Somatic symptom disorder: Assessment and diagnosis

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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 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 assessment, diagnosis, and differential diagnosis of somatic symptom disorder. The epidemiology, pathogenesis, clinical presentation, course of illness, and treatment of somatic symptom disorder are discussed separately. (See "Somatic symptom disorder: Epidemiology and clinical presentation" 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 [1,2]. The clinical features and diagnostic criteria are discussed separately. (See "Somatic

symptom disorder: Epidemiology and clinical presentation", section on 'Clinical presentation' and 'Diagnostic criteria' below.)

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 [1,4]. 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 [3]. 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 [4]. 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 [4,11] 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.

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].

SCREENING

Although screening instruments can facilitate diagnosis of somatic symptom disorder, screening is not standard practice. Patients who screen positive need to be interviewed in sufficient depth to determine if diagnostic criteria are satisfied to verify the diagnosis. In addition, it is not known whether screening improves outcomes. Based upon studies of major depression, screening is beneficial only if follow-up is available to provide diagnostic interviews and treatment. (See "Screening for depression in adults", section on 'Improved depression outcomes'.)

For clinicians who want to screen for somatic symptom disorder, we suggest self-report measures, which can save interviewer time. However, self-report instruments are more prone to false-positives than clinician-administered instruments.

A core feature of somatic symptom disorder is the presence of one or more current somatic symptoms that are long-standing and cause distress or psychosocial impairment. Self-administered instruments that screen for physical symptoms include the following:

- Patient Health Questionnaire – 15 Item (PHQ-15) (table 3) – The PHQ-15 is the most widely used instrument to assess the number of distressful somatic symptoms, due to its well-established psychometric properties, brevity, and availability in multiple languages [13]. It comprises 15 somatic symptoms that are commonly encountered in primary care, with each symptom scored 0 ("not bothered at all"), 1 (“bothered a little”) or 2 ("bothered a lot") [14]. The total score provides an index of severity; higher scores are associated with poorer functioning (occupational, social, and physical), increased health care utilization, and more symptoms of depression and anxiety. PHQ-15 scores and somatic symptom severity are as follows:

  - 0 to 4 – minimal
  - 5 to 9 – low
  - 10 to 14 – moderate
  - 15 to 30 – high

- Somatic Symptom Scale-8 – The Somatic Symptom Scale-8 was derived from the PHQ-15 and is an eight-item measure that quantifies the burden of somatic symptoms [15,16]. The eight items are stomach or bowel problems; back pain; pain in your arms, legs, or joints; headaches; chest pain or shortness of breath; dizziness; feeling tired or having low energy; and trouble sleeping. Each of the eight items is rated as follows:

  - Not at all – 0
  - A little bit – 1
  - Somewhat – 2
  - Quite a bit – 3
  - Very much – 4

  A total score of 0 to 3 indicates no to minimal burden, 4 to 7 low burden, 8 to 11 medium burden, 12 to 15 a high burden, and a score of 16 to 32 indicates a very high burden. The reliability and validity of the scale is comparable to that of the PHQ-15 [17].

The other core feature of somatic symptom disorder is excessive thoughts, worrying, or behaviors related to the somatic symptoms or to health concerns. Self-administered instruments that screen for this feature include:

- The seven-item Whiteley Index (table 4), which is the most widely studied measure for health anxiety. It has acceptable psychometric properties, and includes validated subscales that assess illness worrying (items number two, four, and six; sensitivity 0.37, specificity 0.70, and positive predictive value 0.41) and illness conviction (items number three, five, and seven; sensitivity 0.63, specificity 0.87, and positive predictive value 0.73) [18,19].

- The 12-item Somatic Symptom Disorder-B Criteria Scale (table 5), which assesses excessive thoughts, worrying, or behaviors related to somatic symptoms, has good to excellent psychometric properties and was developed specifically for the diagnosis of somatic symptom disorder [20,21]. Higher scores on this scale are associated with greater general medical comorbidity and increased health care utilization [22].

