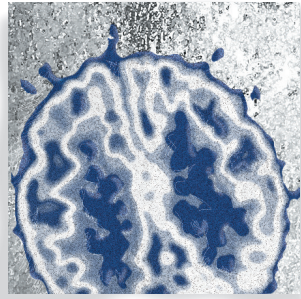


## *Management of somatic symptom disorder*

*Peter Henningsen, MD*



### Introduction

**P**atients at all levels of health care frequently suffer from bodily complaints, such as pain in different locations of the body, from fatigue, or from perceived disturbances of the cardiovascular, gastrointestinal, or other organ functions. The latter might appear as palpitations, dizziness, diarrhea, limb weakness, etc. Many patients complain of multiple symptoms concurrently and over time, but some suffer from only one persisting symptom. Suffering is not confined to the experience of bodily complaints; it also entails psychological and behavioral aspects like high health anxiety and checking behavior. In most patients, suffering is dominated by the experience of bodily distress itself, but in some, anxiety is central to their suffering, and bodily symptoms are negligible. The spectrum of severity is wide, from mild symptoms with little functional impairment to severely disabling conditions.<sup>1</sup> Central problems are due to the fact that bodily complaints are persistently attributed to organic disease and that diagnostic and therapeutic approaches to the patients vary substantially across and within medical specialties, from biomedicine to psychiatry and psychology—and these approaches usually are not complementary, but all too often contradictory. Even when recognized correctly as a problem of bodily distress, there are several diagnostic possibilities. In psychiatry, diagnostic categories, such as Somatic Symptom Disorder (SSD; *Diagnostic and Statistical Manual for Mental Disorders*, fifth edition [DSM-5]), Somatoform

*This review paper gives an overview of the management of somatic symptom disorder. It starts with a description of the clinical problem of patients with persistent bodily distress, discusses classificatory, epidemiological, and etiological issues and then describes the evidence and practical principles of dealing with these patients who are often seen as “difficult” to treat. It is concluded that the best-suited approach is stepped care with close cooperation of primary care, a somatic specialist, and mental health care professionals operating on the basis of a biopsychosocial model of integrating somatic as well as psychosocial determinants of distress and therapeutic factors.*

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*Dialogues Clin Neurosci.* 2018;20:23-30.

**Keywords:** *etiology; classification; management; somatic symptom disorder; somatoform disorders*

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Disorders (10th revision of the *International Statistical Classification of Diseases and Related Health Problems [ICD-10]*) or Bodily Distress Disorder (11th revision of the *ICD [ICD-11]*, likely) are used, and in somatic specialist care, there are many single functional somatic syndrome diagnoses (like irritable bowel syndrome [IBS] or fibromyalgia syndrome [FMS]).

After suffering long and ultimately unsuccessful treatments, patients are often frustrated. Doctors therefore experience them as difficult to treat, costs are high, and this type of health problem contributes—to a large and still growing extent—to the global burden of disease.<sup>2</sup>

Typically, there is no well-defined structural organic pathology to be found that correlates to the symptoms; hence, the symptoms are said to be functional in nature. If organic pathology is present, it does not explain the extent of bodily symptoms and suffering, and even successful treatment and/or remission of the underlying pathology do not relieve the symptoms. Many medical specialists feel uncertain when having to decide about the relevance (or not) of underlying organic disease. However, in careful diagnostic follow-up studies, only 0.5% of diagnoses of so-called functional symptoms and syndromes have to be revised. On the other hand, a thorough evaluation of patients who are sent with an initial diagnosis of a functional symptom or syndrome reveals underlying organic pathology in up to 8% of cases.<sup>3,4</sup>

