Somatic Symptom Disorder (DSM-V)

Prof. Dóra Perczel-Forintos
Semmelweis University
Dep. of Clinical Psychology
Psychiatry – 5th year

Somatoform Disorders (DSM-IV)

1. SOMATIZATION DISORDER
2. CONVERSION DISORDER
3. HYPOCHONDRIASIS
4. PAIN DISORDER
5. BODY DYSMORPHIC DISORDER

Somatic Symptom Disorder (SSD) DSM – V.

- Replaces somatoform disorders with somatic symptom and related disorders
- significant changes to the criteria to eliminate overlap across somatoform disorders
- clarify their boundaries
- better reflection of the complex interface between mental and physical health.

Characteristics of Somatic Symptom Disorder

- SSD is characterized by somatic symptoms that are

- either very distressing or

result in significant disruption of functioning, as well as excessive and disproportionate thoughts, feelings and behaviours regarding those symptoms.

- To be diagnosed with SSD, the individual must be persistently symptomatic (min. 6 months).

Key changes in the DSM-5

- somatic symptoms must be significantly distressing or disruptive to daily life and must be accompanied by excessive thoughts, feelings, or behaviors
- SSD dignosis does not require that the somatic symptoms are medically unexplained;
- it is not appropriate to diagnose individuals with a mental disorder solely because a medical cause cannot be demonstrated;

Clarify confusing terms in SSD

- primarily seen in general medical practice
- clarify confusing terms
- reduce the number of disorders and sub-categories
- to make the criteria more useful to non-psychiatric care providers.

Unexplained symptoms versus disproportionate thoughts, feelings and behaviors

- Comprehensive assessment of patients requires the recognition that psychiatric problems often co-occur in patients with medical problems.
- SSD notes that some patients with physical conditions such as heart disease or cancer will indeed experience disproportionate and excessive thoughts, feelings, and behaviors related to their illness: they may qualify for a diagnosis of SSD.
- 30–80% of patients attending primary care show medically unexplained symptoms
- 5–7% of population suffer from somatization disorder

Somatic Symptom Disorder

Diagnostic Criteria — 300.82 (F45.1)

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:

   1. Disproportionate and persistent thoughts about the seriousness of one's symptoms.
   2. Persistently high level of anxiety about health or symptoms.
   3. 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).

Specify if:

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

Specify if:

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

Specify current severity:

Mild: Only one of the symptoms specified in Criterion B is fulfilled.

Moderate: Two or more of the symptoms specified in Criterion B are fulfilled.

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).

Conversion Disorder (Functional Neurological Symptom Disorder)

Diagnostic Criteria

A. One or more symptoms of altered voluntary motor or sensory function.
B. Clinical findings provide evidence of incompatibility between the symptom and recognized neurological or medical conditions.
C. The symptom or deficit is not better explained by another medical or mental disorder.
D. The symptom or deficit causes clinically significant distress or impairment in social, occupational, or other important areas of functioning or warrants medical evaluation.

Coding note: The ICD-9-CM code for conversion disorder is **300.11,** which is assigned regardless of the symptom type. The ICD-10-CM code depends on the symptom type (see below).

Specify symptom type:

(F44.4) With weakness or paralysis
(F44.4) With abnormal movement (e.g., tremor, dystonic movement, myoclonus, gait disorder)
(F44.4) With swallowing symptoms
(F44.4) With speech symptom (e.g., dysphonia, slurred speech)
(F44.5) With attacks or seizures
(F44.6) With anesthesia or sensory loss
(F44.6) With special sensory symptom (e.g., visual, olfactory, or hearing disturbance)
(F44.7) With mixed symptoms

Conversion Disorder (Functional Neurological Symptom Disorder)

Specify if:

Acute episode: Symptoms present for less than 6 months.
Persistent: Symptoms occurring for 6 months or more.

Specify if:

With psychological stressor *(specify stressor)*
Without psychological stressor

Illness Anxiety Disorder

Diagnostic Criteria **300.7 (F45.21)**

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 behaviors (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.

