

*DRAFT*      *April 18, 2011*

## **Somatic Symptom Disorders**

### **Introduction**

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

These disorders typically present first in non-psychiatric settings and somatic symptom disorders can accompany diverse general medical as well as psychiatric diagnoses. Having somatic symptoms of unclear etiology is not in itself sufficient to make this diagnosis. Some patients, for instance with irritable bowel syndrome or fibromyalgia would not necessarily qualify for a somatic symptom disorder diagnosis. Conversely, having somatic symptoms of an established disorder (e.g. diabetes) does not exclude these diagnoses if the criteria are otherwise met.

There are other psychiatric disorders, which may present with prominent somatic symptoms such as depression or panic; therefore, not all presentations with somatic symptoms would qualify for these diagnoses.

The presentation of these symptoms may vary across the lifespan. A corroborative historian with a life course perspective may provide important information for both the elderly and for children.

<b>I.      Psychological factors affecting medical condition (#316).</b>
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The essential feature of this disorder is the presence of one or more clinically significant psychological or behavioral factors that adversely affect a medical condition by increasing the risk for suffering, death, or disability. These factors can adversely affect the medical condition by influencing its course or treatment, by constituting an additional health risk factor, or by exacerbating the physiology that is related to the medical condition.

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

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

PFAMC can occur across the lifespan. Particularly with young children, corroborative history from parents or school can assist the diagnostic evaluation.

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

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

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

This disorder is characterized by a combination of distressing (often multiple) symptoms and an excessive or maladaptive response to these symptoms or associated health concerns. The patient's suffering is authentic, whether or not it is medically explained. Patients typically experience distress and a high level of functional impairment. The symptoms may or may not accompany diagnosed general medical disorders or psychiatric disorders. There may be a high level of medical care utilization, which rarely alleviates the patient's concerns. From the clinician's point of view, many of these patients seem unresponsive to therapies, and new interventions or therapies may only exacerbate the presenting symptoms or lead to new side effects and complications. Some patients feel that their medical assessment and treatment have been inadequate.

Patients with this diagnosis typically have multiple, current, somatic symptoms that are distressing; sometimes, they may have only one severe symptom. The symptoms may or may not be associated with a known medical condition. Symptoms may be specific (such as localized pain) or relatively non-specific (e.g. fatigue). The symptoms sometimes represent normal bodily sensations (e.g., orthostatic dizziness), or discomfort that does not generally signify serious disease (e.g., bad taste in one's mouth). Health-related quality of life is frequently severely impaired.

Patients with this diagnosis tend to have very high levels of health-related anxiety. They appraise their bodily symptoms as unduly threatening, harmful, or troublesome and often fear the worst about their health. Even when there is evidence to the contrary, they still fear the medical seriousness of their symptoms. Health concerns may assume a central role in the individual's life, becoming a feature of his/her identity and dominating interpersonal relationships.

If all of the somatic symptoms are consistent with another psychiatric disorder (e.g. panic disorder), and the diagnostic criteria for that disorder are fulfilled, then that psychiatric disorder should be considered as an alternative or additional diagnosis. If the patient has worries about health but no somatic symptoms, he/she may be more appropriately considered for an anxiety disorder diagnosis.

In the elderly somatic symptoms and comorbid medical illnesses are more common, and thus a focus on criteria B becomes more important. In the young child, the "B criteria" may be principally expressed by the parent.

CSSD is a disorder characterized by chronicity, symptom burden, and excessive or maladaptive response to symptoms. When patients do not meet criteria for these domains, other diagnoses should be considered such as Simple Somatic Symptom Disorder (SSSD).

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

**A. Somatic symptoms:**

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

**B. Excessive thoughts, feelings, and behaviors related to these somatic symptoms or associated health concerns:** At least two of the following are required to meet this criterion:

*(1) Disproportionate and persistent concerns about the medical seriousness of one's symptoms.*

*(2) High level of health-related anxiety*

*(3) Excessive time and energy devoted to these symptoms or health concerns*

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

For patients who fulfill the CSSD criteria, the following optional specifiers may be applied to a diagnosis of CSSD where one of the following dominates the clinical presentation:

XXX.1 Predominant somatic complaints (previously, somatization disorder)

XXX.2 Predominant health anxiety (previously, hypochondriasis) If patients present solely with health-related anxiety with minimal somatic symptoms, they may be more appropriately diagnosed as having Illness Anxiety Disorder (see V.B below).

XXX.3 Predominant Pain (previously pain disorder). This classification is reserved for individuals presenting predominantly with pain complaints who also have many of the features described under criterion B. Patients with other presentations of pain may better fit other psychiatric diagnoses such as adjustment disorder or psychological factors affecting a medical condition.

For assessing severity of CSSD, metrics are available for rating the presence and severity of somatic symptoms (see for instance PHQ, Kroenke et al, 2002). Scales are also available for assessing severity of the patient's misattributions, excessive concerns and preoccupations (see for instance Whiteley inventory, Pilowsky , 1967).

### **III. Simple (or abridged) somatic symptom disorder [xxxxxxx] e.g. pain (# XXX)**

This diagnosis requires the following 3 criteria:

**A. Somatic symptoms:** One or more somatic symptoms that are distressing and/or result in significant disruption of daily life.

**B. Excessive thoughts, feelings, and behaviors related to these somatic symptoms or associated health concerns:** This diagnosis requires one of the following:

*(1) Disproportionate and persistent thoughts about the seriousness of one's symptoms.*

*(2) High level of anxiety about health or symptoms*

*(3) Excessive time and energy devoted to these symptoms or health concerns*

**C. Symptom duration >1 month.**

### **IV. Illness Anxiety Disorder (hypochondriasis without somatic symptoms)**

This disorder is characterized by high illness anxiety that is distressing and/or disruptive to daily life with minimal somatic symptoms. Most patients previously diagnosed with hypochondriasis have somatic symptoms and will now be included in CSSD. However, some patients previously diagnosed with hypochondriasis have minimal somatic distress and

instead are concerned primarily with the *idea* that they are sick. They are now diagnosed with illness anxiety disorder. The following 6 criteria must be met.

