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A REVIEW OF SOMATOFORM DISORDERS IN DSM-IV AND SOMATIC SYMPTOM DISORDERS IN PROPOSED DSM-V

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SUMMARY

Psychiatric care providers should be trained to use current changes in the somatoform disorders criteria. New diagnostic criteria for Somatic Symptom disorders in the proposed DSM-V is discussed and compared with its older counterpart in DSM-IV. A new category called Somatic Syndrome Disorders is suggested. It includes new subcategories such as "Complex Somatic Symptom Disorder" (CSSD) and "Simple Somatic Symptom Disorder" (SSSD). Some of the subcategories of DSM-IV derived disorders are included in CSSD. While there are some changes in diagnostic criteria, there are concerns and limitations about the new classification needed to be more discussed before implementation. Functional somatic disturbance, the counterpart of converion disorder in DSM-IV, can be highly dependet on the developmental level of children. However, the role of developmental level needs to be considered.

Key words: *somatoform disorders - somatic symptom disorder - DSM-IV - DSM-V*

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INTRODUCTION

One of the psychiatric diagnoses, that there are a lot of controversies about its diagnostic criteria, is somatoform disorders. Medically unexplained symptoms are categorized as 'somatoform disorders' in both DSM-IV and ICD-10 (Rief & Isaac 2007). The name of this diagnostic criterion is criticized (Starcevic 2006). Instead, new names such as functional somatic syndromes, and psychosomatic distress syndromes are suggested (Starcevic 2006). Meanwhile, medicine calls these problems as Functional Somatic Syndromes (Wessely et al. 1999). Moreover, there is a wide heterogenosity in the group of somatoform disorders. For example, Body Dysmorphic Disorder is completely different from other subcategories (Starcevic 2006).

Mind and body exert powerful effects on each other. Bodily symptoms can be the manifestations of some changes in the inner world of the individual. The delicate changes in some parts of the brain result in changes in bodily sensation, movement and the functions of internal organs.

Despite the clear reciprocal relationship between the mind and the body which has been known since ancient times, psychiatry and medicine has not been able to formulate any etiological explanation for the so called medically unexplained symptoms yet. However, our patients are not waiting for us to reach a conclusive result and their complaints have been continued along history.

Neurobiological and psychodynamic approaches are two explanatory models for such medically unexplained disorders called somatoform disorders by DSM-IV. These two approaches are representative of two complementary subjective and objective perspectives. Until present time, no satisfactory biological model has been offered to explain the quality of interaction between the mind and the body which result in the signs and symptoms of patients with somatoform disorders. Psychiatry community has had to classify them according to a superficial criterion. This approach has had a number of difficulties in the management of patients especially among third world physicians who have had to rely on their talents and expertise rather than technology and also among the patients living in the countries which expression of emotions is suppressed. In these countries, the physicians have learned to think about depression as the first diagnostic hypothesis before to think about somatoform disorders (Seifsafari et al. 2012).

According to four basic-emotion command systems introduced by Panksepp (Solmes & Turnbull 2002), the emotional turmoil of somatoform patients which is released via bodily symptoms, may be explained based on reward, rage, fear and panic systems. For instance, the inexhaustible complaints of patients with somatization disorder can be explained by reward system and the need of these patients for attention and care whereas the hypochondriac patients can be understood as individuals with a hidden rage rooted in childhood frustrations. Similarly, the behavior of patients suffering from factitious disorder can be referred to a disturbance in panic (separation-distress) system. Different types of emotions lead to different presentations of bodily symptoms. These basic emotions in combination with the effects of environmental influences especially in the early childhood are responsible for different presentations of medically unexplained symptoms.

In the last decades of eighteen century, the concept of "functional Delta" had occupied the mind of some physicians. This concept pointed to a discrepancy between signs and symptoms of patients. The patients who showed more symptoms than detectable signs were labeled as hysteria. As the result of working with such patients, Joseph Breuer and Sigmund Freud showed the effects of unconscious world on the physical symptoms of their patients. Freud asserted "after we have completed our psychoanalysis work we shall have to find a point of contact with biology" (Freud 1915). As Solms and Turnbull announced in their book: "It was only a temporary strategy, designed to allow the subjective perspective on the mind maximum scope for unexpected insight and discoveries, where after those discoveries can and must be reconciled with neurobiology" (Solmes & Turnbull 2002).