- The 15-item Somatic Symptoms Experiences Questionnaire (table 6), which asks about health worries, experience of illness, problems interacting with physicians, and consequences of illness. The instrument is valid and reliable, and was developed specifically for the diagnosis of somatic symptom disorder [23].

- The 14- and 18-item versions of the Short Health Anxiety Inventory [24,25] and the 29-item Illness Attitude Scales (particularly the three-item Bodily Preoccupation subscale) [26,27].

Combining either the PHQ-15 or the Somatic Symptom Scale-8 with the Somatic Symptom Disorder-B scale considerably improves identification of people at risk for somatic symptom disorder [28].

ASSESSMENT

When to suspect the disorder — In primary care or general medical settings, the presence of somatic symptom disorder is suggested by the following clues [1]:

- History of present illness is vague and inconsistent.

- Health care concerns are rarely alleviated despite high utilization of medical care – Reassurance and explanation by clinicians that the symptoms are not caused by a serious general medical condition provides only temporary relief, or is viewed as a sign that the clinician does not understand the patient's symptoms and is not taking them seriously.

- Multiple courses of standard treatment fail to mitigate the symptoms.

- Attributing normal physical sensations to medical illnesses.

- Repeatedly checking one's body for abnormalities.
- Avoiding physical activity.
- Unusually high sensitivity to medication side effects.
- Seeking care from multiple doctors for the same somatic symptom(s).
- Clinicians find themselves feeling frustrated.
- Refuses to grant permission to speak with other clinicians.

General approach — The evaluation of a patient presenting with possible somatic symptom disorder includes taking a general medical history with a full review of systems (not just the presenting symptom), taking a psychiatric history, performing a physical examination and a mental status examination, reviewing laboratory data, and communicating with other clinicians [29]. A thorough physical examination will help the clinician and patient feel comfortable that no important diagnosis will be missed. Ancillary laboratory testing should be conservative (see 'Laboratory tests' below). A general medical illness may be present but not recognized because of insufficient attention to the history, physical examination, or laboratory tests; insufficient use of contemporary diagnostic techniques; the medical illness is due to iatrogenic adverse effects; or the medical illness represents a new disease that has yet to be identified [30].

To make the diagnosis in children and adolescents, we suggest obtaining information about the symptoms from the patient, family, and potentially other sources (eg, school teachers) [31]. Engaging both the patient and parent/caregiver during evaluation and management is key, because the parents' interpretation of and response to the somatic symptoms may influence the child's level of emotional distress; the extent of medical evaluation, tests, and interventions; and time away from school and play.

Both a general medical and a psychiatric etiology for the patient's symptoms should be explored simultaneously so that the patient has confidence that medical needs are being addressed, and because somatic symptom disorder can be a maladaptive response to a serious medical illness. In addition, patients who present with a new general medical illness may be more willing to discuss psychosocial concerns at the onset of their evaluation, rather than after all medical examinations have failed to identify a cause for their symptoms [32]. Many of these patients will have previously seen several other clinicians and been dissatisfied.

Establishing trust and minimizing the chance that the patient feels rejected or humiliated are essential. Patients need to feel respected and understood. It is counterproductive to tell

patients that there is nothing wrong with them or that they are making too big a deal out of their symptoms.

The Health Preoccupation Diagnostic Interview is a structured, interviewer-administered instrument that is available for diagnosing somatic symptom disorder, but is seldom used in routine clinical care. The instrument enables the interviewer to clarify ambiguous or contradictory responses, and can help differentiate the diagnosis of somatic symptom disorder from illness anxiety disorder, and differentiate patients with somatic symptom disorder from normal controls. Reliability was demonstrated in a study of persons with clinically significant health anxiety (n = 52) and healthy controls (n = 52) [7]. However, structured instruments are labor intensive and generally reserved for specialized evaluation, treatment, or research settings.

