses such as somatization disorder and hypochondriasis), which were eliminated from DSM-5. Most of the patients who previously received the somatoform diagnoses are now diagnosed in DSM-5 with somatic symptom disorder [1] (see 'Terminology and DSM-5' above). Thus, estimates about the prevalence of somatic symptom disorder comes from the literature on somatoform disorders. In addition, prevalence estimates for somatic symptom disorder draw upon studies of "somatization," which is a broad construct that has been used to describe patients with

medically unexplained symptoms that cause distress and impairment, but is not a formal diagnosis in DSM-5.

Multiple studies suggest that somatic symptom disorder is common and occurs most often in primary care patients [1,13]. The prevalence of somatic symptom disorder can be approximated as follows [14]:

- **General population** – 4 to 6 percent. This estimate is based upon a community survey in the United States, which defined somatization as four or more unexplained physical symptoms in men and six or more unexplained physical symptoms in women; the study found that the lifetime prevalence of somatization in was 4 percent [14,15]. In addition, a review and reanalysis of community survey data from six studies estimated that the 12-month prevalence of somatoform disorders in the general population of Europe was approximately 6 percent [16].

- **Primary care patients** – 17 percent. This estimate is based upon a review of six primary care studies, which defined somatization as four or more unexplained physical symptoms in men and six or more unexplained physical symptoms in women; the median point prevalence of somatization was 17 percent [14,17].

Prevalence rates of somatic symptom disorder are probably higher in patients with functional disorders such as fibromyalgia, irritable bowel syndrome, and chronic fatigue syndrome (also known as myalgic encephalomyelitis/chronic fatigue syndrome). Among these patients, the reported frequency of somatic symptom disorder, diagnosed according to DSM-5 criteria, ranges from 25 to 60 percent [9,18-20].

The evidence suggests that onset of prodromal symptoms often begins in childhood [21] and that symptoms meeting criteria for somatic symptom disorder are frequently present during adolescence [22]. Consistent with this is a community study of adolescents, which found that persistent distressing somatic symptoms, combined with psychological concerns, were present in 5 percent [23].

Risk factors — Based upon studies of somatoform disorders and somatization, likely risk factors for somatic symptoms disorder include [1,14,24-33]:

- Female sex
- Fewer years of education
- Lower socioeconomic status or other social stressors
- History of childhood chronic illness
- History of sexual abuse or other childhood and adult trauma

- Concurrent general medical disorders (especially in older patients)
- Health anxiety
- Concurrent psychiatric disorder (especially depressive or anxiety disorders)
- Family history of chronic illness

Health care utilization — Patients with somatic symptom disorder have physical symptoms that are accompanied by disproportionate emotional and behavioral reactions, and are thus presumed to utilize more health care than other patients [1]. Evidence that suggests health care use is greater in somatic symptom disorder includes studies of patients with distressing somatic symptoms and high health anxiety, which correspond to the two core features of somatic symptom disorder (see 'Signs and symptoms' below). As an example [34]:

- In a four-year prospective study in an age-representative sample of the German general population (n = 321), somatic symptom disorder at baseline (n = 108) predicted higher health care utilization, as well as more somatic symptoms and greater subjective impairment [35].

- An analysis of individual patient data from nine community studies (total n >28,000 individuals) found that after controlling for potential confounding factors (eg, age, general medical illness, anxiety, and depression), a greater number of burdensome somatic symptoms was associated with greater health care use [25].

- In a representative sample from Hong Kong (n >3000 individuals), a larger number of distressing somatic symptoms and increased health anxiety were each associated with greater health care utilization, independent of the other [33]. Individuals with both high somatic symptom burden and high health anxiety demonstrated the greatest use of health care, as well as functional impairment. A study of a nationally representative sample from Australia (n >8000) also found that health anxiety was associated with health service utilization [36].

