ACLP How To Guide: Somatic Symptom Disorder

How to Diagnose and Manage Somatic Symptom Disorder

Learning Objectives

1) Describe Somatic Symptom Disorder (SSD).
2) Understand diagnostic criteria and key signs of SSD to help differentiate it from similar disorders.
3) Learn how to manage therapeutic relationships with patients with SSD while managing their symptoms.

Step 1: What is Somatic Symptom Disorder?

- Somatic Symptom Disorder (SSD) is a collection of signs and symptoms (i.e., a clinical syndrome) in a patient who struggles with not only somatic symptoms but also consequent thoughts, feelings, and behavioral manifestations that are out of proportion to the symptoms they are experiencing (1).
- To make a diagnosis of Somatic Symptom Disorder, the following must be present (2):
    - One or more somatic symptoms that are distressing or cause significant disruption in one's life (Criteria A).
    - One or more of the following: persistent, disproportionate thoughts regarding one's somatic symptom; persistent high level of anxiety regarding symptoms; OR excessive time and energy spent addressing these symptoms (Criteria B).
    - The above criteria must be present for at least 6 months. At least one somatic symptom must be present for a 6-month period, which may or may not be the same symptom throughout this time (Criteria C).
    - Specifiers should be applied to the diagnosis of Somatic Symptom Disorder if the appropriate condition is met:
        - <u>With predominant pain</u> – this should be added to the diagnosis when the somatic symptom is primarily pain.
        - <u>Persistent</u> – should be added if a specific somatic symptom lasts longer than 6 months.
        - <u>Severity</u> – is applied to describe the number of Criteria B symptoms present. Mild should be applied to the diagnosis if there is only one symptom, moderate if two symptoms are present, or severe if three symptoms are present.
- The somatic symptom(s) can vary widely and, while required to make the diagnosis, are not a crucial part of management once the diagnosis is made. The abnormal thoughts and feelings in response to the somatic symptom cause a significant impact on the patient's life and these should be the focus of management (3).
- This diagnosis replaces an older classification, called Somatization Disorder, which focused on numerous unrelated or decentralized symptoms that were present across different systems in the body. SSD replaced Somatization Disorder in 2013 when the DSM-5 was published, shifting the focus of the diagnosis towards the response to the somatic symptoms rather than the symptoms experienced by the person (2).

Bennis Pavisian MD, Samuel I Kohrman MD, Patrick A Ho MD MPH, James K Rustad MD, Residency Education Subcommittee.
Vers. 9/15/2024

ACADEMY OF CONSULTATION-LIAISON PSYCHIATRY

Step 2: Differentiating SSD from related disorders

- Research has shown that the impetus for SSD is anxiety. This can be used as a differentiating factor from related disorders (see Table 1). Patients become anxious regarding symptoms with excessive rumination regarding bodily sensations and repeated behaviors to address and relieve this anxiety (4).
- If there is no evidence that the patient's reaction to their symptoms is causing significant stress or disruption in their life, then you may be able to rule out SSD. However, if thoughts and behaviors conflict with recovery, SSD should remain on the differential.
- Risk factors such as female sex, older age (>50), fewer years of education, lower socioeconomic status, significant illness/injury in childhood, or childhood trauma could significantly increase risk of SSD later in life. Personality traits such as catastrophic thinking, negative affectivity, and avoidant or self-defeating personality also raise the risk of SSD (1).
- It is imperative to keep cultural-specific meaning of somatic symptoms in the differential when treating a diverse patient population. There are several cultures with stigma revolving around mental health. Symptoms of depression and anxiety can manifest with somatic complaints in these populations. Identifying and treating the underlying cause is critical and may resolve the patient's somatic complaints (3).
    - In the African American (AA) population, it was found that anxiety can manifest as somatic symptoms secondary to experiences with racial discrimination (5), with more than ~80% of AA women and ~70% of AA men who met criteria for diagnosis of SSD in one large study (6).
    - Latino and Asian Americans may exhibit more somatic symptoms of depression and anxiety than their European counterparts (7).
    - There is limited data on SSD in gender minorities and the LGBTQ+ community (8), however, there has been a link between gender-affirming care and improvement in SSD symptoms (9).