Specify whether:

Care-seeking type: Medical care, including physician visits or undergoing tests and procedures, is frequently used.

Care-avoidant type: Medical care is rarely used.

TREATMENT

- Stress management
- Reduction of reinforcing or supporting consequences
- Group therapy
- Cognitive behaviour (CBT) therapy

PAIN DISORDERS
diagnostic criteria

1. Pain in one or more anatomical sites is the predominant focus of the clinical presentation and is of sufficient severity to warrant clinical attention.

2. The pain causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

DIAGNOSTIC CRITERIA

3. Psychological factors are judged to have an important role in the onset, severity, exacerbation or maintenance of the pain.

4. The symptom or deficit is not intentionally produced or feigned (as in factitious disorder or malingering).

5**.** The pain is not better accounted for by a mood, anxiety, or psychotic disorder and does not meet criteria for dyspareunia.

ACUTE: less 6 mo.; CHRONIC: 6 mo. or more

The bio-psycho-social model

(Engel, 1977)

Environmental processes

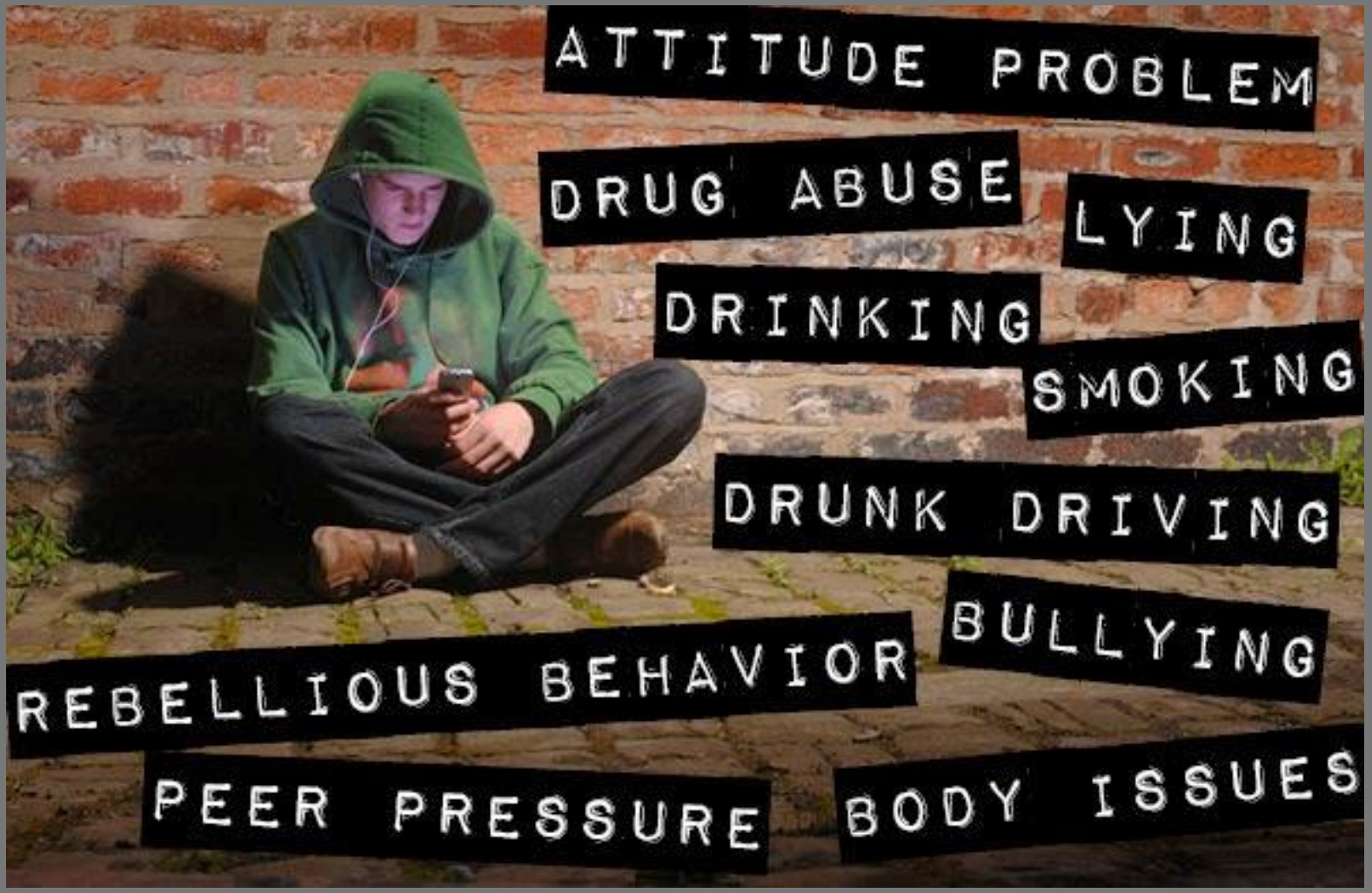
Genetic and biologocal processes

&

Mental/ cognitive processes

People can't tell to the doctor…

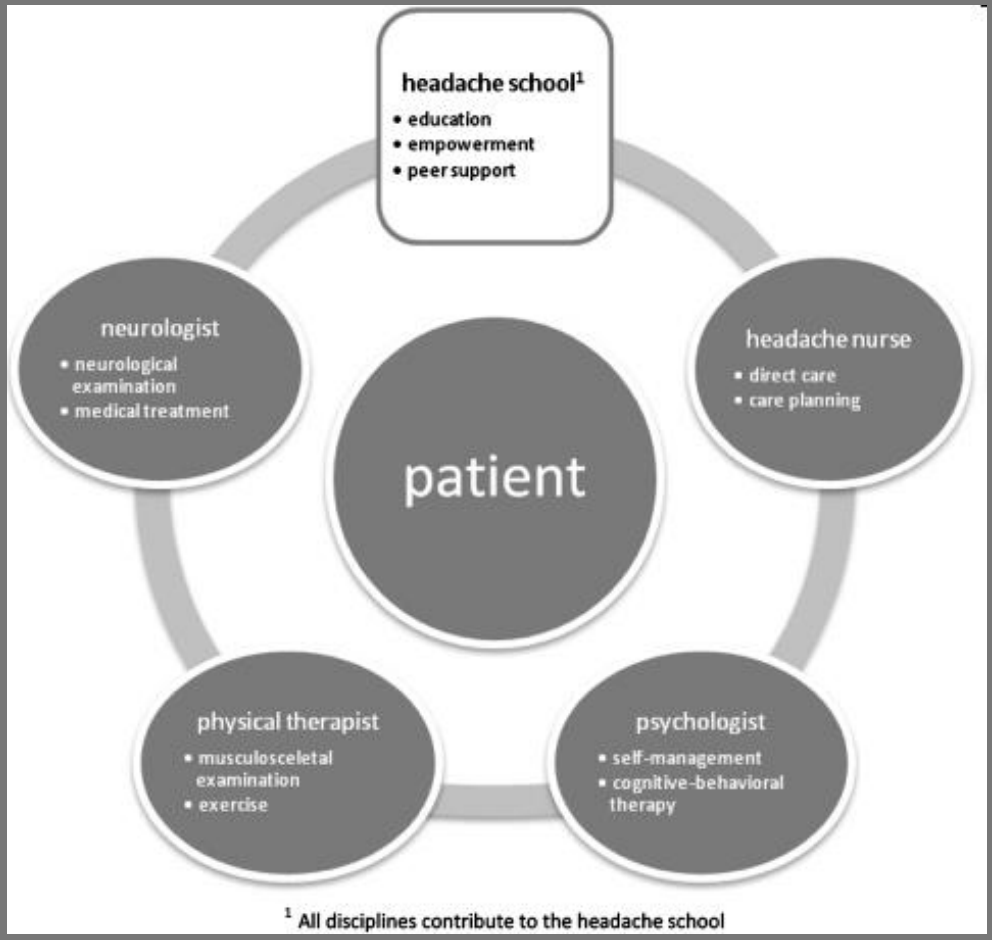
how painful that they do not like each other…


