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Editorial

The proposed diagnosis of somatic symptom disorders in *DSM-V* to replace somatoform disorders in *DSM-IV*—a preliminary report

Introduction

This editorial is being written to update colleagues on *DSM-V* discussions concerning proposed changes to the *DSM-IV* chapter "Somatoform Disorders." One suggestion is to rename the chapter "Somatic Symptom Disorders." The change of title is mirrored by a proposal to substantially recast the constituent diagnoses.

An overview of the *DSM-V* process has been published elsewhere [1,2]. An important aspect of this process is the collaboration between the American Psychiatric Association (APA) and the US National Institute of Mental Health (NIMH) to expand the scientific basis for psychiatric classification and diagnosis [1]. This multiyear effort at refining psychiatric diagnoses embraces both the basic sciences relevant to the etiology of psychiatric disorders and the public health implications of the classification including issues relating to gender, culture, life span, and the psychiatric/general medical interface. There is also a strong move to develop dimensional approaches to diagnosis as well as categorical ones [3].

The APA wishes to disseminate widely the information and research recommendations generated by the *DSM-V* workgroups in order to work toward a unified international system for classification of mental disorders. This requires feedback from a wide spectrum of clinicians and researchers on the deliberations of the workgroups, and feedback is invited on the APA website.[1] The workgroup would be grateful for comments on this provisional document, which should be considered a work in progress. Given that the *International Classification of Disease* (*ICD-10*) is also in the process of revision, feedback from colleagues around the world is desired. To this end, we present here a summary of how the Somatic Symptom Disorders workgroup and its various advisors are considering these issues.

Concerns about *DSM-IV* somatoform disorders

The particular issues facing the Somatic Symptom Disorders workgroup have been presented previously [4]. There has been widespread criticism of some aspects of the "Somatoform Disorders" chapter in *DSM-IV*, expressed both at the APA/NIMH special conference [5] and elsewhere [6-8]. Some of the main criticisms concern the terms used in the "Somatoform" chapter of *DSM-IV*, which have been described as unacceptable to patients and incomprehensible to primary care doctors who see the bulk of patients described by these disorders [5].

A major difficulty with the *DSM-IV* somatoform disorders classification has been the reliance on "medically unexplained" symptoms. Use of this term perpetuates mind–body dualism and means that many disorders have been defined by negative rather than positive criteria; in addition, doctors often disagree about whether a particular symptom is medically unexplained or not. It is thought that this may underlie the limited specificity of the somatoform disorders [9]. There have been calls for positive diagnosis based on the psychological and behavioral characteristics of the disorders [9,10].

It is not clear that the component disorders, such as hypochondriasis and somatization disorder, are truly distinct disorders. There is, for example, considerable overlap of somatization disorder and hypochondriasis in some studies [11]. Future research may be hindered rather than helped by having several apparently distinct disorders when their independence is, in fact, uncertain.

There has been confusion about the role of concurrent depression and anxiety disorders, and some authors have advocated diagnosing some patients with multiple somatic complaints under the mood disorder chapter rather than in this section of *DSM-V*. Although there is a close association between the presence of multiple bodily symptoms and anxiety and depression, only about half of primary care patients with high somatization scores also have high anxiety or depression scores [12]; the same is true in patients with functional somatic syndromes [13]. It has also been observed that treatment of multiple somatic symptoms may be

[1] APA members can feedback comments to APA *DSM-5* website; others may e-mail LJawdat@psych.org.

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successful even without change in depression or anxiety [14]. Thus, allowing diagnoses under both chapters of *DSM-V* (somatic symptom disorder and mood or anxiety disorder) may be more realistic in the current state of knowledge rather than asking clinicians to choose between them. In other words, there may be considerable utility in moving away from hierarchical rules regarding diagnoses.

In the proposed new classification for *DSM-V*, it is hoped that many of these problems will be overcome and that the new diagnoses will be more useful and will reflect better the frequency with which these disorders are seen in clinical practice.