Table 1: Differentiating between SSD and related disorders (2).

	Core feature	**Differentiation from SSD**
Somatic Symptom Disorder	Significant anxiety revolved around somatic symptoms that affect daily life significantly.	___
Illness anxiety disorder	Significant anxiety regarding potential somatic symptoms.	There is no somatic symptom present
Functional neurological symptom disorder*	Loss of function, usually of limbs, with no evidence of neurological cause.	Anxiety is not usually associated in presentation and distress is much lower
Factitious disorder OR Malingering	Presentation involves evidence of self-induced injury or falsified physical symptoms.	SSD is not self-induced, and patients suffer greatly when symptoms are present
Obsessive-Compulsive disorder*	Patients usually present with obsessions or compulsions that appear as repetitive behaviors to alleviate anxiety.	In SSD, thoughts are less intrusive and do not include compulsions.
Delusional disorder, somatic type*	Delusions of somatic symptoms are intense and firmly held, usually are easily ruled out with imaging or testing.	Patients with SSD do not have as firmly held beliefs as those with delusional disorder

*** may co-exist with Somatic Symptom Disorder**

Bennis Pavisian MD, Samuel I Kohrman MD, Patrick A Ho MD MPH, James K Rustad MD, Residency Education Subcommittee.
Vers. 9/15/2024

Step 3: Assessment of SSD

- It is important to recognize the signs of SSD as early as possible to make the diagnosis and start the appropriate management for several reasons, including;
    - People with SSD have an increased risk of suicidal thoughts and attempts (10)**.**
    - People with SSD often feel ignored or marginalized by the healthcare system as they perceive their complaints are not taken seriously (11)**.**
    - There is often over utilization of healthcare resources to rule out medical etiologies of symptoms, even in the setting of known SSD (11)**.**
- A thorough history and physical is critical to rule out other etiologies of anxiety such as substance use, trauma, significant changes in life circumstances, stressors, psychiatric and social history.
- Can use several validated rating scales including the Somatic Symptom Scale-8 (SSS-8) or Somatic Symptom Disorder B-Criteria Scale (SSD-12), particularly to assess severity of symptoms (12).
- Negative results on imaging studies and laboratory tests to rule out medical illness are not usually reassuring to patients with SSD when their overall risk is low for a given illness or disease. In fact, this can be detrimental as research suggests referrals to specialists and extensive work-up resulting in negative findings can further cement the patient's belief that their symptoms are going undiagnosed (3).

Step 4: Management of SSD

- When SSD is suspected, it is critical to foster a positive therapeutic alliance and use proper communication techniques (3).
    - Discussing SSD after an appropriate screening/work up for concerning symptoms is complete is important to show the patient they are not being ignored. If the diagnosis of SSD is discussed prior to work-up, this could be detrimental to the therapeutic alliance. Reassurance that the symptoms are not life-threatening is also important to address anxiety about symptoms.
    - Be clear and concise, framing the diagnosis as a shortfall of medical understanding, rather than blaming the patient or minimizing their distress. It may also be helpful to the patient to make measurable outcomes clear (e.g., reducing pain level).
    - It may be beneficial for the patient to hear neurological or anatomic etiologies of how stress and mind-body connection can explain their symptoms (e.g., HPA axis).
- There is no established standard of care for SSD. The goal of management is to improve functioning by alleviating anxiety regarding symptoms, and an approach is described in this review (13). Kathol argues for a six-step approach to reassurance: question and examine the patient in detail, assure the patient that serious illness is not present, suggest the symptom will resolve, encourage the patient to return to normal activity, consider non-specific treatment, and follow the patient (14).
- Symptomatic relief can be helpful for patient comfort and therapeutic alliance. (e.g., beta-blocker for palpitations, anti-emetic for nausea, etc.). Care should be taken when using pharmacological agents in treatment for patients with SSD because of the potential increase of sensitivity to side effects (3,13).