The total number of bodily symptoms is a more relevant predictor of disability, health care use, and hence, overall severity than the severity of single symptoms or the specification of a subgroup of bodily symptoms as “medically unexplained.”<sup>5,6</sup> High health anxiety independently adds to overall severity, especially in terms of use of specialist medical services.<sup>7,8</sup> Functional limitations in this group of patients (quality of life and work participation) are as severe as in well-defined medical diseases with comparable symptoms.<sup>9,10</sup> Long-term outcome is surprisingly poor, with high rates of disability after many years.<sup>11</sup>

Functional somatic symptoms and bodily distress in general are associated with higher rates of depression and anxiety than diseases with comparable symptoms but well-defined organic pathology (ie, IBS vs inflammatory bowel disease, FMS vs rheumatoid arthritis). However, many patients with enduring somatic symptoms do not have anxiety or depression, so this association can be seen neither as an unspecific psychological

reaction to the presence of bodily complaints nor as masked or somatized depression or anxiety alone.<sup>12</sup>

## Classification in *DSM-5*

In 2013, *DSM-5* introduced a new classification category—SSD (*DSM-5* 300.82)—within the wide field of bodily distress.<sup>13</sup> It contains two major changes in comparison to Somatoform Disorders in *DSM-IV*: the requirement that the somatic symptoms be organically unexplained has been dropped, and certain psychobehavioral features now have to be present in order to justify the diagnosis. So, to fulfill the diagnostic criteria, the following must be present:

- One or more somatic symptoms that are distressing and/or result in significant disruption in daily life.
- One or more excessive thoughts, feelings, and/or behaviors related to the following somatic symptoms or associated health concerns: (i) disproportionate and persistent thoughts about the seriousness of one’s symptoms; (ii) persistently high level of anxiety about health or symptoms; and (iii) excessive time and energy devoted to these symptoms or health concern.
- Although any one symptom may not be continuously present, the state of being symptomatic is persistent and lasts more than 6 months.

The condition is considered to be mild when only one of the psychobehavioral symptoms is fulfilled; moderate, when two or more of these symptoms are fulfilled; and severe, when two or more of the psychobehavioral symptoms are fulfilled, plus when there are multiple somatic complaints (or one very severe somatic symptom).

Illness Anxiety Disorder (IAD, *DSM-5* 300.7) is a follow-up category for the somatoform hypochondriasis in older *DSM* editions. Whereas most patients with hypochondriasis also complained of distressing bodily symptoms and hence will in future qualify for SSD in *DSM-5*, a minority of patients with hypochondriasis only complained of the preoccupation with having a serious illness, without suffering from bodily distress, hence they will now qualify for IAD in *DSM-5*.<sup>14</sup>

Abandoning a strict criterion of “unexplainedness” in SSD has largely been welcomed, not least because of the problematic conceptual and pragmatic problems of judging symptoms as “medically unexplained”.<sup>15</sup> However, the potential overinclusiveness of the “one size fits all” category has raised fears about mislabeling patients with medical illness as having a mental disorder.<sup>16</sup> In

addition, the selection of the positive psychobehavioral criteria has been criticized as arbitrary and not capturing the predictively most relevant psychobehavioral features, such as a self-concept of bodily weakness.<sup>17</sup>

### Classification in ICD and classificatory overlap

In the *ICD-11*, which is due out in 2018, the category of Somatoform Disorder will also be replaced. *ICD-11* will probably introduce a category of Bodily Distress Disorder that very much resembles the central characteristics of SSD in *DSM-5*, with emphasis on distressing bodily symptoms and psychobehavioral features.<sup>18</sup> The term “bodily distress” may better describe the fact that patients indeed suffer from their bodily symptoms, but for some, “distress” implies a difficult to accept psychological component of this primarily bodily condition. In any case, similarity in the content but differences in terminology between *DSM* and *ICD* has to be considered as unfortunate.

Functional somatic syndromes are usually diagnosed in the different medical sections of *ICD*, eg, IBS in the chapter on gastroenterological diseases, FMS in the chapter on rheumatic diseases. For a few functional somatic syndromes, there exist research diagnostic criteria that help to define them more strictly, eg, Rome criteria for IBS or Oxford criteria for chronic fatigue syndrome (CFS). Most diagnoses of functional somatic syndrome include no indication of severity.