We can speculate that we need such "temporary strategy" in the field of somatoform disorders. Erik Kandel in his remarkable papers noted "psychoanalysis still represent the most coherent and intellectually satisfying view of the mind that we have"(Kandel 1999). Despite technological advances in the field of neuroscience and brain imaging, the underlying brain mechanisms contributing in the development of somatoform disorders are still unknown. Instead of reliance on a descriptive model which in itself has no correlation with the reality of medically unexplained symptoms, we need a more deep-looking approach in the service of mutual understanding in the process of doctor-patient relationship. Perhaps an interdisciplinary approach and creation of a circle of experts in the fields of cognitive neuroscience and psychoanalysis could be a satisfactory solution of this problem.

GENERAL ARGUMENTS ABOUT DSM-IV DIAGNOSTIC CRITERIA FOR SOMATOFORM DISORDERS

Axis I or III

Some authors suggest that this category should be dropped from axis I and it should be transferred to axis III (Mayou et al. 2005). They rationalize that this category is a medical problem rather than being a mental disorder (Mayou et al. 2005). They also rationalize that these patients usually refer to medical practitioners rather than psychiatrists (Mayou et al. 2005). However, some others do not support this suggestion. Because, many other psychiatric disorders such as schizophrenia can be presented by somatic complaints. Nevertheless, schizophrenia is well known as a psychiatric disorder (Rief & Isaac 2007).

Stigmatization

Another problem is that many patients do not like the term of somatoform disorder (Mayou et al. 2005). Because, this term means that the problem is related to psychological problems. Moreover, it is questionable whether we can classify somatic complaints into medical problems or psychological conditions (Mayou et al. 2005). In addition, their overlap is not just limited to medical conditions. They also overlap with other psychiatric disorders such as depression. Therefore, as much as differentiating somatic complaints from medical conditions is not easy, its differentiation from other psychiatric problems is somewhat problematic. Moreover, its compatibility with some cultures is questionable (Mayou et al. 2005). According to our experience, many patients prefer to refer to a physician due to a somatic problem rather than a psychological problem or conflict. Stigmatization can be an explanation that why most of the patients with somatic symptoms usually prefer to refer to other physicians rather than psychiatrists cannot be justified for prevention of stigmatization. This stigmatization happens for most of the other psychiatric disorders including those are placed in other axis (Rief & Isaac 2007).

Ambiguity

Mayou et al. reported that it is ridicules that the ambiguity in the exclusion criteria for somatoform disorders leads to classifying a problem such as irritable bowel syndrome in axis III as a medical condition. While, at the same time, it is mentioned in axis I as a somatoform disorder or undifferentiated somatoform disorder (Mayou et al. 2005). NOS somatoform disorder and undifferentiated somatoform disorder are rarely diagnosed and used by psychiatrists (Rief & Isaac 2007). Ambiguity in definition of these disorders may be a reason for this rarity. Furthermore, the threshold of symptoms to make the diagnosis of somatoform disorder is questionable (Mayou et al. 2005). This ambiguity is extended into legal and medical conditions. It is possible that some somatic complaints are being interpreted as psychological problems or vice versa in legal or insurance systems (Mayou et al. 2005).

Compatibility in different cultures

Atypical non-cardiac chest pains are common in patients with history of myocardial infarction. Should atypical non-cardaic pain in these patients be labeled as somatoform disorder? (Mayou et al. 2005). Socio-economic condition and access to medical examinations are very different between cultures. When a physician has not access to expensive medical diagnostic instruments, he/she less likely finds the underlying origin of a symptom (Rief & Rojas 2007). It increases inter-rater variability among psychiatrists in different cultures.

Counting of symptoms

In DSM-IV, the number of somatic symptoms is counted to fulfill a diagnosis. Meanwhile, some authors argue and criticize this method (Fink 1996). Because it does not have enough face validity (Mayou et al. 2005). For example, the memory problems of patients may

negatively impact on the number of remembered somatic symptoms.

Stability and reliability

"Not fully explained by a known general medical condition" is a criterion for diagnosis of somatoform disorders. There is a large variability among physicians for rating of this criterion. So, the diagnosis can be unstable and unreliable (Rief & Rojas 2007).

