Somatic symptom disorder

What is somatic symptom disorder?

This is a chronic condition in which there are numerous physical complaints. These complaints can last for years and result in a substantial impact on quality of life.

In the International Classification of Diseases 10th edition (ICD-10), somatisation is defined as multiple, recurrent and frequently changing physical symptoms usually present for several years, (at least two years) before the patient is referred to a psychiatrist. In the 2022 revision ICD-11, the term has been extensively revised and is now know as 'bodily distress disorder' which describes patients presenting with any physical symptom and frequent medical visits in spite of negative investigations. This new term will be assessed for acceptability and utility over the next few years and shows significant overlap with somatic symptom disorder.[1]

In the Diagnostic and Statistical Manual of Mental Disorders version 5 (DSM-5), the condition has been renamed somatic symptom disorder (SSD).[2] There are significant departures from the DSM-IV categorisation which identified somatisation disorder, hypochondriasis, pain disorder,and undifferentiated somatoform disorder. All these are now included under the heading of SSD. Another innovation is that the symptoms need no longer to be medically unexplained but may or may not be associated with another medical condition. Thus, patients who had organic comorbidities such as heart disease, osteoarthritis or cancer - who were previously excluded under DSM-IV - can now be included in the diagnosis of SSD and be considered for appropriate treatment.

The DSM-IV diagnosis of somatisation disorder requiring a specific number of complaints from four symptom groups is no longer a requirement in the DSM-5 diagnosis of SSD. Recent literature has used the terms somatisation disorder, somatic symptom disorder, functional somatic syndromes and somatisation syndromes more or less interchangeably. Much of the evidence base relating to somatisation disorder is, however, also relevant to SSD and has been quoted where appropriate.[3] There are subsets of SSD which include conversion disorder, factitious illness disorder and illness anxiety disorder.[4]

SSD may still be associated with a great deal of stigma; there is a risk that patients may be dismissed by their physicians as having problems that are 'all in their head' but hopefully this occurrence is becoming less common as awareness improves.

However, as researchers study the connections between the brain, the digestive system and the immune system, SSD is becoming better understood.

Somatic symptom disorder aetiology

- Research has shown higher percentages of this disorder in people with irritable bowel syndrome and in chronic pain patients.[5]
- A high proportion of patients with post-traumatic stress disorder also have somatisation.[6]
- Antisocial personality disorder is associated with a risk for SSD.[7]
- The somatising patient seems to seek the sick role, which affords relief from stressful or impossible interpersonal expectations ('primary gain'):[8]
    - In most societies this provides attention, caring and sometimes even monetary reward ('secondary gain').
    - This is not malingering, because the patient is not aware of the process through which the symptoms arise, cannot will them away and genuinely experiences the symptoms.

- Several studies have suggested an association between somatisation and a history of sexual or physical abuse in a significant proportion of patients.[9]
- One study reported that patients with somatisation syndromes were often associated with the interpersonal representation of the unmet need for closeness with others.[10]
- Another study suggested that neuroendocrine genes may be implicated.[11]
- There is evidence that an individual displaying negative psychological features (such as catastrophising, rumination, avoidance, negative affectivity, or health anxiety) is more likely to transition from untroubling medically unexplained symptoms to a severely impairing complaint.[12]

How common is somatic symptom disorder? (Epidemiology)

- A German 2022 study reported a prevalence of 7.7% for somatic symptom disorder (SSD) in primary care.[13]
- A large scale, 2022 community-based study in China reported that SSD was more prevalent in people over 60 years of age.[14]
- Epidemiological studies generally quote a prevalence of 5-7% for the general population.[15]
- The disorder usually begins before the age of 30 years and occurs more often in women than in men.[16]

Presenting features

DSM-5 has reformulated the criteria to rely less on strict patterns of somatic symptoms and more on the degree to which a patient's thoughts, feelings and behaviours about their symptoms are disproportionate or excessive.[17] The symptoms are generally severe enough to affect work and relationships and lead the person to consult a doctor and take medication. A lifelong history of 'sickliness' is often present:

- DSM-5 acknowledges that patients may have a combination of symptoms for which an organic cause can be found and symptoms for which there is no underlying physical explanation.
- Stress often worsens the symptoms.