Extensive overlap exists between the more specific, lead-symptom-oriented diagnostic perspective of functional somatic syndrome and the more general, symptom-pattern-oriented perspective of somatic symptom/bodily distress disorders. In one study based on diagnostic interviews, 95% of all patients fulfilling criteria for at least one functional somatic syndrome also fulfilled criteria for bodily (dis)stress syndrome as defined by Fink and Schröder.<sup>19</sup> In unselected samples of psychosomatic inpatients, SSD and Somatoform Disorders according to *DSM-IV* criteria appear to identify similar numbers of patients with a degree of overlap of 60% or more, depending on the operationalization of the SSD criteria, in particular the psychobehavioral ones.<sup>20</sup>

### Epidemiology

There is currently no reliable epidemiology on SSD or on IAD. However, there is good reason to assume that

the rate of patients with SSD will definitely be higher in the population, as well as in primary, specialist, and mental health care, than the rates for the narrowly defined multisymptomatic somatoform subcategory of Somatization Disorder. These very low rates of between 0.1% and 0.7% of the population<sup>21</sup> misleadingly contributed to the under recognition of the problem of patients with persistent physical symptoms in general. The requirement for positive psychobehavioral features in SSD will prevent the diagnosis from becoming as frequent and unspecific as the somatoform subcategory of “undifferentiated somatoform disorder.”

Estimates for SSD based on a combination of proxy criteria for distressing symptoms and for the presence of at least one psychobehavioral aspect currently vary between nearly 4% in the population and nearly 25% in a sample of patients with FMS.<sup>14,22</sup>

### Etiology

Early (psychodynamic) models of bodily distress in general often implied a top-down mechanism, ie, psychogenic activations of peripheral physiology, as the major mechanism underlying the experience of enduring bodily symptoms. Models of the last decades predominantly implied bottom-up mechanisms where peripheral input from nociceptive and other sensors was considered as being overly amplified by central or psychosocial factors.<sup>23</sup> Empirical confirmation of this type of model is mixed at best, with aspects like the consistently worsening accuracy of interoception in patients with bodily distress speaking against their unchallenged validity.<sup>23</sup> More recently, a model of bodily distress as a disorder of perception has been gaining ground. In this case, perception is seen as being determined as much by expectations or predictions as by peripheral sensory input—the brain constantly “constructing” its environment, including bodily states. In this model, which is based on a view of the brain as a predictive coding machine, disorders of perception can arise, eg, from failures of inference due to overly precise predictions.<sup>23-25</sup> Such a model has implications for prevention and therapy, as it stresses the direct importance of communicative modifications of expectations and attention for the perception of bodily distress.

Genetic factors contribute to the predisposition to bodily distress, as well as to chronic pain in general, but only to a limited extent, explaining up to 30% of

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the variance.<sup>26,27</sup> Genome-wide investigation and other searches trying to identify single genes responsible for this disposition so far have yielded inconsistent results; epigenetic mechanisms are increasingly seen as also highly relevant.<sup>27</sup> As these mechanisms are clearly shaped by early, often prenatal experiences, they offer a potential mechanistic link to the well-established role that childhood adversities have as a predisposing factor for bodily distress—they raise the odds for the development of bodily distress up to fourfold.<sup>28</sup>

Attachment patterns form another link between childhood adversity and somatization, with maternal insensitivity at 18 months predicting somatization in children aged 5 years and attachment insecurity in adults predicting somatization, with the strongest links existing between attachment anxiety and health anxiety.<sup>29</sup> Another developmentally induced deficiency, in emotion recognition and regulation, has also long been linked to the different facets of bodily distress, with alexithymia as the most prominent concept. Despite worries about the nonspecificity of this deficiency, recent evidence supports the relevance of this link, and psychotherapeutic trials specifically addressing this deficiency in patients with bodily distress are underway.<sup>30</sup> On another level, cultural factors contribute to the predisposition to bodily distress, with some cultures showing that more somatizing tendencies and disability are due to bodily distress independent of individual and group level or health care system factors.<sup>31</sup>