- A. Somatic symptoms are not present or, if present, are only mild in intensity.
- B. Preoccupation with having or acquiring a serious illness. If a general medical condition or high risk for developing a general medical condition is present, the illness concerns are clearly excessive or disproportionate. The individual's concern is focused not on any physical distress per se, but rather on a suspected, underlying medical diagnosis.
- C. High level of anxiety about health or having or acquiring a serious illness. These individuals have a low threshold for considering themselves to be sick and a low threshold for becoming alarmed about their health.
- D. The person performs related excessive behaviors (e.g. checking one's body for signs of disease, repeatedly seeking information and reassurance from the internet or other sources), or exhibits maladaptive avoidance (e.g. avoiding doctor's appointments and hospitals, avoiding visiting sick friends or relatives, avoiding triggers of illness fears such as exercise).
- E. Although the preoccupation may not be continuously present, the state of being preoccupied is chronic (at least 6 months)
- F. The illness-related preoccupation is not better accounted for by the symptoms of another mental disorder such as complex somatic symptom disorder, panic disorder, generalized anxiety disorder, or obsessive compulsive disorder.

<b>V. Functional Neurological Disorder (previously, Conversion disorder (#300.11))</b>
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The essential feature of this disorder is neurological symptoms that are found, after appropriate medical assessment, to be incompatible with a neurological condition. The symptoms might include weakness or paralysis, events resembling epilepsy or syncope, abnormal movements, sensory symptoms (including loss of vision and hearing), or speech and swallowing difficulties. In addition, the diagnosis will usually be supported by evidence of internal inconsistency or incongruity with neurological disease. This evidence may include physical signs (such as, Hoover's sign of functional weakness) or diagnostic investigations (such as seizure-like behaviour in the absence of simultaneous convulsive activity on EEG). The symptoms may be acute or chronic. Psychological stressors or personally meaningful life events may often be associated with onset of symptoms, but their identification is not necessary for the diagnosis. Co-morbid neurological disease may also be present and does not exclude the diagnosis.

If there is evidence that the symptoms are intentionally feigned, the condition is not conversion disorder but rather either factitious disorder or malingering. Cognitive complaints that are incompatible with objective findings may be coded as a variant of functional neurological symptoms, dissociative disorder, factitious disorder, malingering, illness anxiety disorder, or CSSD, depending on the clinician's overall assessment of the clinical situation.

Given the increased prevalence of neurological disorders in the elderly, special care should be taken in diagnosing functional neurological disorder in older patients who have not previously had such symptoms.

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

- A. One or more neurologic symptoms such as altered voluntary motor, sensory function, or seizure-like episodes
- B. The symptom, after appropriate medical assessment, is not found to be due to a general medical condition, the direct effects of a substance, or a culturally sanctioned behavior.
- C. The physical signs or diagnostic findings are internally inconsistent or incongruent with recognized neurological disorder.
- D. The symptom causes clinically significant distress or impairment in social, occupational, or other important areas of functioning or warrants medical evaluation.

## **VI. Factitious disorder #300**

Individuals with Factitious Disorders falsify medical and/or psychological impairment in themselves and/or others. They present with unexpected and/or unexplained symptoms. The diagnosis requires demonstrating that the individual is taking surreptitious actions to cause or simulate illness in the absence of obvious external rewards. Methods of illness falsification can include exaggeration, fabrication, simulation and/or induction. While a preexisting medical condition may be present, the deceptive behavior associated with this disorder causes others to view such individuals (and/or their proxy) as more ill or impaired than they are and can lead to excessive clinical intervention.

When an individual falsifies illness in another (children, adults, or pets), the diagnosis is ‘factitious disorder imposed on another.’ The perpetrator, not the victim, is given the diagnosis of factitious disorder imposed on another. The victim may be given a V code abuse diagnosis.

Malingering is differentiated from factitious disorder in that there is intentional reporting of symptoms for obvious external awards (e.g. money, time off from work, etc).

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

1. A pattern of falsification of physical or psychological signs or symptoms, or of induction of injury or disease, associated with identified deception.
2. A pattern of presenting oneself to others as ill or impaired.
3. The behavior is evident in the absence of obvious external rewards.
4. The behavior is not better accounted for by another mental disorder such as delusional belief system or acute psychosis.

**VI B. Factitious Disorder imposed on another (previously, factitious disorder by proxy) (#300.X)** To make this diagnosis, all 4 criteria must be met. Note that the perpetrator, not the victim, receives this diagnosis.

1. A pattern of falsification of physical or psychological signs or symptoms or of induction of injury or disease in another, associated with identified deception.
2. A pattern of presenting another (victim) to others as ill or impaired.
3. The behavior is evident in the absence of obvious external rewards.
4. The behavior is not better accounted for by another mental disorder such as delusional belief system or acute psychosis.

## **VII. Pseudocyesis**

The patient has a false belief of being pregnant that is associated with objective signs of pregnancy, which may include abdominal enlargement, reduced menstrual flow, amenorrhea, subjective sensation of fetal movement, nausea, breast engorgement and secretions, and labor pains at the expected date of delivery. While endocrine changes may be present, the syndrome cannot be explained by a general medical condition that causes endocrine changes (e.g., a hormone-secreting tumor).

## **Body dysmorphic disorder**

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