History of present illness — Clinicians taking a history should assess [29,33-36]:

- Which somatic symptoms trigger health anxiety and how the patient responds to the anxiety.
- Whether the patient manifests persistent thoughts and anxiety related to the somatic symptoms. In addition, assess illness/pain behaviors and whether the patient devotes excessive time and energy to the somatic symptoms.
- Degree of insight, ie, whether the patient recognizes that the concern about health may be excessive.
- Whether the initiation, maintenance, or exacerbation of the physical symptoms are related to the patient's emotions and social situation, and if any stressful personal events such as losses have occurred. Listening for family or marital conflict is important because family conflict is associated with increased somatic symptoms and both may follow a similar trajectory over time. Patients frequently disclose psychosocial problems directly or indirectly.
- What exacerbates or alleviates the somatic symptoms, and the pattern of pain if it is present.
- What the patient thinks is wrong – Patients may believe they are suffering because they are convinced that they have a specific disease, are seriously ill, or are dying.
- Whether current symptoms are acute or chronic.
- The quality of relationships with current and past primary care clinicians.

- Whether the patient can be reassured.
- Whether patients are undergoing other current medical evaluations.
- Current medications and other treatment, including over-the-counter, prescription, and complementary and alternative products and interventions.
- Whether patients have experienced physical or sexual abuse, whether they feel safe in their current relationships, and whether they feel threatened or afraid in any way, either at home or in other settings.
- Psychiatric comorbidity, such as anxiety disorders, depressive disorders, substance use disorders (eg, alcohol and marijuana), personality disorders, and other somatic symptom disorders.
- Suicidal ideation and behavior.
- Psychosocial functioning.
- Family history of serious diseases.

For patients with an established, significant general medical disease, ask whether they worry about their symptoms more than others with their illness, or more than they think they should.

For otherwise healthy patients, ask:

- Do you think your symptoms are serious?
- How much do you worry about your symptoms?
- How much attention do your symptoms require?

Past illness — Some patterns of somatic symptom expression are characterized by a longitudinal course beginning in childhood. Patients may report that their parents/caregivers were attentive only when they were sick.

Ask about a past history of serious illnesses, particularly in childhood, past medical evaluations, as well as a lifetime history of anxiety disorder, depressive disorder, or multiple unexplained symptoms. In addition, prior treatment with psychotropic medications should be assessed.

Examine past medical records. The past history is essential to document whether there is a pattern of multiple physical symptoms, increased health care utilization, and greater psychosocial impairment than expected. A history of multiple surgical procedures without

pathologic confirmation of disease increases the likelihood of somatic symptom disorder. Patients may have a history of changing doctors frequently or leaving the hospital against medical advice.

Family history — The family history should be examined for a model of disability or somatization, the presence of depression or anxiety disorder, and anniversaries of deaths of loved ones with similar symptoms.

Social history — Consider the social context in which the physical symptoms appear, including likely stressors at the patient's stage of development (eg, desire to have children or care for children, work pressures, and grief). Financial pressures, work, unemployment, disability history, history of arrests, time in prison, probation, and legal suits may provide context for the somatic symptoms.

Physical examination — The physical examination can achieve the following:

- Help satisfy the clinician that the patient does not have a general medical disease, or if a disease is present, provide perspective on its severity.
- Provide a baseline for detecting change over time.
- Help assure patients that their complaints are taken seriously.

Laboratory tests — Laboratory testing should be judicious when evaluating current and new physical symptoms. Often, extensive testing has previously been done to look for a diagnosis or reassess an established one. Criteria for selective use of tests include objective signs rather than the volume of the concerns expressed by the patient, the presence of complex symptoms, and persistence of symptoms [37].

Clinicians often pursue excessive diagnostic tests, even when patients offer clues that the etiology is psychiatric [32,35,38]. Adverse effects of diagnostic testing include increased false-positive results that can lead to additional procedures, as well as increased costs and false-negative results [37].