PATHOGENESIS

The pathogenesis of somatic symptom disorder is unclear because it was introduced as a diagnosis in the DSM-5, which was published in 2013 [1]. Somatic symptom disorder was derived in part from the somatoform disorders (diagnoses such as somatization disorder and hypochondriasis), which were eliminated from DSM-5. Most of the patients who previously received the somatoform diagnoses are now diagnosed in DSM-5 with somatic symptom disorder [1] (see 'Terminology and DSM-5' above). Thus, hypotheses about the pathogenesis of

somatic symptom disorder come from the literature on somatoform disorders. In addition, the pathogenesis of somatic symptom disorder is informed by studies of illness anxiety disorder and functional somatic syndromes (eg, fibromyalgia and irritable bowel disorder), as well as studies of "somatization." Somatization is a broad construct that has been used to describe patients with medically unexplained symptoms that cause distress and impairment, but is not a formal diagnosis in DSM-5. (See "Illness anxiety disorder: Epidemiology, clinical presentation, assessment, and diagnosis", section on 'Pathogenesis' and "Pathogenesis of fibromyalgia" and "Pathophysiology of irritable bowel syndrome".)

Psychosocial factors — Several psychosocial factors may be involved in the pathogenesis of somatic symptom disorder [37]:

- **Developmental factors** – Poor awareness of emotions and higher levels of negative emotions during childhood are associated with somatic symptoms in children [38], and the tendency to report functional or somatic symptoms often persists from childhood to adulthood [39,40]. In addition, having a family member with a chronic illness during childhood may be a precursor to somatization as an adult [41-43]. Childhood experiences of parental neglect or indifference, such as inadequate food, clothing, or interest in the child's well-being, may be associated with somatization during adulthood and frequent visits to general medical outpatient clinics [42,44].

  Negative or unpredictable parenting during childhood may lead to insecure attachment (emotional closeness); one model proposes that somatic symptoms represent care-seeking behavior in patients with insecure attachment [45].

- **Physical and sexual abuse** – Childhood sexual abuse and recent exposure to physical or sexual violence are consistently associated with somatization in adult women [26,27]. As an example, a meta-analysis of 23 studies (total n >4600) examined the association between a history of sexual abuse or rape and a lifetime diagnosis of functional somatic syndromes (eg, chronic noncyclic pelvic pain, fibromyalgia, or functional gastrointestinal disorders); each study included patients with a functional syndrome and controls without the syndrome [28]. The meta-analysis found that sexual abuse or rape had occurred approximately three times more often in patients with functional somatic syndromes than controls (odds ratio 3, 95% CI 2-4).

- **Cognitive and perceptual distortions and behavioral abnormalities** – Somatization may involve an over-inclusive or unrealistic concept of good health, dysfunctional assumptions about the prevalence and communicability of severe illnesses, increased attention to bodily processes to detect possible signs of illness, catastrophic

interpretations of bodily sensations, problematic expectations about somatic symptoms and the course and treatment of illnesses, and difficulty with information processing [43,46]. Perception of symptoms affects how they are reported, and perception is influenced by attitudes, beliefs, and psychologic distress.

Benign somatic sensations and physical symptoms may be amplified by some patients, such as those with low pain thresholds, patients who have become sensitized to pain (ie, have a heightened response to pain because of past pain experiences), and patients who pay more attention to their bodily sensations. Normal bodily sensations may thus be perceived as abnormally intense and misattributed to serious medical disease [47]. The patient may then seek assurance of good health.

Despite medical reassurance, patients with somatic symptom disorder remain anxious about their health. One reason is that patients vigilantly monitor their bodies for symptoms and become sensitive to slight homeostatic fluctuations that occur normally [47]. In addition, it is thought that health anxiety leads patients to confirm their fears through selective attention toward information that is consistent with having a disease and away from information that is consistent with good health.

- **Difficulties with self-expression** – Physical symptoms may offer a means to express distress when patients do not easily express emotions in words (alexithymia) [48]. Patients may also present to nonpsychiatric clinicians with physical complaints when psychiatric symptoms are experienced as stigmatizing, or when clinicians appear uninterested in hearing about psychiatric problems.

Another psychosocial factor that may be involved in the pathogenesis of somatic symptom disorder is family conflict [49].

Once patients develop somatic symptom disorder, it may be perpetuated by chronic stressors and maladaptive coping skills [31]. In addition, behavior related to the symptoms and sick role add another psychologic dimension that maintain the disorder [50]. The symptoms may offer benefits such as social support, escape from obligations, disability payments, and a compromise for internal conflicts. Litigation may also perpetuate symptoms.