Symptoms

Some of the numerous symptoms that can occur with somatisation disorder include:

Cardiac

- Shortness of breath.
- Palpitations.
- Chest pain.

Gastrointestinal

- Vomiting.
- Abdominal pain.
- Difficulty with swallowing.
- Nausea.
- Bloating.
- Diarrhoea.

Musculoskeletal

- Pain in the legs or the arms.
- Back pain.
- Joint pain.

Neurological

- Headaches.
- Dizziness.

- Amnesia.
- Vision changes.
- Paralysis or muscle weakness.

Urogenital

- Pain during urination.
- Low libido.
- Dyspareunia.
- Impotence.
- Dysmenorrhoea, irregular menstruation and menorrhagia.

Making a diagnosis[4]

- A thorough physical examination and diagnostic tests are performed to rule out physical causes - which tests are done are determined by the symptoms present.
- A psychological evaluation should also be performed to rule out related disorders:
    - However, finding evidence of a psychiatric condition does not rule somatisation in or out.
    - It can be a clue to the diagnosis.
    - There is considerable evidence that patients with common psychiatric conditions, such as depression and anxiety disorders, may present with nonspecific symptoms (including fatigue, aches and pains, palpitations, dizziness and nausea) to primary care health professionals.

Somatisation is often a diagnosis of exclusion; however, it is much more effective to pursue a positive diagnosis of somatisation when the patient presents with typical features:

- There may be multiple symptoms, often occurring in different organ systems.

- Symptoms that are vague or that exceed objective findings.
- Chronic course.
- Presence of a psychiatric disorder.
- History of extensive diagnostic testing.
- Rejection of previous physicians.

The general practitioner's emotional response to a patient can serve as an early cue to pursue a somatisation diagnosis:

- A feeling of frustration or anger at the number and complexity of symptoms and the time required to evaluate them in an apparently well person.
- A sense of being overwhelmed by a patient who has had numerous evaluations by other physicians.

These can be a signal to the clinician to consider somatisation in the differential diagnosis early in the patient's evaluation.

Management[18]

Doctors' explanations of their symptoms are often at odds with these patients' own thinking and clinicians should take time to ensure their explanations are 'tangible, exculpating and involving'. Empowering explanations have been shown to improve these patients' well-being.[16]

The first occasion that the diagnosis is discussed (after the initial investigations have failed to show any organic pathology) is a key moment in the physician-patient relationship. The challenge is to describe the condition to the patient in a manner that avoids any implication of a psychosomatic illness. One journal suggests the following:

'The results of my examination and of the tests we conducted show that you do not have a life-threatening illness. However, you do have a serious and impairing medical condition, which I see often but which is not completely understood. Although no treatment is available that can cure it completely, there are a number of interventions that can help you deal with the symptoms better than you have so far'.[19]

Once other causes have been ruled out and a diagnosis of SSD secured, the goal of treatment is to help the person learn to control the symptoms:

- There is often an underlying mood disorder which can respond to antidepressants.
- Unfortunately, those with this disorder rarely admit that it can be caused, at least in part, by mental health problems and may refuse psychiatric treatment.

It is important to ask open-ended questions. The BATHE technique provides a framework for exploration of psychosocial stressors in less than five minutes:[20]

- **B**ackground: 'What is going on in your life?'
- **A**ffect: 'How do you feel about it?'
- **T**rouble: 'What troubles you the most about that situation?'
- **H**andle: 'What helps you handle that?'
- **E**mpathy: 'This is a tough situation to be in. Your reaction makes sense to me.'