Overlap of diagnostic criteria

More than one third of physicians reported that the border between the diagnostic criteria for pain disorder and somatoform disorder not otherwise specified are "unclear". A similar rate of physicians considered these criteria as "not useful." An overlap between somatization disorder, pain disorder, hypochondriasis, and "somatoform disorder not otherwise specified" is reported by more than 90% of physicians (Dimsdale et al. 2011). Maybe, this is a reason that psychiatric consultation in the care of patients with somatization disorders just reduces further health care costs. This psychiatric consultations do not change in health status or patients' satisfaction with their health care (Smith et al. 1986).

ARGUMENTS ABOUT DSM-IV CRITERIA FOR SPECIFIC SOMATOFORM DISORDERS

Hypochondriasis

There is a phenomenological overlap between anxiety disorder and hypochondriasis (Noyes 1999). Hypochondriasis is consisted of three main symptoms including believing to a disease, associated worriness about the disease, and treatment seeking behaviors. Why is apprehension to future categorized as an anxiety disorder while worryness about health condition is categorized in somatoform disorders?

Conversion disorder

Dissociative symptoms are very frequent in patients with conversion disorder (Espirito-Santo & Pio-Abreu 2009). In other words, current evidence support that the relationship between dissociative symptoms and conversion disorder is very close. So, the question is that why conversion disorder is not categorized as a dissociative disorder. It is interesting that the rate of dissociative symptoms in patients with somatization disorder is lesser than that of conversion disorder (Espirito-Santo & Pio-Abreu 2009, Guz et al. 2004).

Body dysmorphic disorder

Body dysmorphic disorder is a type of repetitive and intrusive thoughts about physical appearance. It is a concern about patient's appearance. Sometimes, patients with body dysmorphic disorder try to correct his/her appearance or try to hide it or try to re-check it again and again (Fang & Hofmann 2010). It is interesting that the most common parts which are usually checked are nose, hair, and face (Phillips et al. 2005). In fact, these patients are worried about the judgment of other people regarding their appearance. Is not it social anxiety (Fang & Hofmann 2010)? There are many similarities between body dysmorphic disorder and social anxiety disorder and obsessive compulsive disorder. Moreover, the typical age onset of both social anxiety disorder and body dysmorphic disorder are late childhood and early adolescent at about age of 14 (Fang & Hofmann 2010, Phillips et al. 2005). Regarding their treatment, selective serotonin reuptake inhibitors are effective for both social anxiety disorder and obsessive compulsive disorder (Ganasen & Stein 2010, Ipser et al. 2009).

Pain disorder

Pain disorder is another somatoform disorder. There has been a large question mark about the validity of pain disorder and somatoform disorder as distinct disorders from DSM-III-R (Birket-Smith & Mortensen 2002).

All of these mentioned-above limitations support that there is a need for clarifying and revising the diagnostic criteria of somatoform disorders (Rief & Isaac 2007). This new version should incorporate both somatic and psychological symptom severity (Voigt et al. 2010). Until we do not know the underlying neuro-biological causes of symptoms, every classification based on symptoms clusters has its own limitations (Dimsdale & Creed 2009).

DSM-V DIAGNOSTIC CRITERIA, THE PROPOSED REVISION

According to a draft published on April 18, 2011, there is a group of disorders called Somatic Symptom Disorders (APA 2011). Somatic Symptom Disorders is a new category appeared in the proposed DSM-V. The disorders included in this category are indicated in Table 1. Simple Somatic Symptom Disorder (SSSD) and Complex Somatic Symptom Disorder (CSSD) are two sub-categories newly added to psychiatric classification.

DSM-V website related documents indicate that somatic symptoms with unknown etiology are not enough to make a somatic syndrome disorder. However, somatic symptoms due to a general medical condition such as diabetes does not exclude this diagnosis (APA 2011). Somatic symptoms may co-occur with other psychiatric disorders such as schizophrenia. For this reason, not every somatic symptom will be called somatic syndrome disorder (APA 2011).