ATTITUDE PROBLEM
DRUG ABUSE
LYING
DRINKING
SMOKING
DRUNK DRIVING
BULLYING
REBELLIOUS BEHAVIOR
PEER PRESSURE
BODY ISSUES


LOOKING
FOR A FRIEND

Very difficult to assess if pain is primarily psychological or physical.

Important feature: pain is real whether psychological or physical.



PAIN DISORDER

TREATMENT

1. Multidisciplinary clinic
2. CBT
3. Hypnobehavior therapy
4. Pharmacotherapy
5. Biofeedback
6. Mindfulness training

Conversion Disorder (Functional Neurological Symptom Disorder)

Diagnostic Criteria

A. One or more symptoms of altered voluntary motor or sensory function.
B. Clinical findings provide evidence of incompatibility between the symptom and recognized neurological or medical conditions.
C. The symptom or deficit is not better explained by another medical or mental disorder.
D. The symptom or deficit causes clinically significant distress or impairment in social, occupational, or other important areas of functioning or warrants medical evaluation.

Coding note: The ICD-9-CM code for conversion disorder is **300.11,** which is assigned regardless of the symptom type. The ICD-10-CM code depends on the symptom type (see below).

Specify symptom type:

(F44.4) With weakness or paralysis
(F44.4) With abnormal movement (e.g., tremor, dystonic movement, myoclonus, gait disorder)
(F44.4) With swallowing symptoms
(F44.4) With speech symptom (e.g., dysphonia, slurred speech)
(F44.5) With attacks or seizures
(F44.6) With anesthesia or sensory loss
(F44.6) With special sensory symptom (e.g., visual, olfactory, or hearing disturbance)
(F44.7) With mixed symptoms

Conversion Disorder (Functional Neurological Symptom Disorder)

Specify if:

Acute episode: Symptoms present for less than 6 months.
Persistent: Symptoms occurring for 6 months or more.

Specify if:

With psychological stressor *(specify stressor)*
Without psychological stressor

PREVALENCE

- 1% - 30%;
  in adolescence and thereafter,
  primarily women, tough
  frequently seen in men during great stress

- higher incidence in less educated, lower socioeconomic groups where knowledge about disease and medical illness is not as well developed

- other family member's experience with illness (patients tend to „learn" symptoms).

CONVERSION DISORDER TREATMENT

- Attention to traumatic or stressful life events
- Reduction of any reinforcing or supportive consequences of the symptom
- Hypnosis/self-hypnosis
- Cognitive behaviour therapy

Illness Anxiety Disorder

Diagnostic Criteria — 300.7 (F45.21)

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 behaviors (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.

Specify whether:

Care-seeking type: Medical care, including physician visits or undergoing tests and procedures, is frequently used.

Care-avoidant type: Medical care is rarely used.

Reinforcing Factors

- a. Social environment
- Fear of having illness increases anxiety, which increases symptom perception (vicious cycle)
- Enhanced perceptual sensitivity to illness cues, causing them to interpret as dangerous and threatening any stimuli
- d. Disproportionate incidences of illness in childhood

COGNITIVE MODEL of ILLNESS ANXIETY

(Salkovskis, 1996)

TRIGGER SITUATION:

listening to a radio program about disorders

AUTOMATIC NEGATIVE THOUGHTS:

„It will happen to me, too."

„My liver is not healthy." „I will die"

„I suffer from an uncurable disease."