The disorder may also be inadvertently maintained by clinicians. Rather than pursue psychosocial clues voiced by patients, clinicians may order additional diagnostic tests despite a low probability of serious disease [50], as well as biomedical interventions and referrals [51,52]. (See "Somatic symptom disorder: Assessment and diagnosis", section on 'Laboratory tests'.)

Genetics — The pathogenesis of somatic symptom disorder may have a genetic component, but the effect appears modest:

- A national registry study of monozygotic and dizygotic twins (n >28,000 individuals) found that the relative contribution of genetic factors (heritability) to somatic symptoms (eg, abdominal discomfort, dizziness, fatigue, and pain) was 7 to 21 percent, and the remaining contribution was attributable to nonshared (unique) environmental factors [53].
- A prospective community study of primary care patients (n >900) found that after controlling for comorbid anxiety, depression, and pain, multiple single nucleotide polymorphisms were associated with the number of somatic symptoms [54].

Anxiety disorders and/or depressive disorders are probably common in somatic symptom disorder, and studies suggest that there may be a genetic component involved in the co-occurrence of anxiety and depression with somatic symptoms [55].

CLINICAL PRESENTATION

Signs and symptoms — There are two core features that both occur in somatic symptom disorder [1,24]:

- One or more current somatic symptoms that are long-standing and cause distress or psychosocial impairment. Multiple symptoms are typically present, but one severe symptom (eg, pain) is sufficient to make the diagnosis.
- Excessive thoughts, worrying, or behaviors (time and energy) related to the somatic symptoms or to health concerns.

The spectrum of severity in somatic symptom disorder ranges from mild to severe [1].

Among moderately to severely ill patients, the physical symptoms can become a central feature of the patient's identity and dominate interpersonal relationships [1]. Psychosocial and physical functioning decline [1,9,56], and the patient's disability imposes a significant burden upon families [56]. The most severely ill patients may become invalids [1].

Somatic symptoms that are common in somatic symptom disorder include [25]:

- Pain symptoms – Joint pain, leg/arm pain, back pain, headache, chest pain, abdominal pain, dysuria, and diffuse pain
- Nonspecific symptoms – Fatigue, syncope, and dizziness

- Gastrointestinal symptoms – Nausea, vomiting, abdominal pain, bloating, gas, and diarrhea
- Cardiopulmonary symptoms – Chest pain, shortness of breath, and palpitations
- Neurologic symptoms – Movement disorders, sensory loss, weakness, and paralysis
- Reproductive organ symptoms – Dyspareunia, dysmenorrhea, and erectile dysfunction

An analysis of individual patient data from nine community studies (total n >28,000) found that the most frequent burdensome symptom was pain [25].

Somatic symptom disorder is not defined by the number of distressful physical symptoms that are present; however, patients who complain of multiple symptoms are more likely to have the disorder. In addition, a larger number of somatic symptoms (eg, >6, based upon clinical experience) is associated with poorer outcomes, such as physical functioning [25,57-59]. The number of symptoms refers to the number that the patient complains of without being asked, rather than the number elicited by the clinician asking symptom by symptom. As an example, a patient with congestive heart failure who does not have somatic symptom disorder may present with shortness of breath as their sole compliant. When asked by the clinician, the patient may affirm anorexia, dyspnea upon exertion, paroxysmal nocturnal dyspnea, peripheral edema, fatigue, and right upper quadrant discomfort; however, the patient does not present spontaneously complaining of all these symptoms.

Somatic symptom disorder can occur with or without a general medical illness that “explains” the somatic symptoms [1]. The key to establishing whether the patient with a significant general medical disorder also has somatic symptom disorder is determining whether the cognitive, emotional, and behavioral responses to the medical disease is excessive compared with most other patients with that medical disorder. (See "Somatic symptom disorder: Assessment and diagnosis", section on 'Diagnostic criteria'.)

The degree of insight among patients with somatic symptoms disorder varies. Some patients recognize that they excessively focus upon and overreact to their physical symptoms, while others firmly maintain their conviction that they are direly ill. However, the intensity of the belief is not delusional, ie, their physical symptoms and related concerns are plausible and not bizarre. (See "Somatic symptom disorder: Assessment and diagnosis", section on 'Delusional disorder, somatic subtype'.)