It is sensible to avoid setting unrealistic goals:

- In severe cases of SSD, symptoms are unlikely to resolve completely. Therefore, avoid making the goal of the treatment plan to relieve the patient's illness. The physician and patient will soon become frustrated and tempted to engage in a new flurry of diagnostic tests and invasive procedures.
- Attempts to 'take away the symptom' may cause the patient to substitute another symptom as a result of the need-to-be-sick phenomenon.

A better goal is to help the patient succeed in coping with the symptoms. Treatment is successful if it keeps the patient out of the hospital.

General advice

- The whole primary care health team should be aware of the diagnosis and management plan. This will make the approach to management consistent across the practice.
- Interventions directed at reducing specific sources of stress are most helpful; these may include advice about dealing with marital conflict.
- Some physical exercise is important, as it prevents loss of fitness, enhances self-esteem and provides an opportunity for patients to take a break from oppressive duties or unpleasant situations. Pleasurable private time should be encouraged as a way to manage stress.[21]

Some patients may request tests repeatedly but they should be reminded that they will be followed with frequent and regular visits so that any problems will be identified early. Sometimes requesting investigations becomes a 'negotiating' process designed to give the patient some control over what test is performed and to enhance the trust level between the physician and patient.

> **NB**: somatising patients also develop organic diseases, especially common disorders such as **osteoarthritis**, **coronary artery disease** and cancer. Thus, preventative health measures and regular screenings must be integrated into the overall treatment plan.

Psychotherapy

Changes in definitions have not helped the collection of data related to treatment approaches. A 2014 Cochrane review (not yet updated) concluded that when all psychotherapy approaches were combined, they were superior to no care, or 'usual care' for symptom control in patients, but data on specific approaches were too small to be specific.[22] Approaches derived from cognitive behavioural therapy have been shown to reduce the intensity and frequency of somatic complaints and to improve functioning in many somatising patients:[23]

- This type of treatment starts with the mutual agreement that whatever the patient has been thinking and doing about the condition has not been successful.
- It then begins to challenge the patient's beliefs and maladaptive behaviours in a caring manner.

- Short course intervention therapy (8-16 sessions) specifically for treatment of somatising patients has been shown to be remarkably effective in improving function and reducing distress.[24]
- The sessions combine general advice such as stress management, problem solving and training in social skills, with specific interventions targeted at the amplification and need-to-be-sick features of somatisation.

Mindfulness therapy is a feasible and acceptable treatment and can be used in conjunction with SSRIs.[25]

Pharmacological

There is only low-quality evidence for the use of selective serotonin reuptake inhibitors (SSRIs) vs placebo or other treatment for treating SSD.[26] There are psychiatric disorders associated with somatisation, specifically anxiety and depression. These respond well to treatment with antidepressants,[27] but it is important to start with low doses and to increase them progressively to avoid side-effects that may be present at the beginning of treatment and which might discourage the patient from continuing. One study reported the successful use of duloxetine.[28]

A supportive relationship with a sympathetic healthcare provider is the most important aspect of treatment. Regular appointments should be maintained to review symptoms and the person's coping mechanisms.

Complications[15]

- Complications may result from invasive testing and from multiple evaluations that are performed while looking for the cause of the symptoms.
- A dependency on alcohol, pain relievers or sedatives may develop.
- A poor relationship with the healthcare provider seems to worsen the condition, as does evaluation by many providers.

Further reading

- Grochtdreis T, Zimmermann T, Puschmann E, et al; Cost-utility of collaborative nurse-led self-management support for primary care patients with anxiety, depressive or somatic symptoms: A cluster-randomized controlled trial (the SMADS trial). Int J Nurs Stud. 2018 Apr;80:67-75. doi: 10.1016/j.ijnurstu.2017.12.010. Epub 2017 Dec 29.
- Hybelius J, Gustavsson A, Af Winklerfelt Hammarberg S, et al; A unified Internet-delivered exposure treatment for undifferentiated somatic symptom disorder: single-group prospective feasibility trial. Pilot Feasibility Stud. 2022 Jul 19;8(1):149. doi: 10.1186/s40814-022-01105-0.

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