Organic illnesses, stressful work conditions, and adverse life events are important precipitating factors for bodily distress.<sup>32-36</sup> If persisting, these factors and predisposing personality aspects obviously also contribute to the maintenance of the symptoms of bodily distress. Further maintaining factors arise from the often difficult interactions of these patients with the health care system, leading to missed or late correct diagnosis, inappropriate treatments, and frustrations on all sides. Somatizing communication behavior and persistent beliefs about biomedical causations of patients and doctors alike, but also systemic factors of the health care system, contribute to these significant barriers for better diagnosis and treatment.<sup>37,38</sup>

## Diagnosis

In mental health care settings and in psychosomatic and psychiatric consultation liaison services, patients are usu-

ally referred with a suspected (differential) diagnosis of SSD in mind. In such a situation, it is not complicated to ascertain presence or absence of the relevant diagnostic criteria, and the fact that there is no longer a necessity to ascertain bodily symptoms as being organically unexplained makes it easier to arrive at a diagnosis than for a somatoform disorder. Valid self-report questionnaires exist for screening and for aiding in diagnosis; well-known examples are the Patient Health Questionnaire-15 (PHQ-15) for somatic symptom burden<sup>39</sup> and the Whiteley Index for health anxiety.<sup>4</sup> The first self-report instruments to assess the psychobehavioral B-criteria in SSD have also now been published.<sup>41</sup>

Although diagnostic ascertainment is not a major challenge in these contexts, the establishment of a stable doctor-patient relationship as basis for treatment very often remains a difficult initial challenge, see below.

The diagnosis of SSD is more difficult in the context of primary and specialist somatic care, where the common initial assumption of patient and doctor is usually that an underlying organic cause might be found that explains bodily symptoms.

The following recommendations are aimed at primary care physicians and somatic specialists, and also form a basis for interventions by mental health specialists<sup>42,43</sup>:

- For patients with persistent physical symptoms, consider the possibility of SDD as early as possible; do not equate them with malingering.
- Avoid repetitive, especially risky investigations that serve only to calm the patient or yourself.
- Be attentive to clues from the patient indicating bodily or emotional distress beyond the current main symptom and outside your specialist field. Screen for other physical symptoms, anxiety, and depression. Do not miss medication or alcohol misuse, or suicidal ideations.
- Assess the patient's experiences, expectations, functioning, beliefs, and illness behavior, especially with regard to catastrophizing, body checking, avoidance, and dysfunctional health care utilization.
- If SSD is diagnosed, decide whether it is mild, moderate, or severe according to specifiers.

## Treatment—the evidence base

Recent years have seen considerable efforts to aggregate evidence-based recommendations for the management of patients with bodily distress, including several



national guidelines and Cochrane reviews for the overall pattern of symptoms, and many systematic and Cochrane reviews for single functional somatic syndromes. They not only identified the (mostly moderate) effects of various treatments, but also the unmet needs of this large group of patients and the barriers to better diagnosis and treatment.<sup>1,38,44-48</sup>

As mentioned above, bodily distress in general is covered by diagnostic categories like somatoform disorders and now SSD that are mostly used in mental health settings. Unfortunately, for treatment trials, this broader perspective on bodily symptom patterns and psychobehavioral features is applied infrequently; hence, there are only a few trials and systematic reviews covering this treatment perspective. In trials performed under this perspective, primary end points often refer to functioning, eg, in measures of health-related quality of life, and not to symptom intensity. By the very nature of this perspective and its underlying concept, trials and reviews focusing on peripherally acting drugs and passive physical interventions do not exist. For different forms of short-term psychotherapy and self-help interventions, there is consistently low-to-moderate evidence for efficacy, as there is for consultation letters and psychiatric consultations in primary care. There is no evidence for the efficacy of trainings in enhanced care for primary care physicians.