Overview of somatic symptom disorders

In the present draft, the *DSM-V* workgroup have described these disorders as a group of disorders that is characterized predominantly by somatic symptoms resulting in significant distress or dysfunction. These disorders typically present first in nonpsychiatric settings. Psychosocial factors may initiate, exacerbate, or maintain these symptoms. Somatic symptoms are multiply determined and are common in everyday life. These disorders may accompany diverse general medical as well as psychiatric diagnoses. When criteria are fulfilled, for example, for major affective disorder and for complex somatic symptom disorder, both diagnoses should be coded (i.e., there is no implicit hierarchy of diagnoses).

Within this section of *DSM-V*, the following disorders are listed:

I. Complex somatic symptom disorders (acute or chronic)
II. Factitious disorder (and factitious disorder by proxy)
III. Conversion disorder
IV. Somatic symptom NOS

I. Complex somatic symptom disorders

A. Chronic somatic symptom disorder

This diagnosis includes the previous diagnoses of somatization disorder (*DSM-IV* Code 300.81), undifferentiated somatoform disorder (*DSM-IV* Code 300.81), hypochondriasis (*DSM-IV* 300.7) and pain disorder (*DSM-IV* Code 307).

These disorders have been brought together under a single heading because their similarities outweigh their differences. If, as is proposed, they are diagnosed using positive cognitive and behavioral features, it becomes apparent that these disorders are overlapping with differing dimensions such as number of somatic symptoms, health anxiety, and duration of disorder, among others. It should be remembered that patients diagnosed in this category may also be scored on the dimensions representing anxiety or depression.

The proposed classification identifies somatic symptoms as one aspect of complex somatic symptoms disorder; another aspect concerns misattributions, excessive concern or preoccupation with symptoms and illness. The third aspect is increased health care use.

Somatic symptoms. The hallmark of this disorder is the patient's difficulty in tolerating physical discomfort and in coping adaptively with bodily symptoms. Patients with this diagnosis typically have multiple, current, somatic symptoms that are severe, intense, and bothersome, but some may have a single severe symptom. Such symptoms may be specific (e.g., localized pain) or nonspecific. Although any one symptom may not be continuously present, the state of being symptomatic is chronic and persistent (provisionally greater than 6 months). The symptoms sometimes represent normal bodily sensations (e.g., orthostatic dizziness), and discomfort that does not generally signify serious disease (e.g., bad taste in one's mouth) or are incompatible with known pathophysiology. Such patients often manifest a poorer health-related quality of life than patients with other serious medical disorders.

In addition to somatic symptoms, diagnosis of the disorder requires a high level of at least one of the following.

Misattributions, excessive concern or preoccupation with symptoms and illness. This aspect focuses on patients who believe in the medical seriousness of benign symptoms despite evidence to the contrary and who are unable to accept the absence of a serious medical explanation for these symptoms. These patients may have high levels of health-related anxiety, with a low threshold for alarm about the presence of illness, and a tendency to assume the worst about their health. Health concerns are diffuse and may assume a central role in their lives, becoming a feature of their identity, a way of responding to stressful events, a topic of interpersonal communication, or a basis for interpersonal relationships.

Increased pattern of health care utilization. As a consequence of the symptoms and beliefs, there is a high level of medical care utilization, which rarely alleviates concerns. In severe cases, patients do not feel their physicians try hard enough to diagnose their ailments. From the physician's point of view, these patients seem unresponsive to therapies, and new interventions or therapies tend to exacerbate the presenting symptoms or lead to new side effects and complications.

B. Acute somatic symptom disorder

This disorder is similar to the chronic form but is characterized by transient severe symptoms that last <6 months.

II. Factitious disorder

Factitious disorders entail long-term, persistent problems related to illness perception and identity. They can be

associated with unexpected and/or unexplained symptoms. Individuals with factitious disorders falsify medical and/or psychological impairment in themselves and/or others. While an underlying 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.

