

# Somatic symptoms – An update according DSM-5

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## ABSTRACT

Somatization represents the appearance of unexplained symptoms or other unintentionally produced complaints which are frequently related to nervous system, so that neurologists are often the first step where patients come for diagnosis. After exclusion of organic pathology and lack of results of symptomatic treatments, patients are sometimes related to a psychiatrist, even though this should happen more often, but fear of attending a psychiatrist is one of the greatest prejudices of the Romanian society today.

We're reviewing the Classification of Somatic Symptoms and Related Disorders according to Diagnosis and Statistical Manual (DSM-5) of Mental Disorders; this is a new category in the classification, as this kind of pathology is a frequent one, in direct relation with anxiety and mood disorders, and incidence of this kind of troubles is increasing constantly, with immense associated health care costs and a high burden of disease, as up to 33.7% of the population is affected by an anxiety disorder during their lifetime (1) and this percent is constantly rising.

**Keywords:** Somatic symptoms, anxiety, depression, medical care, burden

**Somatic Symptom and Related Disorders** is a new chapter in DSM-5, which replaces the ancient DSM-IV term of **Somatoform Disorders**, in which there was a great deal of overlap across these disorders and a lack of clarity to define the diagnosis, as very often patients with this kind of pathology primarily present in medical rather than mental health settings and non-psychiatric physicians have a great burden to manage this type of patients, consumers of time and resources (2). The goal of this change was to avoid problematic overlap of categories for this kind of psychiatric conditions with excessive medical symptoms that lack an underlying medical disease.

Almost always this kind of patients attend neurology clinic care and lead to a significant economic burden to the costs of brain disorders, as prevalence of this category in general population is estimated between 5% and 7% (2), and this is one of the most common categories of patient concerns in clinical practice (3). It is estimated that up to 25% of these patients

will develop a chronic somatic illness during lifetime (4), the estimated female to male ratio being 10:1(5).The costs of this kind of patients overwhelm health systems with inappropriate costs, as they have twice the annual medical care expenses and use twice as much outpatient and inpatient services as controls (6). Patients often seek multiple consultations in various doctors, they are dissatisfied with their medical care and have difficulties to accept that psychological factors are the underlying problem and only a correct psychiatric treatment will improve their health (7), as stigma is one of the greatest burden in psychiatry, even among doctors.

The patho-physiology of somatic symptom disorder is unknown but modern evidence suggests that this kind of pathology can be explained by the bio-psycho-social model of mental illness, with a multi-factorial etiology (8); genetic and biological factors in association with modulation of symptoms by mood disorders which are constantly increasing and reactions of siblings, friends and nearby per-

sons can lead to crystallize somatic symptoms, persistent, difficult to manage with the usual symptomatic therapies, as long as the organic pathology doesn't confirm, causing the patient to be frustrated, always looking for a doctor who understands his disorder. Some other factors can play a role in the appearance of this disorder, like: negativity personality traits, problems in how the patient is managing symptoms and learned behaviors like seeking attention or benefits gained from being ill, or other "pain behaviors" in response to symptoms, with avoidance of activity and increased disability (9).

Patients seek help in all specialties, except psychiatry, which is the only field able to really help them cope with the disorder. As neurologists we often come in contact with this kind of patients, especially in emergency room, where they can often come accusing back pain, headaches, dizziness, fainting or even visual loss (10), and as a rule, everything on a background marked by anxiety and irritability.

As stated before, mood disorders are constantly increasing: the proportion of the global population with depression in 2015 was estimated to be 4.4%, with an increased percent of 18.4% between 2005 and 2015 and the same proportion for anxiety disorders in 2015 was estimated to be of 3.6%, reflecting an increase of 14.9% during the same decade (11). Many people experience both conditions (comorbidity), and the range of severity showed that at least one-third of the cases have a moderate-severe course (12), generating a considerable burden not only for patients but also for siblings and medical health systems.

Other risk factors that can favor the disorder are: a medical condition or recovering from one, a strong family history of a disease, previous or present traumatic experiences, violence or other stressful events, and also a lower level of education and socio-economic status.