Most trials by far still refer to the treatment of single functional somatic syndromes, without stratification according to a total number of bodily symptoms, comorbidity, or other indicators of severity. In this group, IBS and FMS are the functional syndromes with most trials to report.

In IBS, there is a low level of evidence for the efficacy of antidepressants. Various forms of psychological and activating therapies—from cognitive behavioral therapy (CBT) to hypnotherapy to mindfulness-based therapy and yoga—have demonstrated low-to-moderate efficacy in treating IBS, but none of these reviews report no efficacy, and none report strong effects either.

In FMS, many reviews refer to centrally acting agents, such as antidepressants, pregabalin, or gabapentin. For most of the components in this group, there is only low or no evidence for efficacy. Tricyclic antidepressants still show moderate, and hence better, evidence for efficacy than newer antidepressants or other agents.

There are many reviews on trials on a wide range of activating and psychological therapies, including differ-

ent forms of exercise training and different psychotherapies. For all of these forms of therapy, there is at least low, occasionally moderate, and in two cases, hypnotherapy and multidisciplinary therapy, strong evidence for efficacy.

### Treatment—the practice principles

The principles of treatment described below apply to all levels of care—in the knowledge that these principles are also seen as helpful for mental health professionals.

The diagnostic process in itself, if done well, has therapeutic potential. Good management of this group of patients should avoid the traps of entrenched dualistic “either mental or physical” thinking. The bodily complaints of the patients have to be taken seriously even if no well-defined organic pathology is demonstrated and if no clear cut (other) mental disorder is present. Good communication with the patient is essential at all stages of disease and levels of care, including reassurance, anticipation of likely outcomes of diagnostic tests, positive explanations of the “functional” character of the disorder, and motivation of the patient to actively engage in coping with bodily distress. Encouraging a healthy lifestyle, physical, social, and other activities, such as sleep hygiene, regular exercise, and fulfilling hobbies, is helpful.

In mild cases, these principles of initial basic care can be sufficient, combined with a “watchful waiting” attitude and follow-up contacts. If these principles turn out not to be sufficient, try, in extended basic care, some of the following:

- Introduce context factors as amplifiers rather than causes for the patient’s symptoms. Build an effective, blame-free narrative that is linked to physical as well as psychosocial mechanisms and makes sense to the patient.
- Encourage—and monitor—more functional attitudes and behaviors, such as positive thinking, relaxation techniques, graded exercise, self-help guides, and groups. Set realistic goals together with the patient.
- Provide symptomatic measures such as pain relief or digestives; allow measures from complementary medicine according to patient’s wishes; explain that these measures are temporarily helpful but less effective than self-management.
- Consider antidepressant medication if there is predominant pain or depression.

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- If appropriate, set appointments at regular intervals rather than waiting for them to be patient initiated.

If these measures are still not sufficient, consider the following:

- Ensure that traumatic stressors and maintaining context factors, such as domestic violence, medication misuse, factitious symptoms, or litigation, are assessed.
- If applicable, carefully frame a referral to a psychotherapist in addition to reappointment with you.

If applicable, consult with the psychotherapist on diagnosis, possible difficulties, and further treatment planning.

- When outpatient care is not available or seems insufficient, consider integrated care with multidisciplinary treatment, including symptomatic measures, activating physiotherapy, and occupational therapy, as well as psychotherapy.