Those with factitious disorder by proxy have been known to falsify illness in children of any age, adults, and pets. The victim (or proxy) is not given the diagnosis of factitious disorder by proxy but would have a V code designation to indicate the abuse and may have other related psychopathology (such as posttraumatic stress disorder).

Malingering, defined as intentional reporting of symptoms for personal gain (money, time off work, etc) is not a psychiatric disorder.

A. Factitious disorder

A pattern of falsification of physical or psychological signs or symptoms, associated with identified deception.

1. A pattern of presentation to others as ill or impaired.
2. The behavior is evident even in the absence of obvious external rewards.
3. The behavior is not due to a delusional belief system or acute psychosis.
4. The behavior is not better accounted for by another mental disorder.

B. Factitious disorder by proxy

A pattern of falsification of physical or psychological signs or symptoms in another, associated with identified deception.

1. A pattern of presentation of the other (victim) to others as ill or impaired.
2. The behavior is evident even in the absence of obvious external rewards.
3. The behavior is not due to a delusional belief system or acute psychosis.
4. The behavior is not better accounted for by another mental disorder.

III. Functional neurologic symptoms/conversion disorder

This disorder is still under discussion.

IV. Somatic disorder, NOS

Body dysmorphic disorder will probably move to anxiety/dissociative/obsessive compulsive disorder group.

Psychological factor affecting general medical condition

Some authors have recommended wider use of this category as it is a diagnosis that encompasses the interface between psychiatric and general medical disorders [6]. It has also been stated that this diagnosis has been underused because of the dichotomy, inherent in the "Somatoform" section of *DSM-IV*, between disorders based on medically unexplained symptoms and patients with organic disease; in the latter, the concepts of somatization, hypochondriasis, etc, were not seen as relevant [15]. By doing away with the controversial concept of "medically unexplained," the proposed classification may diminish this problem. The conceptual framework that we propose will allow a diagnosis of somatic symptom disorder in addition to a general medical condition, whether the latter is a well-recognized organic disease or a functional somatic syndrome such as irritable bowel syndrome or chronic fatigue syndrome.

In fact, the diagnosis of "psychological factors affecting a general medical condition" includes a variety of different subtypes. The first includes a specific psychiatric disorder which affects a general medical condition. Other subtypes include psychological distress in the wake of a general medical condition and personality traits or poor coping that contribute to worsening of a medical condition. These presentations might well be considered in the rubric *adjustment disorders*. The location of this type of adjustment disorder has yet to be settled within the draft of *DSM-V*. The text (and placement) for these different variants of the interface between psychiatric and general medical disorders is still under active review.

Conclusion

The current structure of the somatic symptoms disorder disorders proposed for *DSM-V* differs considerably from that of the somatoform disorders in *DSM-IV*. This article gives an indication of a likely new structure, but much remains to be done before this is finalized. The next steps include a series of field trials of the new diagnoses, defining the criteria for disorders, and the relevant dimensions which may be used and close coordination with other chapters of *DSM-V*. One aspect of field trials is formal and informal feedback from users of *DSM* or *ICD* classifications. It is hoped that this editorial, although reflecting "work in progress," will stimulate discussion and feedback that can be constructively fed into the workgroup.

Joel Dimsdale
University of California, San Diego
La Jolla, CA, USA
E-mail address: jdimsdale@ucsd.edu

Francis Creed
Psychiatry Research Group
School of Medicine
University of Manchester

Rawnsley Building, Oxford Road
M13 9WL Manchester, UK
E-mail address: francis.creed@manchester.ac.uk

on behalf of the *DSM-V* Workgroup on Somatic Symptom Disorders[2]

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[2] Members of the Somatic Symptom Disorders workgroup for *DSM-V*. Joel Dimsdale (Chair), Arthur J. Barsky, Francis Creed, Nancy Frasure-Smith, Michael R. Irwin, Frank Keefe, Sing Lee, James L. Levenson, Michael Sharpe, Lawson R. Wulsin, Javier Escobar.