What's Next for Somatic Symptom Disorder?

DSM-5 made major changes by introducing the diagnosis of somatic symptom disorder. Our commentary describes the contours of this new diagnosis and provides an overview of the rationale for the changes. We also make some cautious predictions of how the field will develop in the next 10 years in order to base clinical practice on a sound scientific footing.

Somatic symptom disorder represents a consolidation of several disorders (primarily somatization disorder, undifferentiated somatoform disorder, and hypochondriasis) that were noteworthy for their high degree of overlap. The criteria for somatization disorder were difficult to use and so restrictive that the diagnosis was rarely made (1). In DSM-III, the diagnosis required 14 symptoms in women and 12 in men from a list of 37. In DSM-IV, diagnosis required four pain symptoms, two gastrointestinal symptoms, one sexual symptom, and one neurological symptom.

In contrast, the criteria for undifferentiated somatoform disorder created far too low a diagnostic threshold. Clinicians seldom used these diagnostic labels, and psychiatric epidemiology rarely included their assessment. However, the major limitation of the DSM-III and DSM-IV somatoform diagnoses was the overemphasis on medically unexplained symptoms as their hallmark (2). The reliability of diagnosing medically unexplained symptoms is poor, and the emphasis on these symptoms promotes mind-body dualism (3). In fact, psychiatric and general medical disorders commonly co-occur. "Somatizing" frequently occurs in patients with diagnosed medical disorders, amplifying "explained" symptoms.

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The diagnosis of somatic symptom disorder is established when three criteria are met: distressing and impairing somatic symptoms are present; the symptoms are persistent (i.e., >6 months); and the symptoms are associated with abnormal and excessive thoughts, feelings, and behaviors, typically manifested by disproportionate catastrophizing, high levels of anxiety, and illness behavior. For example, following an uncomplicated myocardial infarction, a man is advised to resume normal activities, but he worries constantly about a recurrence and experiences dizziness, dyspnea, and palpitations unrelated to exertion, he restricts his activities, and he checks his pulse hourly. Note that the diagnosis of somatic symptom disorder in this case is based on criteria that are present rather than lack of explanation of symptoms; furthermore, these criteria focus on territory familiar to psychiatrists and psychologists—thoughts, feelings, and behaviors. The removal of the emphasis on medically unexplained symptoms allows a focus on patient suffering without questioning its legitimacy or "reality." Furthermore, finding somatic symptoms of unclear etiology is not sufficient to make this diagnosis. In the

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absence of abnormal thoughts, feelings, and behaviors, patients with irritable bowel syndrome, chronic fatigue, or fibromyalgia would not qualify for a diagnosis of somatic symptom disorder.

Clinical Challenges

For decades, psychiatry has emphasized medically unexplained symptoms. It will be daunting to consider these patients from this new perspective. Two particular issues will be prominent. Is it right to group together patients with medically explained and unexplained symptoms? How do we operationalize disproportionate thoughts, feelings, and behaviors?

Psychiatrists who are experienced working with medically ill patients know that even in life-threatening medical conditions, the majority of patients manage to cope. However, a minority manifest a maladaptive response, spending far more time thinking and worrying about their physical symptoms than others with the same medical disease. Research has demonstrated that in many medical disorders, psychological factors account for more of the variance in physical symptoms than objective measures of disease severity (4, 5). For reasons only partially understood and which must be a core area for future research, some patients develop incapacitating somatic symptoms, such as pain, even with relatively little evident pathology. When patients' somatic symptoms become persistent and distressing, associated with disproportionate thoughts, feelings, and behaviors disrupting their daily lives, a diagnosis of somatic symptom disorder is made, regardless of whether there is a medical explanation for the symptoms and regardless of whether the patient also meets criteria for another psychiatric disorder.

The magnitude and persistency of somatic symptoms are relatively straightforward to measure, but it takes careful clinical judgment to determine when the thoughts, feelings, and behaviors are sufficiently excessive to warrant a diagnosis. How do the patient's cognitive, affective, and behavioral responses to physical symptoms compare with other patients' responses with the same severity of medical illness? The same sort of judgment about proportionality is necessary in making other psychiatric diagnoses (e.g., is a patient's anxiety or depressive symptoms outside the normal range in response to a particular stressor?).

Research Challenges

There is good face validity to the DSM-5 somatic symptom disorder criteria, and field trial data support their reliability (6). Recent studies (7, 8) suggest that, when compared with DSM-IV, the DSM-5 somatic symptom disorder diagnosis represents an improvement in predictive, construct, and descriptive validity, but much more research is needed. How reliable is the diagnosis when made by a nonspecialist? How stable is the diagnosis over time? Should the criteria be more restrictive? There is also a need to operationalize the criteria for epidemiological studies in the general population. The wording of questionnaire items is extremely important because they greatly influence estimates of prevalence. The best inventories will be those that are composed by epidemiologists working closely with clinicians who are familiar with somatic symptom disorder.

The relationship of somatic symptom disorder with other psychiatric disorders needs more study. How often does this disorder co-occur with depressive disorders or panic disorder? How is the clinical course affected by the co-occurrence of somatic symptom disorder with another psychiatric disorder?

The neurobiology of somatic symptom perception will be a critical area for future research. At least three intellectual strands will facilitate this work: neural imaging, laboratory studies of somatic symptom amplification, and studies of how inflammatory factors influence symptom reports.

For the past 40 years, psychiatric practice has been enriched by extensive clinical trials in the treatment of anxiety and depression. With some notable exceptions, there have been relatively few clinical trials in this area of psychopathology (9). Given the increased and timely emphasis on integrating psychiatric and general medical care, one hopes that the new diagnosis of somatic symptom disorder will facilitate clinical trials that can change practice to deliver optimal care for such patients.

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