Diagnostic tests are frequently ordered for patients who present with somatic symptoms but have a low probability of serious disease (eg, 1 to 3 percent) [37]. Although the purpose of the tests is to rule out illnesses and provide reassurance, studies indicate that such testing does not reassure patients [39]. As an example, a meta-analysis of 14 randomized trials compared diagnostic testing (eg, endoscopy or imaging) with a nontesting control condition (usual care or empirical treatment) in 3828 patients who presented with physical symptoms (eg, dyspepsia)

and had a low pretest probability of serious disease [40]. Most of the studies occurred in primary care settings. The findings included the following:

- Resolution of somatic symptoms in the testing and nontesting groups was similar in the short term (≤3 months; odds ratio 0.9, 95% CI 0.6-1.4) and long term (>3 months; odds ratio 1.0, 95% CI 0.9-1.2).
- Reduction of illness concern and anxiety was comparable for the two groups, both in the short and long term.
- The number of subsequent visits was modestly smaller in the testing group than the nontesting group (odds ratio 0.77, 95% CI 0.62-0.96).

DIAGNOSIS

Somatic symptom disorder is usually diagnosed in general medical settings based upon a history, physical and mental status examination, and laboratory tests. (See 'Assessment' above.)

Diagnostic criteria — We recommend that somatic symptom disorder be diagnosed according to the DSM-5; the diagnosis requires each of the following [1,4]:

- One or more somatic symptoms that cause distress or psychosocial impairment.
- Excessive thoughts, feelings, or behaviors associated with the somatic symptoms, as demonstrated by one or more of the following:
  - Persistent thoughts about the seriousness of the symptoms
  - Persistent, severe anxiety about the symptoms or one's general health
  - The time and energy devoted to the symptoms or health concerns is excessive
- Although the specific somatic symptom(s) may change, the disorder is persistent (usually more than six months).

In addition, DSM-5 includes several specifiers (qualifiers) for making a more precise diagnosis [1]:

- With predominant pain – The predominant somatic symptom is pain.
- Current severity – With regard to excessive thoughts, feelings, and behaviors, how many of these three features are present. The number of somatic symptoms is also used to

determine severity:

- Mild – Only one feature is present (eg, excessive time and energy devoted to somatic symptom).
- Moderate – Two or more of the features are present (eg, both persistent thoughts and severe anxiety).
- Severe – Two or more of the features are present, plus the patient manifests either multiple somatic complaints (eg, fatigue, dizziness, and gastrointestinal distress) or one very severe somatic symptom.

- Persistent – The course of illness lasts more than six months, psychosocial functioning is markedly impaired, and the current severity is rated as severe.

As an example, clinicians can diagnose "somatic symptom disorder, with predominant pain, moderate."

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 [2,11]. As an example, both coronary artery disease **and** somatic symptom disorder are diagnosed in a patient who has had an uncomplicated myocardial infarction and has been advised by his clinician that he may resume normal work, exercise, and sex, but instead constantly monitors his chest sensations, possible shortness of breath, and pulse; limits his activities to the level he was at when discharged from the hospital; and reads about coronary disease for hours on the internet.

Somatic symptom disorder may be underdiagnosed in older adults [1]. This can occur if clinicians incorrectly view certain somatic symptoms (eg, fatigue or pain) as a normal part of aging, or incorrectly consider anxiety about illness as "understandable" in older adults, given their higher rate of general medical illnesses, compared with younger patients.

Discussing the diagnosis — In discussing the diagnosis of somatic symptom disorder with patients, clinicians should acknowledge the patient's physical and emotional suffering, emphasize that the somatic symptoms are real, and assure patients that the presence of a psychiatric disorder does not negate the reality of their suffering, and offer empathy [38,41]. Telling patients that the symptoms "are all in your head" is not helpful. Many patients can accept the diagnosis if it is presented properly.

When no general medical disorder has been identified, clinicians should avoid debating with patients whether the symptoms are due to psychiatric or nonpsychiatric illness. Directly challenging the patient's belief that symptoms are caused by a medical condition may undermine the relationship with the patient. It is more reasonable for clinicians to explain there is no evidence of a life-threatening illness and to present this as good news. In addition, we tell patients that they have a common, well-described, although not well-understood, condition that results in the set of current symptoms [42].