Many patients with somatic symptom disorder engage in the same behaviors seen in illness anxiety disorder and check their bodies frequently to reassure themselves; examples include

excessive breast self-examination or blood pressure and pulse monitoring. This behavior may increase during times of stress. (See "Somatic symptom disorder: Assessment and diagnosis", section on 'Illness anxiety disorder'.)

The preoccupation with symptoms and high level of health anxiety in somatic symptom disorder often leads to high health care utilization (see 'Health care utilization' above), with multiple normal examinations and tests that do not allay the patient's concern [14,60]. Seeking care from multiple clinicians ("doctor-shopping") is also common. Patients may press their clinicians to order progressively more invasive diagnostic tests and higher-risk treatments, which can reinforce the sick role and increase the probability of iatrogenic complications. The use of laboratory tests in assessing patients with a possible diagnosis of somatic symptom disorder is discussed separately. (See "Somatic symptom disorder: Assessment and diagnosis", section on 'Laboratory tests'.)

Despite extensive medical attention, patients with somatic symptom disorder are often disappointed with their care and frustrated with their clinicians [31]. Clinicians in turn may experience negative feelings (eg, frustration, doubt, dysphoria, and anger) because their efforts at managing and reassuring the patient seem futile. These patients are often viewed as "difficult patients" [61-63].

Some patients with somatic symptom disorder fear iatrogenic illness (eg, adverse medication effects or radiation exposure), avoid mainstream medical clinicians, and pursue a diagnosis and remedies through complementary and alternative practitioners. In addition, many patients use the internet to obtain information about unorthodox prevention and treatment of medical diseases, and consume vitamins, over-the-counter remedies, and fad diets.

Somatic symptom disorder can also be recognized by a vague and inconsistent history, underlying sense of anguish, and lack of factors that alleviate symptoms. Other diagnostic clues that are associated with somatic symptom disorder are discussed elsewhere. (See "Somatic symptom disorder: Assessment and diagnosis", section on 'When to suspect the disorder'.)

Self-reported physical and mental health status in somatic symptom disorder is impaired [59]. Occupational/role functioning is also diminished.

Among children and adolescents with somatic symptom disorder, the most common symptoms are abdominal pain, back pain, blurry vision, fatigue, headache, and nausea [1,64]. Youth with the disorder are more likely than adults to have only one prominent somatic symptom. Parental response to the symptom can often influence the level of the youth's distress and determine the amount of medical care time off from school.

Patients with somatic symptom disorder are thought to be at increased risk for suicide [1]. However, it is not clear if the risk is intrinsically due to the disorder, or is due to comorbid psychopathology such as unipolar major depression. A prospective study of primary care patients with a lifetime history of somatoform disorders (n = 142) found that a lifetime history of attempted suicide was present in 18 percent [65]. In addition, active suicidal ideation in the past six months was associated with comorbid symptoms of depression. (See 'Comorbid psychopathology' below.)

Cultural aspects — Several studies in primary care and community settings have demonstrated that syndromes consisting of multiple somatic symptoms and high illness worry, along with impairment, anxiety, depression, and increased health care utilization, are similar in a wide variety of countries and cultures [1,66,67]. In addition, the most common physical symptoms appear to be the same regardless of culture.

However, the manner in which somatic symptoms are expressed can vary across cultures [1,24,68]. Somatic symptoms can have specific meanings for a particular culture and affect how somatic symptoms are interpreted and how patients conceptualize causation of symptoms. In addition, culture may influence how and when patients seek medical care and the course of illness in somatic symptom disorder.

Comorbid general medical disorders — Many patients with a recognized general medical disorder also meet criteria for somatic symptom disorder; in such cases, both disorders are diagnosed [1,11]. The key to establishing whether the patient with a significant general medical disorder also has somatic symptom disorder is determining whether the cognitive, emotional, and behavioral responses to the medical disease is excessive compared with most other patients with that medical disorder. Impairment of functioning (eg, interpersonal, occupational, and physical) is usually greater among patients with a medical illness plus somatic symptom disorder, compared with patients who have a medical illness alone.