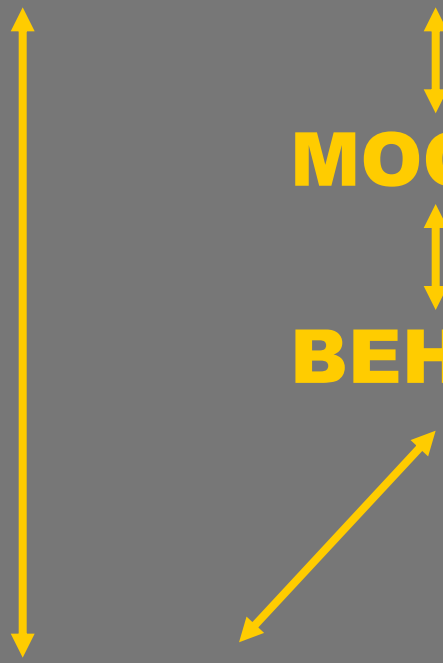
MOOD: *anxiety, fear*

AUTOMATIC NEGATIVE THOUGHTS:

„It will happen to me, too."

„My liver is not healthy." „I will die"

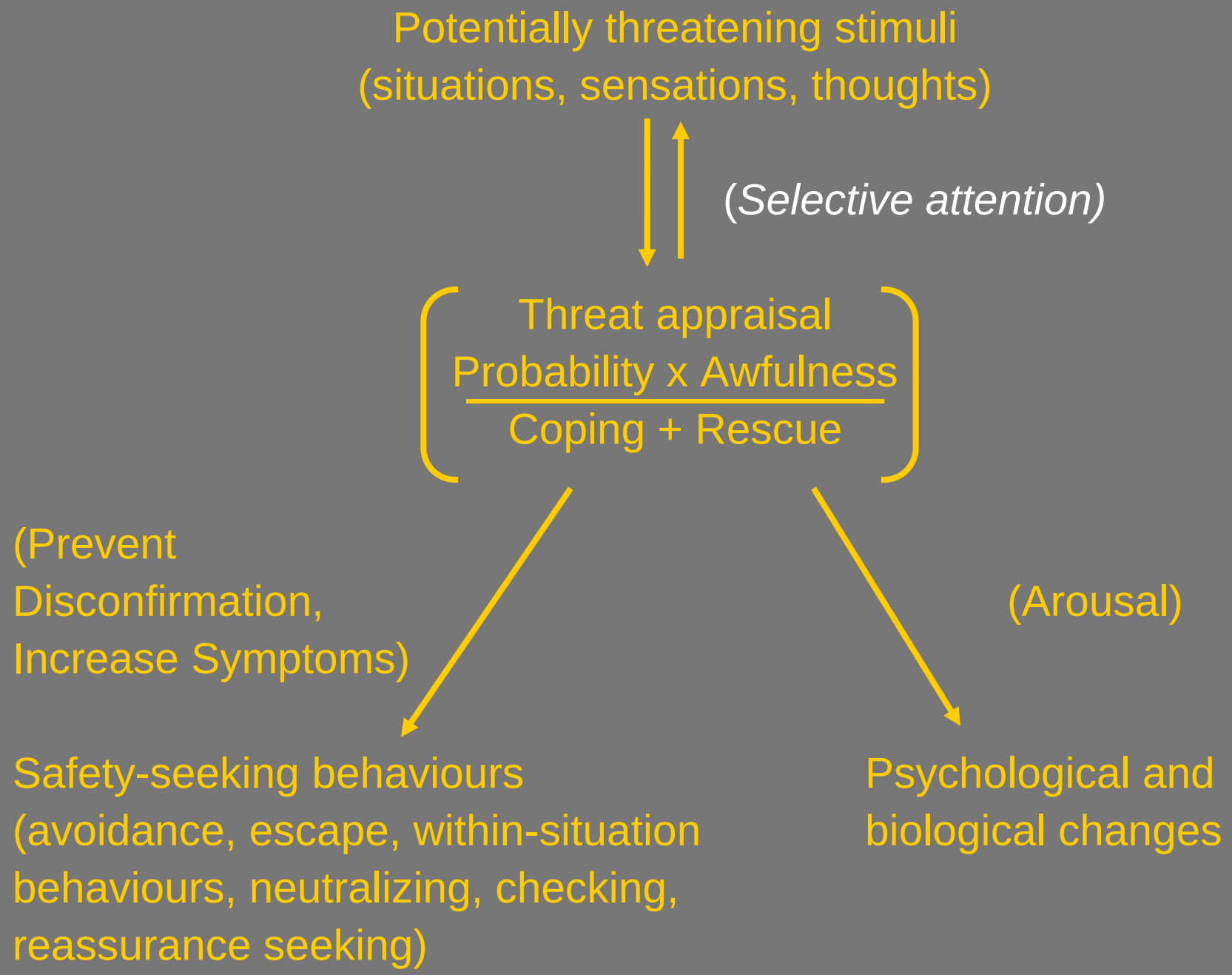
„I suffer from an uncurable disease."