For patients with somatic symptom disorder that occurs in the context of an identified medical disorder, clinicians should not tell patients that they are blowing their symptoms out of proportion, which can leave patients feeling discounted and disrespected. A better approach starts with an empathic reflection back to the patient about the clinician's recognition that the somatic symptoms are a significant burden on the patient, followed by an explanation of how sensitivity to pain (or other somatic symptoms) is affected by stress and coping style. The wording of the diagnosis "somatic symptom disorder" was specifically chosen to be neutral to avoid implying their symptoms were unjustified, and hopefully to be more acceptable to patients.

DIFFERENTIAL DIAGNOSIS

The symptoms of somatic symptom disorder overlap with symptoms of other disorders; distinguishing between the disorders is important for treatment. In many cases, somatic symptom disorder accompanies a general medical disorder or another psychiatric disorder.

General medical disorders — The presence of "medically unexplained" somatic symptoms is not in itself sufficient to diagnose somatic symptom disorder; other criteria are also necessary (see 'Diagnostic criteria' above) [2,11]. As an example, many patients with disorders of unclear etiology, such as fibromyalgia and irritable bowel syndrome, do not satisfy the criterion that stipulates that patients manifest excessive thoughts, feelings, or behaviors associated with the somatic symptoms.

On the other hand, the presence of a recognized medical disorder that can cause the patient's symptoms does not exclude the diagnosis of somatic symptom disorder if all of the diagnostic criteria are met. (See "Somatic symptom disorder: Epidemiology and clinical presentation", section on 'Comorbid general medical disorders'.)

Psychiatric disorders — Symptoms of somatic symptom disorder may overlap with symptoms of other psychiatric disorders [1]. The differential diagnosis for somatic symptom disorder

includes the psychiatric disorders that are described in the subsections below [1,43].

Some of the psychiatric disorders that are part of the differential diagnosis can also occur in conjunction with it. If the patient meets full diagnostic criteria for both somatic symptom disorder and another psychiatric disorder (eg, unipolar major depression or generalized anxiety disorder), both conditions are diagnosed and should be treated. Comorbid psychopathology is discussed separately. (See "Somatic symptom disorder: Epidemiology and clinical presentation", section on 'Comorbid psychopathology'.)

Adjustment disorder — Patients with general medical conditions may develop adjustment disorder or somatic symptom disorder. Both adjustment disorder and somatic symptom disorder are characterized by disproportionate emotional or behavioral responses to the general medical illness, as well as distress and impaired functioning. However, adjustment disorder is a residual diagnosis and is not diagnosed if the patient meets criteria for another specific disorder, such as somatic symptom disorder.

Body dysmorphic disorder — Patients with body dysmorphic disorder and somatic symptom disorder both manifest excessive thoughts, feelings, and behavior related to somatic concerns, and both groups exhibit distress and impaired functioning. The primary distinction between the two disorders is that the preoccupation in body dysmorphic disorder is with a perceived defect in appearance in physical features (being ugly or deformed) (table 7), whereas the preoccupation in somatic symptom disorder is with one or more physical symptoms. (See "Body dysmorphic disorder: Assessment, diagnosis, and differential diagnosis", section on 'Diagnostic criteria'.)

Conversion disorder — Both conversion disorder and somatic symptom disorder are characterized by physical symptoms. Conversion disorder (table 8) is defined by the presence of a neurologic symptom (eg, loss of function in a limb) that is incompatible with anatomy or pathophysiology, or is inconsistent at different times (internally inconsistent; eg, a “paralyzed” limb will move inadvertently when the patient is distracted by performing movements in their unaffected limb). By contrast, the key feature in somatic symptom disorder is the patient’s excessive response to their physical symptoms. Many patients with conversion show **less** than expected concern about their neurologic symptoms. (See "Functional neurological symptom disorder (conversion disorder) in adults: Terminology, diagnosis, and differential diagnosis", section on 'Diagnosis'.)