Complex Somatic symptom disorder (CSSD)

The DSM-IV diagnoses of somatization disorder, undifferentiated somatoform disorder, hypochondriasis,

Table 1. The proposed DSM-V disorders included in Somatic Symptom Disorders category and its related somatoform disorders in DSM-IV

Disorders in DSM-V			Related somatoform disorders in DSM-IV
Psychological factors affecting medical condition			-
Complex Somatic symptom disorder (CSSD)	Specifies	Predominant somatic complaints	Somatization disorder
		Predominant health anxiety	Hypochondriasis
		Predominant Pain	Pain disorder
Simple (or abridged) somatic symptom disorder e.g. pain			-
Illness Anxiety Disorder (hypochondriasis without somatic symptoms)			-
Functional Neurological Disorder			Conversion disorder
Factitious disorder	Types	Factitious Disorder	
		Factitious Disorder imposed on another	
Pseudocyesis			

and some presentations of pain disorder are included in a group called Complex Somatic Symptom Disorder (CSSD). CSSD emphasizes the cognition abnormality too. So, just presence of somatic symptoms is not enough to make this diagnosis. Excessive thought, feeling, and behaviors related to the somatic symptom or associated health concern is a diagnostic criteria. Moreover, clinical observation or patient's report is acceptable for assessment of cognitive abnormalities (Table 2).

Simple Somatic Symptom Disorder (SSSD)

Its diagnostic criteria are very similar to CSSD. However, the duration of symptom is more than 1 month. Moreover, contrary to CSSD, presence of one of the criteria related to cognition impairment is enough. CSSD diagnosis needs the presence of two symptoms related to cognition impairment.

Illness Anxiety Disorder

The patients with hypochondiasis according to DSM-IV diagnostic criteria are usually categorized in CSSD in DSM-V. Meanwhile, if the patient does not have any significant somatic symptom and the patient just suffers from anxiety and concern about being illness, the new subcategory of Illness Anxiety Disorder is used (APA 2011).

Somatic symptom disorder, newly presented in DSM-V, seems to be a wide umberella that covers many of the psychiatris disorders in DSM-IV, including Somatization disorder, hypochondriasis, and pain disorder. However, the border between Somatic symptom disorder and Illness Anxiety Disorder is confusing.

Table 2. The proposed DSM-V diagnostic criteria for Complex Somatic Symptom Disorder

To meet criteria for CSSD, criteria A, B, and C are necessary.

A. *Somatic symptoms:*
One or more somatic symptoms that are distressing and/or result in significant disruption in daily life.

B. *Excessive thoughts, feelings, and behaviors related to these somatic symptoms or associated health concerns:* At least two of the following are required to meet this criterion:
(1) High level of health-related anxiety.
(2) Disproportionate and persistent concerns about the medical seriousness of one's symptoms.
(3) Excessive time and energy devoted to these symptoms or health concerns.*

C. *Chronicity:* Although any one symptom may not be continuously present, the state of being symptomatic is chronic (at least 6 months).

For patients who fulfill the CSSD criteria, the following optional specifiers may be applied to a diagnosis of CSSD where one of the following dominates the clinical presentation:

XXX.1 Predominant somatic complaints (previously, somatization disorder);

XXX.2 Predominant health anxiety (previously, hypochondriasis). If patients present solely with health-related anxiety with minimal somatic symptoms, they may be more appropriately diagnosed as having Illness Anxiety Disorder;

XXX.3 Predominant Pain (previously pain disorder). This classification is reserved for individuals presenting predominantly with pain complaints who also have many of the features described under criterion B. Patients with other presentations of pain may better fit other psychiatric diagnoses such as adjustment disorder or psychological factors affecting a medical condition.

Malingering and factitious disorder

Malingering is an intentional reporting of some symptoms. There is an obvious reward in patients with malingering. A DSM-V related document reported that malingering is not a psychiatric disorder. Meanwhile, the falsification of medical and/or psychological symptoms is called factitious disorder. This disorder is classified as a sub-category of somatic symptoms disorders in DSM-V.

SOME OTHER CHANGES AND CONCERNS ABOUT NEW CLASSIFICATION

Is it a medical or psychological problem?

Contrary to DSM-IV classification, proposed DSM-V included both aspects of psychological and medical aspects of somatic disorder. However, it is questionable whether this change reduces diversity between medical practitioners and psychiatrists to make a similar diagnosis. Moreover, it cannot be assured that a symptom is a medical or psychological problem. How should the diagnostic criteria be applied if the patient denies any psychological aspect?