According to the American Psychiatric Association that worked out the Diagnostic and Statistical Manual of Mental Disorders. 5th ed. in 2013:

#### **DSM-5 Diagnostic Criteria for Somatic Symptom Disorder are (2):**

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

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

- a) Disproportionate and persistent thoughts about the seriousness of one's symptoms.
- b) Persistently high level of anxiety about health or symptoms.
- c) Excessive time and energy devoted to these symptoms or health concerns.

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

We have to:

• Specify if:

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

• Specify if:

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

• Specify current severity:

- c) Mild: Only one of the symptoms specified in Criterion B is fulfilled.
- d) Moderate: Two or more of the symptoms specified in Criterion B are fulfilled.
- e) Severe: Two or more of the symptoms specified in Criterion B are fulfilled, plus there are multiple somatic complaints (or one very severe somatic symptom).

Patients previously, by DSM-IV, diagnosed with somatization disorder or undifferentiated somatoform disorder are now merged in Somatic Symptom disorder, only if in addition to their somatic symptoms they experience thoughts, feelings or behaviors that are not appropriate and define the disorder. These types of feelings and behaviors can include:

- 1. worries about potential diseases and their severity
- 2. any minor symptom is considered a sign of serious illness
- 3. intrusive thoughts about seriousness of symptoms even when there is no evidence

4. considering that the condition is far more serious than would be expected from a certain physical problem
5. repeated consultations that are considered ineffective and aggravating feelings of physical harm
6. the ineffectiveness of medication, with the rapid occurrence of the side effects mentioned in the package leaflets

All these these behaviors can have a major impact on the patient's life, mainly the way they are interpreted and how the reaction to the symptoms is made.

Other related disorders from this spectrum are:

- A. Illness anxiety disorder: previously called in DSM-IV as hypochondriasis; these patients experience high levels of health anxiety without somatic symptoms; the main differential diagnosis in this case is a primary anxiety disorder such as generalized anxiety disorder, characterized by excessive worries and anxiety regarding events or activities, such as school or work, for at least 6 months, causing social, occupational and other functioning impairment (2); for example, this nosological entity is estimated in U.S to affect 5.7% of adults at some time in their lives (13).
- B. Psychological factors affecting other medical conditions: This is a new mental disorder in DSM-5: previously listed in DSM-IV as "other conditions that may be a focus of clinical attention".
- C. Factitious disorder: In these cases, the principal aim of patients is to assume the sick role by falsification of medical or psychological signs and symptoms, or induction of injury/disease, associated with an identified deception, of course in the absence of other mental illness as delusional or psychotic disorders (2).
- D. Conversion disorder (functional neurological symptom disorder): Neurological examination is essential, as these patients may have various neurological symptoms as: motor (weakness, paralysis, abnormal movements or postures, tremor, gait disturbance), sensory (altered, reduced or absent skin sensation, vision, hearing), abnormal

limb movements mimicking epileptic seizures, or episodes of unresponsiveness resembling to syncope or coma, speech disturbances (impossibility to speak, absent speech volume, altered articulation or sensation of knot in the throat) (2), and the main differential diagnosis is a neurological disease that might explain symptoms, but we must not forget that conversion disorder may coexist with an organic pathology.

- E. Other specified somatic symptom and related disorder (2): Brief somatic symptom disorder: duration less than 6 months; Brief illness anxiety disorder: duration less than 6 months; Illness anxiety disorder without excessive health related behaviors; Pseudocyesis: a false belief of being pregnant

## MANAGEMENT

The medical approach of somatic symptom disorders requires a multifaceted management tailored to the individual patient. To choose the correct treatment plan, primary care clinicians should keep in mind psychological, social, and cultural factors that influence somatic symptoms (10).