Delusional disorder, somatic subtype — Delusional disorder, somatic subtype, and somatic symptom disorder each involve the belief that something is wrong with one’s body; the two are distinguished by the intensity of the belief. Delusions are false, fixed beliefs that are maintained

despite clear evidence to the contrary. In addition, delusional disorder, somatic subtype, may involve beliefs that are bizarre (eg, delusional parasitosis). Although patients with somatic symptom disorder can have firmly held beliefs (overvalued ideas) about the cause of their somatic symptoms and the level of appropriate concern, the beliefs are not of delusional intensity or character. Patients with somatic symptom disorder can acknowledge the possibility that their somatic symptoms do not represent a serious general medical illness, and the somatic symptoms are not bizarre. (See "Delusional disorder", section on 'Diagnosis'.)

Depressive disorders — Depressive syndromes such as unipolar major depression (table 9) and persistent depressive disorder (table 10) often include somatic symptoms such as fatigue or anergy. However, depressive disorders are characterized by the core symptoms of low mood (dysphoria) and anhedonia, which typically do not occur in somatic symptom disorder. (See "Unipolar depression in adults: Assessment and diagnosis", section on 'Diagnostic criteria and classification'.)

If the somatic symptoms and excessive thoughts, feelings, or behavior of somatic symptom disorder occur only during acute episodes of unipolar major depression, then a separate diagnosis of somatic symptom disorder is not made.

Generalized anxiety disorder — Generalized anxiety disorder and somatic symptom disorder are both marked by high levels of anxiety. However, generalized anxiety disorder is characterized by pervasive anxiety and worry about multiple aspects of life, whereas in somatic symptom disorder the anxiety is focused on physical symptoms and health. Individuals with generalized anxiety disorder may worry about their health and have physical symptoms (eg, muscle tension), but it is not their main focus of concern. (See "Generalized anxiety disorder in adults: Epidemiology, pathogenesis, clinical manifestations, course, assessment, and diagnosis", section on 'Screening, assessment, and diagnosis'.)

Illness anxiety disorder — Both illness anxiety disorder and somatic symptom disorder are characterized by excessive thoughts, fears, and behaviors related to somatic concerns, and are accompanied by distress and impaired functioning. However, physical symptoms in illness anxiety disorder are at most minimal, and patients are more preoccupied with the idea that they are sick (table 2). By contrast, patients with somatic symptom disorder have significant somatic symptoms, and typically there are multiple concurrent somatic symptoms; however, there may be only one severe symptom, such as pain. (See "Illness anxiety disorder: Epidemiology, clinical presentation, assessment, and diagnosis", section on 'Diagnosis'.)

Obsessive-compulsive disorder — Preoccupation with health concerns (eg, germ phobia) can occur in patients with obsessive-compulsive disorder (OCD), similar to what is observed in

somatic symptom disorder. However, in OCD, the obsessive thoughts are experienced as intrusive and unwanted, and repetitive behaviors are performed to suppress the thoughts, neither of which characterize somatic symptom disorder. (See "Obsessive-compulsive disorder in adults: Epidemiology, clinical features, and diagnosis", section on 'Assessment and diagnosis'.)

Panic disorder — In panic disorder, the somatic symptoms (eg, chest pain and dyspnea) and associated anxiety initially occur during intermittent, intense, acute episodes, whereas in somatic symptom disorder, somatic symptoms and associated psychological symptoms are chronic. The differentiation may be more difficult when panic disorder remains untreated and becomes chronic. (See "Panic disorder in adults: Epidemiology, clinical manifestations, and diagnosis", section on 'Diagnosis'.)

Psychological factors affecting other medical conditions — Somatic symptoms, psychological stress, and maladaptive health behaviors can occur in both somatic symptom disorder, as well as the disorder known as psychological factors affecting other medical conditions. However, in somatic symptom disorder, the somatic symptoms are the focus of excessive or maladaptive thoughts, feelings, or behaviors; in psychological factors affecting other medical conditions, the patient's thoughts, feelings, or behaviors are not necessarily excessive. In addition, the physical symptoms in somatic symptom disorder may not be medically explained, whereas a diagnosable general medical disorder is always present in psychological factors affecting other medical conditions.