Comorbid psychopathology — The extent of comorbid psychopathology in somatic symptom disorder is not well known because it was introduced as a diagnosis in the DSM-5, which was published in 2013 [1]. Somatic symptom disorder was derived in part from the somatoform disorders (diagnoses such as somatization disorder and hypochondriasis), which were eliminated from DSM-5. Most of the patients who previously received the somatoform diagnoses are now diagnosed in DSM-5 with somatic symptom disorder [1] (see 'Terminology and DSM-5' above). Thus, indirect information about comorbidity in somatic symptom disorder comes from the literature on somatoform disorders, as well as studies of “somatization,” which is a broad construct that has been used to describe patients with medically unexplained symptoms that cause distress and impairment, but is not a formal diagnosis.

Comorbid anxiety disorders and/or depressive disorders may occur in approximately 30 to 60 percent of primary care patients with somatic symptom disorder, and the prevalence of anxiety and/or depressive disorders is greater in patients with somatic symptom disorder than patients without somatic symptom disorder:

- A prospective study of 697 hospital clinic outpatients found that those with somatic system disorder (34 percent) reported higher levels of anxiety and depressive symptoms, as well as poorer quality of life and greater health care utilization [69].
- A study of primary care patients (n >1400) found that an anxiety or depressive disorder was present in more patients with somatization than patients without somatization (58 versus 14 percent) [34].
- In a study of primary care patients (n >10,000), those with somatization were six times more likely to manifest high levels of anxiety or depressive symptoms compared to those without somatization (30 versus 5 percent) [70].

Risk factors for comorbid anxiety and/or depression in somatic symptom disorder include the following:

- Greater number of somatic symptoms (rather than the specific type of symptoms) – This is a consistent risk factor for comorbid anxiety and/or depression, and there appears to be a dose response relationship: as the number of physical symptoms increase, so do the number of anxiety and depression symptoms [14,31,71].
- Greater number of excessive thoughts, feelings, and behaviors related to the somatic symptoms [9].
- Recent stress [31].
- Poor self-reported health status [31].

Among patients with somatic symptom disorder, comorbid anxiety and depression appear to be associated with greater disability [56], as well as increased use of health care services [34].

Comorbid anxiety can produce its own set of somatic symptoms [72]. As an example, panic attacks are characterized by abdominal distress, chest pain, diaphoresis, dizziness, dyspnea, palpitations, paresthesias, and trembling [1].

Patients with more severe somatic symptoms disorder may also be at increased risk for personality disorders. One review estimated that among patients with somatoform disorders,

comorbid personality disorders occurred in 66 percent [73]. As an example, a study assessed 94 patients with somatization disorder using structured interviews and found that 61 percent met criteria for at least one personality disorder [74]. The most common personality disorders included avoidant, paranoid, and obsessive-compulsive. (See "Overview of personality disorders".)

COURSE OF ILLNESS

The course of illness in somatic symptom disorder is unclear because it was introduced as a diagnosis in the DSM-5, which was published in 2013 [1] (see 'Terminology and DSM-5' above). However, some understanding about the course of illness in somatic symptom disorder can be gleaned from the literature on "somatization," which is a broad construct that has been used to describe patients with medically unexplained symptoms that cause distress and impairment, but is not a formal diagnosis in DSM-5.

Multiple complications may occur in somatic symptom disorder. These include unnecessary surgery, substance use disorders, and divorce [24].

The course of illness in somatization is often chronic (eg, lasts for a minimum of two years) and fluctuating, so this is likely to be the case with somatic symptom disorder, especially since the diagnostic criteria for somatic symptom disorder require persistence of symptoms (eg, at least six months) [1].

Nevertheless, improvement or remission of somatic symptom disorder may eventually be expected to occur in at least 50 percent of patients:

- One review identified five studies of patients with somatization (total n = 762) who were treated in general medical outpatient clinics and were followed on average for 6 to 15 months; improvement occurred in 50 to 75 percent [75].
- Another review estimated that over a one-year period, 50 percent or more of patients with somatization recovered within one year of diagnosis [14].
- A prospective five-year study of 32 primary care patients with somatization (defined as three or more bothersome, medically unexplained symptoms) found that 78 percent no longer met criteria for the condition, although it is not clear how many still had one or two bothersome symptoms [76].