Does it decrease stigmatization?

It is not clear whether this new classification leads to referring the patients with somatic syndrome disorder to psychiatrists and psychologists. If this aim is not met, as in the DSM-IV, many patients with somatic syndrome disorders will not benefit from psychiatric services. However, it is not warranted that the new terms used in DSM-V are less offensive than the terms used in DSM-IV. It is not clear whether these new terms are more patient friendly or more compatible to be used by non-psychiatric physicians.

Does this classification increase the ability of physicians to differentiate somatic syndrome disorders from other psychiatric disorders?

A look at the CSSD criteria, it is clear that anxiety is a major part of its diagnostic criteria. It is not clear whether which one of the cognitive or somatic components is prior to another one. If anxiety is secondary to a somatic symptom, what does differentiate somatic syndrome disorder from adjustment disorder? Is the symptom directionality (anxiety to somatic symptoms or vice versa) important? If the patient cannot remember the directionality, how the diagnosis is made?

Is this classification culture bound?

Similar to DSM-IV, the ability to find a general medical condition in patients with CSSD is dependent on a well equipped health services. Physicians' accesses to the best diagnostic systems and equipments increase the chance to find a general medical condition in a patient with somatic symptoms. Therefore, the patients living in poorer area with less access to diagnostic equipments or treatment facilities have a higher risk to be diagnosed as a somatic symptom disorder. Duration more than one month is required to meet diagnostic criteria for SSD. Experimental studies need to be conducted to investigate whether this may lead to excessive referral to psychiatrists.

Does it decrease the ambiguity for decision making in legal and medical condition?

It is expected that this system reduce this ambiguity. However, the threshold for a symptom to be considered as pathologic is not clearly explained and this can reduce reliability. It does not seem to reduce ambiguity for decision making in legal-medical situations and more studies should be conducted.

Dose it use symptom counts to define disorders?

At least, in some sub-categories, symptoms count strategy is used in DSM-V for somatic syndrome disorder. However, it is less dependent on symptom count. A threshold should be defined to determine pathological condition.

Is it suitable for children and adolescents?

Lack of studies using somatic symptom disorders criteria makes it difficult to reach any firm conclusion. This is much more difficult regarding children and adolescents. Similar to DSM-IV, the patients are blamed as the origin of symptoms (Schulte & Petermann 2011). Nothing is mentioned about the context and its role in somatic symptom disorders. Meanwhile, mental health services usage by children with somatic problems is highly dependent on parents. This matter needs to be considered in any new revision. There is a concern that the impact of labeling of children in their early life will be lifelong. Moreover, children's ability to express their anxiety and worry about somatic symptoms is more limited than the adults. This limitation is much more evident in children with developmental disabilities. This may lead to under-estimization and under-diagnosis of somatic symptom disorders in children and adolescents especially in those with mental developmental problems. In addition, multiple somatic problems happen in a long duration of time. Therefore, it needs enough time to meet diagnostic criteria. Functional neurological disorder and CSSD with specifier of hypochondriasis seems to be very dependent on developmental level. The border between CSSD-predominantly health related anxiety and Illness Anxiety Disorder is not clear. Others recommended the following two items to be added to diagnostic criteria including. Those are "parental excessive concern and preoccupation with the child's symptoms" and "high parental health anxieties" (Schulte & Petermann 2011).

In our experience, many children present with anxiety problems express themselves with abnormal fears or separation anxiety. Therefore, adding a new item with this concept should be considered.

Chronic fatigue syndrome and substance use disorder

Finally, it is not clear that how DSM-V deals with chronic fatigue syndrome and neurasthenia. Differentiating of substance use related-symptom and somatic symptoms disorder needs to be clarified.

CONCLUSION

There are many debates about validity and reliability of somatoform disorders diagnosed according to DSM-IV diagnostic criteria. The new proposed DSM-V diagnostic criteria considered many limitations of DSM-IV. It cannot be guaranteed whether changing the name and the made corrections increase cares towards patients. More studies, discussion and corrections are needed to be conducted before implementing of these new diagnostic criteria.

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