The distinction between the two disorders is often not clear cut; rather, the difference is one of emphasis. Somatic symptom disorder emphasizes the disproportionate and persistently abnormal thoughts, feelings, and/or behaviors centered upon the physical symptoms (eg, patients with angina worry continuously that they will have a heart attack, measure their blood pressure multiple times each day, and unnecessarily limit their activity). By contrast, psychological factors affecting other medical conditions emphasizes that psychological factors adversely affect the course and outcome of the medical condition (eg, angina is precipitated by anxiety).

Additional information about diagnosing psychological factors affecting other medical conditions is discussed separately. (See "Psychological factors affecting other medical conditions: Clinical features, assessment, and diagnosis", section on 'Diagnostic criteria'.)

SUMMARY

- **Terminology** – 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 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.)

- **When to suspect the disorder** – In primary care or general medical settings, the presence of somatic symptom disorder is suggested by the following clues: history of present illness is vague and inconsistent, health care concerns are rarely alleviated despite high utilization of medical care, patient attributes normal physical sensations to medical illnesses, repeatedly checks one's body for abnormalities, and patient elicits negative feelings in clinicians. (See 'When to suspect the disorder' above.)

- **Assessment**

  - **General approach** – The evaluation of a patient presenting with possible somatic symptom disorder includes taking a general medical history with a full review of systems (not just the presenting symptom), taking a psychiatric history, performing a physical examination and a mental status examination, reviewing laboratory data, and communicating with other clinicians. (See 'General approach' above.)

  - **History of present illness** – Clinicians taking a history should determine which somatic symptoms trigger health anxiety and how the patient responds to the anxiety. In addition, determine whether the patient manifests persistent thoughts and anxiety related to the somatic symptoms, and whether the patient devotes excessive time and energy to the somatic symptoms. (See 'History of present illness' above.)

  - **Physical examination** – A thorough physical examination will help clinicians and patients feel comfortable that no important diagnosis will be missed. (See 'Physical examination' above.)

  - **Laboratory tests** – Laboratory testing should be judicious when evaluating current and new physical symptoms. Criteria for selective use of tests include objective signs rather than the volume of the concerns expressed by the patient, the presence of complex symptoms, and persistence of symptoms. (See 'Laboratory tests' above.)

- **Diagnostic criteria** – We recommend that somatic symptom disorder be diagnosed according to DSM-5; the diagnosis requires each of the following:
  - One or more somatic symptoms that cause distress or psychosocial impairment.
  - Excessive thoughts, feelings, or behaviors associated with the somatic symptoms, as demonstrated by one or more of the following:
    - Persistent thoughts about the seriousness of the symptoms
    - Persistent, severe anxiety about the symptoms or one's general health
    - The time and energy devoted to the symptoms or health concerns is excessive
  - Although the specific somatic symptom(s) may change, the disorder is persistent (usually more than six months).

  (See 'Diagnostic criteria' above.)

- **Discussing the diagnosis** – In discussing the diagnosis of somatic symptom disorder with patients, clinicians should acknowledge their physical and emotional suffering, emphasize that the somatic symptoms are real, and should assure patients that the presence of a psychiatric disorder does not negate the reality of their suffering. When no general medical disorder has been identified, clinicians should avoid debating with patients whether the symptoms are due to psychiatric or nonpsychiatric illness. For patients with somatic symptom disorder that occurs in the context of an identified medical disorder, clinicians should not tell patients that they are blowing their symptoms out of proportion. (See 'Discussing the diagnosis' above.)

- **Differential diagnosis** – The differential diagnosis of somatic symptom disorder includes adjustment disorder, body dysmorphic disorder, conversion disorder, delusional disorder (somatic type), depressive disorders, generalized anxiety disorder, illness anxiety disorder, obsessive-compulsive disorder, panic disorder, and psychological factors affecting other medical conditions. (See 'Psychiatric disorders' above.)

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