Somatoform Disorders

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Definition of the Disorder

Somatoform disorders, also known as somatic symptom disorders, include hypochondriasis. Some significant changes to the terminology have been introduced in ICD-10 and DSM 5. In ICD-11 somatoform disorders are now classed under the term *bodily distress disorder*, which is characterized by the presence of bodily symptoms that are distressing to the individual and excessive attention directed toward the symptoms, which may be manifested by repeated contact with health care providers. All somatoform disorders are characterized by repeated presentations of physical symptoms together with requests for medical investigations, despite repeated negative findings and reassurances by a clinician that the symptoms have no physical basis. Somatization disorder in ICD-10 is defined as presenting with multiple, recurrent and frequently changing physical symptoms of at least 2 years' duration. These are often associated with many fruitless investigations with negative results by a variety of clinicians. Hypochondriasis is classed in ICD-11 under obsessive-compulsive and related disorders. In DSM 5 it has been renamed *illness anxiety disorder* and is characterized by 6 or more months of a general and non-delusional preoccupation with fears of having, or the idea that one has, a serious disease based on the person's misinterpretation of bodily symptoms. This preoccupation causes significant distress and impairment in one's life; it is not accounted for by another psychiatric or medical disorder, and a subset of individuals with somatic symptom disorder has poor insight about the presence of this disorder.

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Aetiology and Classification

There are various subtypes of somatisation disorders described in the two main diagnostic systems. There are minor differences between ICD-10 and DSM 5. The latest edition of DSM 5 has moved away from the need to have no medical explanation in order to make the diagnosis of *medically unexplained symptoms* and gain access to appropriate treatment. The emphasis now is on symptoms that are substantially more severe than expected in association with distress and impairment. The diagnosis includes conditions with no medical explanation and conditions where there is some underlying pathology, but an exaggerated response.

The major diagnosis in this diagnostic class, Somatic Symptom Disorder (Table 11.1), emphasizes diagnosis made on the basis of positive symptoms and signs (distressing somatic symptoms plus abnormal thoughts, feelings and behaviours in response to these symptoms) rather than the absence of a medical explanation for somatic symptoms. A distinctive characteristic of many individuals with somatic symptom disorders is not the somatic symptoms per se, but instead the way they present and interpret them.

A new category has therefore been created in DSM 5 under the heading *Somatic Symptom and Related Disorders*. This includes diagnoses of Somatic Symptom Disorder, Illness Anxiety Disorder (Table 11.2), Conversion Disorder, Factitious Disorder and a variety of other related conditions. The last three are not classed under somatoform disorders in ICD-10 or ICD-11 (Table 11.3).

Practice Point
The term Hypochondriasis is no longer included in DSM 5. In ICD-11 it is classed under obsessive-compulsive or related disorders.

The aetiology of somatization disorder is unknown, but it is most likely multifactorial including biological, physiological, psychological, social, cultural and iatrogenic factors. The importance and relevance of these factors can be different at

Table 11.1 DSM-5 criteria to make a diagnosis of Somatic Symptom Disorder

DSM-5 Somatic Symptom Disorder criteria
A. One or more somatic symptoms that are distressing or result in significant disruption of daily life.
B. Excessive thoughts, feelings or behaviours 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).

Table 11.2 DSM-5 criteria to make a diagnosis of Illness Anxiety Disorder

DSM-5 Illness Anxiety Disorder Criteria
A. Preoccupation with having or acquiring a serious illness.
B. Somatic symptoms are not present or if present, are only mild in intensity. If another medical condition is present or there is a high risk for developing a medical condition (e.g. strong family history is present), the preoccupation is clearly excessive or disproportionate.
C. There is a high level of anxiety about health, and the individual is easily alarmed about personal health status.
D. The individual performs excessive health-related behaviours (e.g. repeatedly checks his or her body for signs of illness) or exhibits maladaptive avoidance (e.g. avoids doctor appointments and hospitals).
E. Illness preoccupation has been present for at least 6 months, but the specific illness that is feared may change over that period of time.
F. The illness-related preoccupation is not better explained by another mental disorder, such as *somatic symptom disorder, panic disorder, generalized anxiety disorder, body dysmorphic disorder, obsessive-compulsive disorder or delusional disorder, somatic type*.

Table 11.3 Diagnostic principles in ICD and DSM

ICD 10	ICD 11	DSM 5
Somatoform disorders	Bodily distress disorder BDO Obsessive-Compulsive Disorder (OCD) or related disorders	Somatic Symptom disorder
Somatoform disorders • Hypochondriacal disorder (including Body Dysmorphic Disorder) • Somatoform autonomic dysfunction • Persistent somatoform pain disorder	Bodily distress disorder • BDO (mild to severe) • Body integrity dysmorphia Obsessive-compulsive disorder or related • OCD • Body dysmorphic disorder • Olfactory reference disorder • Hypochondriasis • Hoarding disorder • Body-focused repetitive behaviour disorders	Somatic Symptom and related disorders • Somatic Symptom disorder • Illness Anxiety disorder • Conversion disorder • Factitious disorder • Psychological factors affecting other medical conditions

different times in the natural course of the illness. For instance, it may be a psychological trauma that precipitates the illness, but iatrogenic factors that maintain the illness.