A strong, positive relationship between the physician and the patient is essential and should be coupled with frequent, supportive visits, while avoiding the temptation to medicate or test when these interventions are not clearly indicated (10). A good therapeutic alliance can make the difference in the management of these patients, but first of all they must be convinced that all organic pathology is excluded and somatic symptoms are the result of the bio-psycho-social interactions in persons with multi-factorial vulnerability, in whom doctors must do all efforts to increase the insight, focusing on functioning and methods of coping, so that somatic symptoms will decrease in intensity and patients' quality of life will increase.

## CONCLUSIONS

These patients may require excessive and unnecessary evaluation, as well as ineffective treatments, with a great burden of costs and

dissatisfaction, so increasing adherence to the psychiatric network is an essential goal because methods of cognitive behavioral psychotherapy, sometimes in association with medication as selective serotonin reuptake inhibitors, can bring real benefits to these patients (14), and in the

same time by lowering medical costs and reducing the burn-out for other physicians except psychiatrists, who came into relation with this category of cases, it can be improved the overall satisfaction in health systems.

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## REFERENCES

1. **Borwin Bandelow, Sophie Michaelis.** Epidemiology of anxiety disorders in the 21st century; *Dialogues Clin Neurosci.* 2015 Sep; 17(3): 327–335.
2. American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders-Fifth Edition; Somatic Symptom and Related Disorders: 309-327
3. **Hatcher S., Arroll B.** Assessment and management of medically unexplained symptoms. *BMJ.* 2008; 336(7653):1124–1128.
4. **Croicu C., Chwastiak L., Katon W.** Approach to the patient with multiple somatic symptoms. *Med Clin North Am.* 2014; 98(5):1079–1095
5. **Yates W.R., Dunayevich E.** Somatic symptom disorders. <http://emedicine.medscape.com/article/294908-overview>. Accessed August 5, 2014.
6. **Barsky A.J., Orav E.J., Bates D.W.** Somatization increases medical utilization and costs independent of psychiatric and medical comorbidity. *Arch Gen Psychiatry* 2005; 62:903–910 Crossref
7. **Wesley Davison, Jessica Simberlund.** Somatic Symptom Disorder: Costly, Stressful for Patients and Providers, and Potentially Lethal, August 1, 2016, American Journal of Psychiatry Residents' Journal August 2016, Vol. 11, No. 8, pp. 9 – 11; Published online: April 12, 2017/ <https://doi.org/10.1176/appi.ajp-rj.2016.110805>
8. **Richard Mayou, M. Phil, Laurence J. Kirmayer, Greg Simon, Kurt Kroenke, Michael Sharpe.** Somatoform Disorders: Time for a New Approach in DSM-V; *he American Journal of Psychiatry* Volume 162, Issue 5, May 2005, pp. 847-855; Published online: May 01, 2005 | <https://doi.org/10.1176/appi.ajp.162.5.847>
9. <https://www.mayoclinic.org/diseases-conditions/somatic-symptom-disorder/symptoms-causes/syc-20377776>
10. **Stuart L. Kurlansik, Mario S. Maffei.** Somatic Symptom Disorder *Am Fam Physician.* 2016 Jan 1; 93(1):49-54A.
11. GBD 2015 Disease and Injury Incidence and Prevalence Collaborators, and others.
12. Global, regional, and national incidence, prevalence, and years lived with disability for 310 diseases and injuries, 1990–2015: a systematic analysis for the Global Burden of Disease Study 2015. *The Lancet*, 388: 10053.
13. **Ferrari A.J., Charlson F.J., Norman R.E., Patten S.B., Freedman G., Murray C.J., Vos T., Whiteford H.A.** Burden of depressive disorders by country, sex, age, and year: findings from the global burden of disease study 2010. *PLoS Medicine* 2013; 10: e10015 47.
14. Harvard Medical School, 2007. National Comorbidity Survey (NCS). (2017, August 21). Retrieved from <https://www.hcp.med.harvard.edu/ncs/index.php>. Data Table 1: Lifetime prevalence DSM-IV/WMH-CIDI disorders by sex and cohort.\
15. **Kroenke K.** Efficacy of treatment for somatoform disorders: a review of randomized controlled trials. *Psychosom Med* 2007; 69:881–888 Crossref