MOOD: *anxiety, fear*

BEHAVIOUR: *checking, pushing, reassurrance seeking*

SOMATIC SYMPTOMS: *aches and pains, stubbly feeling in the liver, cardiac chest pain*



Salkovskis (1996): Cognitive model of Hypochondriasis

HYPOCHONDRIASIS

TREATMENT

1. Focus on illness preoccupation
2. Focus directly on the anxiety
3. Cognitive behaviour therapy
4. Psychopharmacotherapy

Cognitive Behavior Therapy and Paroxetine in the Treatment of Hypochondriasis

(Greeven et al., Am J Psychiatry, 2007;164, 91–99.)

	Whiteley Index	
	Pre – treatment	*Post-treatment*
CBT (n=37)	25,2	16,9
Paroxetine (n=37)	23,9	17,5
Placebo (n=35)	23,0	20,3

Psychological Factors Affecting Other Medical Conditions

Diagnostic Criteria — 316 (F54)

A. A medical symptom or condition (other than a mental disorder) is present.

B. Psychological or behavioral factors adversely affect the medical condition in one of the following ways:

   1. The factors have influenced the course of the medical condition as shown by a close temporal association between the psychological factors and the development or exacerbation of, or delayed recovery from, the medical condition.
   2. The factors interfere with the treatment of the medical condition (e.g., poor adherence).
   3. The factors constitute additional well-established health risks for the individual.
   4. The factors influence the underlying pathophysiology, precipitating or exacerbating symptoms or necessitating medical attention.

C. The psychological and behavioral factors in Criterion B are not better explained by another mental disorder (e.g., panic disorder, major depressive disorder, posttraumatic stress disorder).

Specify current severity:

Mild: Increases medical risk (e.g., inconsistent adherence with antihypertension treatment).

Moderate: Aggravates underlying medical condition (e.g., anxiety aggravating asthma).

Severe: Results in medical hospitalization or emergency room visit.

Extreme: Results in severe, life-threatening risk (e.g., ignoring heart attack symptoms).

Factitious Disorder

Diagnostic Criteria — 300.19 (F68.10)

Factitious Disorder Imposed on Self

A. Falsification of physical or psychological signs or symptoms, or induction of injury or disease, associated with identified deception.
B. The individual presents himself or herself to others as ill, impaired, or injured.
C. The deceptive behavior is evident even in the absence of obvious external rewards.
D. The behavior is not better explained by another mental disorder, such as delusional disorder or another psychotic disorder.

Specify:

Single episode

Recurrent episodes (two or more events of falsification of illness and/or induction of injury)

Factitious Disorder Imposed on Another (Previously Factitious Disorder by Proxy)

A. Falsification of physical or psychological signs or symptoms, or induction of injury or disease, in another, associated with identified deception.
B. The individual presents another individual (victim) to others as ill, impaired, or injured.
C. The deceptive behavior is evident even in the absence of obvious external rewards.
D. The behavior is not better explained by another mental disorder, such as delusional disorder or another psychotic disorder.

Note: The perpetrator, not the victim, receives this diagnosis.

Specify:

Single episode

Recurrent episodes (two or more events of falsification of illness and/or induction of injury)

THANKS FOR YOUR ATTENTION!