Prevalence and Age of Onset

The expected prevalence of Somatic Symptom Disorder stated in DSM 5 is higher than that for Somatization Disorder (<1%) but lower than that of Undifferentiated Somatoform Disorder (19%). Both are more common in women.

Somatic symptom disorder usually has an onset before age 30, whereas illness anxiety disorder has a less specific age of onset.

Clinical Features and Presentation

Patients with somatic symptom disorder believe that they have a serious disease that has not yet been detected and they cannot be persuaded to the contrary. Their convictions persist despite negative laboratory results, the benign course of the alleged disease over time, and appropriate reassurances from physicians. Yet, their beliefs are not sufficiently fixed to be delusions.

Practice Point
Somatic symptom disorder is often accompanied by symptoms of depression and anxiety and commonly coexists with a depressive or anxiety disorder.

Patients with illness anxiety disorder (hypochondriasis), like those with somatic symptom disorder, believe that they have a serious disease that has not yet been diagnosed, and they cannot be persuaded to the contrary. Their convictions also persist despite negative laboratory results, the benign course of the alleged disease over time, and appropriate reassurances from physicians. Their preoccupation with illness interferes with their interaction with family, friends and co-workers. They are often addicted to Internet searches about their feared illness, inferring the worst from information (or misinformation) they find there. The feared illness is usually fairly static over time in contrast to the varying aspect of symptoms in somatization (body distress disorder).

Practice Point
Patients with somatic symptom disorder and illness anxiety disorder may maintain a belief that they have a particular disease or, as time progresses, they may transfer their belief to another disease. Illness anxiety disorder shows much less fluctuation in the feared disease.

Deferential Diagnosis and Comorbidity

Somatic symptom disorder must be differentiated from non-psychiatric medical conditions, especially disorders that show symptoms that are not necessarily easily diagnosed (Table 11.4).

Somatic symptom disorder is differentiated from illness anxiety disorder by the emphasis in illness anxiety disorder on fear of having a disease rather than a concern about many symptoms. Patients with illness anxiety disorder usually complain

Table 11.4 Differential diagnosis

Psychiatric	Non-psychiatric medical conditions
• Body dysmorphic disorder • Conversion disorder • Delusional disorder, somatic type • Depression • Dissociative disorders • Dysthymic disorder • Factitious disorder • Generalized anxiety disorder • Malingering • Obsessive-compulsive disorder • Panic disorder • Schizophrenia	• Acquired immunodeficiency syndrome (AIDS) • Degenerative diseases of the nervous system • Endocrinopathies • Multiple sclerosis • Myasthenia gravis • Occult neoplastic disorders • Systemic lupus erythematosus

about fewer symptoms than patients with somatic symptom disorder; they are primarily concerned about being sick.

Practice Point
Illness anxiety disorder must be differentiated from other medical conditions. Too often these patients are dismissed as 'chronic complainers' and careful medical examinations are not performed.

Somatic symptom disorder can also occur in patients with depressive disorders and anxiety disorders. Patients with panic disorder may initially complain that they are affected by a disease (e.g. heart trouble), but careful questioning during the medical history usually uncovers the classic symptoms of a panic attack. Delusional disorder beliefs occur in schizophrenia and other psychotic disorders, but can be differentiated from somatic symptom disorder by their delusional intensity and by the presence of other psychotic symptoms. In addition, schizophrenic patients' somatic delusions tend to be bizarre, idiosyncratic and out of keeping with their cultural milieu.

Practice Point
Patients with body dysmorphic disorder wish to appear normal, but believe that others notice that they are not, whereas those with somatic symptom disorder seek out attention for their presumed diseases.

Practice Point
Illness anxiety disorder can be differentiated from obsessive-compulsive disorder by the singularity of their beliefs and by the absence of compulsive behavioural traits; but there is often an obsessive quality to the patients' fear.

Table 11.5 The primary role of the non-psychiatric specialist is to

- Exclude physical disease and trauma that can be treated medically.
- Make it clear to the patient that he/she does not have the physical disease he/she fears and that there is no indication for any other medical attention.
- There is no medical indication for further diagnostic tests or examinations.
- Coordinate the management with the primary care physician and other doctors that the patient may be in contact with.
- Consider a referral to a psychiatrist for examination or treatment.

Assessment and Treatment

Patients with somatic symptom disorder usually resist psychiatric treatment, although some accept this treatment if it takes place in a medical setting and focuses on stress reduction and education in coping with chronic illness (Table 11.5).

Psychotherapy is an established treatment modality, but it meets with specific challenges in the initial phases, when patients very often find it difficult to accept that a "talking cure" might help with their primarily bodily symptoms and concerns.

Group psychotherapy often benefits such patients, in part because it provides social support and social interaction that seem to reduce their anxiety. Other forms of psychotherapy, such as individual insight-oriented psychotherapy, behaviour therapy, cognitive therapy and hypnosis, may be useful.

Consider treatment with medication; primarily antidepressants. However, an antidepressant with the fewest interactions should be chosen as polypharmacy is common in these patients.