Psychotherapy is an established treatment modality in patients with SSD, 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. The following recommendations for these initial phases of psychotherapy aim at building a sustainable therapeutic relationship independent of later differentiations according to pattern of patient problems and school of psychotherapy (adapted and translated from Henningsson and Martin).<sup>49</sup>

- Clarify motivation of the patient for psychotherapeutic consultation. If applicable, confirm to the patient that you acknowledge his/her initial view that the symptoms have an, as yet, undetected organic basis and that he/she may “only” accept the consultation to please others.
- Use measures described above as appropriate.
- Listen attentively to bodily complaints and relationship experiences connected to them (with doctors and other health professionals, with relatives, colleagues, etc). Give feedback on the emotional aspects of these experiences (anger, disappointment, fear, etc).
- In more chronic patients, give support in organizing the history of presenting complaints (and experiences) into a coherent narrative.
- Encourage patients to extend their view of the possible influence of psychosocial, as well as biological context factors, eg, through time-limited use of a symptom-context diary (not recommended for pa-

tients with very high health anxiety). Do not attempt to “reattribute” symptoms to a predominantly psychosocial cause.

- Negotiate realistic (ie, modest) treatment goals. Advocate “better adaptation” and “coping”; avoid “cure” as a treatment goal.
- Resist the temptation to concentrate on psychosocial issues too early and too independently of lead complaints. If necessary, “somatize,” ie, enquire about current bodily symptoms.
- Liaise with others involved in the care of the patient in order to obtain relevant information, especially concerning the necessity of further somatic diagnostic and therapeutic interventions, but also to send the message to the patient that constructive cooperation in caring for him/her is possible.

## Conclusion

The management of patients with SSD and bodily distress works best when not only the patients but also their doctors achieve a reframing of the clinical problem: from cure to care and coping, from classical biomedical explanations to a broader view of biological and psychosocial aggravating and alleviating factors.<sup>50</sup> Importantly, this reframing from cure to care and coping is also necessary for mental health specialists and psychotherapists, as is the switch from classical psychosocial explanations to a broader view of biopsychosocial modulators.

Stepped-care approaches are best suited to deal with the large spectrum of severity in this group of patients, at all levels of care. The treatment evidence still documents only small-to-moderate effect sizes for all types of treatment available for these patients, with advantages for the types of treatment also typically offered by mental health specialists and psychotherapists, ie, activating, patient involving, and centrally acting treatments.

Importantly, knowing how to deal with these seemingly “difficult” patients will increase not only the likelihood for good treatment results for the patient, but also the satisfaction of all health care workers involved with these patients, be they in primary care, specialist somatic care, or mental health care. □

**Disclosure/Acknowledgments:** The author reports no conflict of interest.

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### **Manejo del trastorno de síntomas somáticos**

*Este artículo de revisión entrega una panorámica sobre el manejo del trastorno de síntomas somáticos. Parte con una descripción del problema clínico de pacientes con distrés corporal persistente, discute aspectos de clasificación, epidemiológicos y etiológicos y luego describe la evidencia y principios prácticos de la relación con estos pacientes, quienes a menudo son considerados de "difícil" tratamiento. Se concluye que el abordaje más adecuado es el tratamiento escalonado con la cooperación estrecha entre la atención primaria, un especialista somático y profesionales de salud mental que funcionen en base al modelo biopsicosocial, con integración de los determinantes somáticos y psicosociales de los factores de distrés y terapéuticos.*

### **Prise en charge des troubles à symptomatologie somatique**

*Cet article donne un aperçu de la prise en charge des troubles à symptomatologie somatique. Il commence par une description du problème clinique des patients ayant une souffrance corporelle persistante, analyse les problèmes de classification, épidémiologiques et étiologiques et expose ensuite les données et les principes pratiques de gestion de ces patients souvent vus comme « difficiles » à traiter. En conclusion, une approche étape par étape semble la meilleure, avec une coopération proche des soins primaires, des spécialistes somatiques et des professionnels de santé mentale agissant sur la base d'un modèle biopsychosocial intégrant des déterminants somatiques et psychosociaux des facteurs thérapeutiques et de souffrance.*