Improvement or remission in these studies does not mean all symptoms of somatization completely resolved. In addition, patients who remitted may have subsequently relapsed and

again met criteria for somatization.

Both reviews suggest that a greater number of somatic symptoms at baseline is associated with a decreased likelihood of improvement [14,75]. Other factors that may possibly be related to unabating somatic symptom disorder include older age, marked impairment, and comorbid anxiety and depression [14], as well as maladaptive personality traits such as harm avoidance (fearfulness, anticipatory worry, and shyness) and being less cooperative [77].

Among patients with somatic symptom disorder who recover, the rate of recurrence is not clear. It is our experience that when somatic symptoms improve or remit, other symptoms may arise.

SUMMARY

- Somatic symptom disorder is a diagnosis that was introduced with publication of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) in 2013. The DSM-5 diagnosis of somatic symptom disorder has largely consolidated and supplanted the diagnoses of somatization disorder, undifferentiated somatoform disorder, hypochondriasis, and pain disorder, which were included in the prior edition of the diagnostic and statistical manual and were collectively referred to as somatoform disorders. The somatoform disorders were eliminated in DSM-5, and most of the patients who previously received somatoform diagnoses are now diagnosed in DSM-5 with somatic symptom disorder. (See 'Terminology and DSM-5' above.)

- Although the prevalence of somatic symptom disorder is unclear because it was introduced in 2013, it is estimated the prevalence in the general population is 4 percent and that among primary care patients is 17 percent. Likely risk factors include female sex, history of sexual abuse or other childhood trauma, and concurrent general medical and psychiatric disorders. We presume that somatic symptom disorder is associated with increased health care utilization. (See 'Epidemiology' above.)

- The pathogenesis of somatic symptom disorder is not known. Several psychosocial factors may perhaps be involved, including developmental factors, physical and sexual abuse, and cognitive and perceptual distortions and behavioral abnormalities. (See 'Pathogenesis' above.)

- There are two core features that each occur in somatic symptom disorder:

- One or more current somatic symptoms that are long-standing and cause distress or psychosocial impairment. Multiple symptoms are typically present, but one severe symptom (eg, pain) is sufficient to make the diagnosis.

- Excessive thoughts, worrying, or behaviors (time and energy) related to the somatic symptoms or to health concerns.

Among moderately to severely ill patients, the physical symptoms can become a central feature of the patient's identity and dominate interpersonal relationships, psychosocial and physical functioning decline, and the patient's disability imposes a significant burden upon families.

Somatic symptoms that are common include pain, nonspecific symptoms (eg, fatigue), gastrointestinal symptoms, cardiopulmonary symptoms, neurologic symptoms, and reproductive organ symptoms.

Somatic symptom disorder can occur with or without a general medical illness that "explains" the somatic symptoms. The key to determining whether the patient with a significant general medical disorder also has somatic symptom disorder is determining whether the cognitive, emotional, and behavioral responses to the medical disease is excessive compared with most other patients with that medical disorder.

Despite extensive medical attention, patients with somatic symptom disorder often are disappointed and frustrated with their clinicians. Clinicians in turn may become frustrated because their efforts at managing and reassuring the patient seem futile.

The degree of insight among patients with somatic symptom disorder varies.

(See 'Signs and symptoms' above.)

- Syndromes consisting of multiple somatic symptoms and high illness worry, along with impairment, anxiety, depression, and increased health care utilization, are similar in a wide variety of countries and cultures. (See 'Cultural aspects' above.)

- Many patients with a recognized general medical disorder also meet criteria for somatic symptom disorder; in such cases, both disorders are diagnosed. (See 'Comorbid general medical disorders' above.)

- Comorbid anxiety disorders and/or depressive disorders may occur in approximately 30 to 60 percent of primary care patients with somatic symptom disorder. Comorbid personality disorders appear common as well. (See 'Comorbid psychopathology' above.)

- Although the course of illness in somatic symptom disorder is unclear, it is thought that the course is often chronic and fluctuating, but that improvement or remission of somatic symptom disorder may eventually be expected to occur in at least 50 percent of patients. However, improvement or remission does not mean all symptoms are completely resolved. In addition, patients who remitted may subsequently relapse. (See 'Course of illness' above.)

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