- Psychodynamic or CBT referral for those with a positive history of trauma or psychological factors not addressed. If referring to mental health, including frequent follow-ups with PCP will help the patient understand a holistic approach is being taken and their physical symptoms are not being ignored (13): scheduling regular visits rather than making appointments dependent on symptoms may be important
- Care and compassion should be at the forefront of communication with patients who have SSD. While the somatic symptoms are usually not life-threatening, the suffering that is experienced by these patients' anxiety is genuine and significantly impacts daily life.
- It is critically important to assertively treat comorbid psychiatric conditions. Common comorbidities include depression, anxiety, OCD, and PTSD (2).

References

1. Smakowski AL, Hüsing P, Völcker S, Löwe B, Rosmalen JG, Shedden-Mora M, et al. Psychological risk factors of Somatic Symptom Disorder: A systematic review and meta-analysis of cross-sectional and longitudinal studies. *Journal of Psychosomatic Research*. 2024;181:111608.

2. American Psychiatric Association, editor. *Diagnostic and statistical manual of mental disorders: DSM-5-TR*. Fifth edition, text revision. Washington, DC: American Psychiatric Association Publishing; 2022. 1050 p.

3. Tuttle MC, Ciampa DJ, Godena E, Kim BK, Sakmar KA, Vanwort-Meng L, et al. The Evaluation and Treatment of Somatic Symptom Disorder in Primary Care Practices. *The Primary Care Companion for CNS Disorders*. 2024;26(1):23f03549.

4. Dunphy L, Penna M, Jihene EK. Somatic Symptom Disorder: a diagnostic dilemma. *BMJ Case Reports CP*. 2019;12(11):e231550.

5. Behbahani SM, Greenstone RM. Assessing Somatoform Disorders with the African American Client. In: *Guide to Psychological Assessment with African Americans*, LT Benuto • BD Leany, eds. 2015;261–73.

6. Cénat JM, Kouamou LN, Farahi SMMM, Darius WP, Dalexis RD, Charles M, et al. Perceived racial discrimination, psychosomatic symptoms, and resilience among Black individuals in Canada: A moderated mediation model. *Journal of Psychosomatic Research*. 2022;163:111053.

7. Kline CL, Shamshair S, Kullgren KA, Leber SM, Malas N. A review of the impact of sociodemographic factors on the assessment and management of pediatric somatic symptom and related disorders. *Journal of the Academy of Consultation-Liaison Psychiatry*. 2023;64(1):58–64.

8. Löwe B, Levenson J, Depping M, Hüsing P, Kohlmann S, Lehmann M, et al. Somatic Symptom Disorder: a scoping review on the empirical evidence of a new diagnosis. *Psychological Medicine*. 2022;52(4):632–48.

9. Lerario MP, Fusunyan M, Stave CD, Roldán V, Keuroghlian AS, Turban J, et al. Functional neurological disorder and functional somatic syndromes among sexual and gender minority people: A scoping review. *Journal of Psychosomatic Research*. 2023;174:111491.

10. Torres ME, Löwe B, Schmitz S, Pienta JN, Van Der Feltz-Cornelis C, Fiedorowicz JG. Suicide and suicidality in somatic symptom and related disorders: A systematic review. *Journal of Psychosomatic Research*. 2021;140:110290.

11. Kop WJ, Toussaint A, Mols F, Löwe B. Somatic Symptom Disorder in the general population: associations with medical status and health care utilization using the SSD-12. *General Hospital Psychiatry*. 2019;56:36–41.

12. Toussaint A, Hüsing P, Kohlmann S, Löwe B. Detecting DSM-5 Somatic Symptom Disorder: criterion validity of the Patient Health Questionnaire-15 (PHQ-15) and the Somatic Symptom Scale-8 (SSS-8) in combination with the Somatic Symptom Disorder–B Criteria Scale (SSD-12). *Psychological Medicine*. 2020;50(2):324–33.

13. Henningsen P. Management of Somatic Symptom Disorder. *Dialogues in Clinical Neuroscience*. 2018;20(1):23–31.

13. Kathol RG. Reassurance Therapy: What to Say to Symptomatic Patients with Benign or Non-Existent Medical Disease. *The International Journal of Psychiatry in Medicine.* 1997;27(2):173-180.