American Psychiatric Association
Division of Research

Highlights of Changes from DSM-IV to DSM-5

Somatic Symptom and Related Disorders

Abstract: In DSM-5, somatoform disorders are now referred to as somatic symptom and related disorders. In DSM-IV, there was significant overlap across the somatoform disorders and a lack of clarity about their boundaries. These disorders are primarily seen in medical settings, and nonpsychiatric physicians found the DSM-IV somatoform diagnoses problematic to use. The DSM-5 classification reduces the number of these disorders and subcategories to avoid problematic overlap. Diagnoses of somatization disorder, hypochondriasis, pain disorder, and undifferentiated somatoform disorder have been removed.

Somatic symptom disorder

DSM-5 better recognizes the complexity of the interface between psychiatry and medicine. Individuals with somatic symptoms plus abnormal thoughts, feelings, and behaviors *may or may not* have a diagnosed medical condition. The relationship between somatic symptoms and psychopathology exists along a spectrum, and the arbitrarily high symptom count required for DSM-IV somatization disorder did not accommodate this spectrum. The diagnosis of somatization disorder was essentially based on a long and complex symptom count of medically unexplained symptoms. Individuals previously diagnosed with somatization disorder will usually meet DSM-5 criteria for somatic symptom disorder (Table 1), but only if they have the maladaptive thoughts, feelings, and behaviors that define the disorder, in addition to their somatic symptoms.

In DSM-IV, the diagnosis undifferentiated somatoform disorder had been created in recognition that somatization disorder would only describe a small minority of "somatizing" individuals, but this disorder did not prove to be a useful clinical diagnosis. Because the distinction between somatization disorder and undifferentiated somatoform disorder was arbitrary, they are merged in DSM-5 under somatic symptom disorder, and no specific number of somatic symptoms is required.

Medically unexplained symptoms

DSM-IV criteria overemphasized the importance of an absence of a medical explanation for the somatic symptoms. Unexplained symptoms are present to various degrees, particularly in conversion disorder, but somatic symptom and related disorders can also accompany diagnosed medical disorders. The reliability of medically unexplained symptoms is limited, and grounding a diagnosis on the absence of an explanation is problematic and reinforces mind-body dualism. The DSM-5 classification defines disorders on the basis of positive symptoms (i.e., distressing somatic symptoms plus abnormal thoughts, feelings, and behaviors in response to these symptoms). Medically unexplained symptoms do remain a key feature in conversion disorder and pseudocyesis because it is possible to demonstrate definitively in such disorders that the symptoms are not consistent with medical pathophysiology.

Table 1. DSM-5 Criteria for Somatic Symptom Disorder 300.82 (F45.1)[a]

A. One or more somatic symptoms that are distressing or result in significant disruption of daily life.
B. Excessive thoughts, feelings, or behaviors related to the somatic symptoms or associated health concerns as manifested by at least one of the following:
1. Disproportionate and persistent thoughts about the seriousness of one's symptoms.
2. Persistently high level of anxiety about health or symptoms.
3. Excessive time and energy devoted to these symptoms or health concerns.
C. Although any one somatic symptom may not be continuously present, the state of being symptomatic is persistent (typically more than 6 months).
Specify if:
• **With predominant pain** (previously pain disorder): This specifier is for individuals whose somatic symptoms predominantly involve pain.
Specify if:
• **Persistent:** A persistent course is characterized by severe symptoms, marked impairment, and long duration (more than 6 months).
Specify current severity:
• **Mild:** Only one of the symptoms specified in Criterion B is fulfilled.
• **Moderate:** Two or more of the symptoms specified in Criterion B are fulfilled.
• **Severe:** Two or more of the symptoms specified in Criterion B are fulfilled, plus there are multiple somatic complaints (or one very severe somatic symptom).

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Hypochondriasis and illness anxiety disorder

Hypochondriasis has been eliminated as a disorder, in part because the name was perceived as pejorative and not conducive to an effective therapeutic relationship. Most individuals who would previously have been diagnosed with hypochondriasis have significant somatic symptoms in addition to their high health anxiety, and would now receive a DSM-5 diagnosis of somatic symptom disorder. In DSM-5, individuals with high health anxiety without somatic symptoms would receive a diagnosis of illness anxiety disorder (unless their health anxiety was better explained by a primary anxiety disorder, such as generalized anxiety disorder).

Pain disorder

DSM-5 takes a different approach to the important clinical realm of individuals with pain. In DSM-IV, the pain disorder diagnoses assume that some pains are associated solely with psychological factors, some with medical diseases or injuries, and some with both. There is a lack of evidence that such distinctions can be made with reliability and validity, and a large body of research has demonstrated that psychological factors influence all forms of pain. Most individuals with chronic pain attribute their pain to a combination of factors, including somatic, psychological, and environmental influences. In DSM-5, some individuals with chronic pain would be appropriately diagnosed as having somatic symptom disorder, with predominant pain. For others, psychological factors affecting other medical conditions or an adjustment disorder would be more appropriate.

Psychological factors affecting other medical conditions and factitious disorder

Psychological factors affecting other medical conditions is a new mental disorder in DSM-5 (Table 2), having formerly been included in the DSM-IV chapter "Other Conditions That May Be a Focus of Clinical Attention." This disorder and factitious disorder are placed among the somatic symptom and related disorders because somatic symptoms are predominant in both disorders, and both are most often encountered in medical settings. The variants of psychological factors affecting other medical conditions are removed in favor of the stem diagnosis.

Conversion disorder (functional neurological symptom disorder)

Criteria for conversion disorder (functional neurological symptom disorder) are modified to emphasize the essential importance of the neurological examination, and in recognition that relevant psychological factors may not be demonstrable at the time of diagnosis.

Table 2. Psychological Factors Affecting Other Medical Conditions 316 (F54)[a]

A. A medical symptom or condition (other than a mental disorder) is present.
B. Psychological or behavioral factors adversely affect the medical condition in one of the following ways:
1. The factors have influenced the course of the medical condition as shown by a close temporal association between the psychological factors and the development or exacerbation of, or delayed recovery from, the medical condition.
2. The factors interfere with the treatment of the medical condition (e.g., poor adherence).
3. The factors constitute additional well-established health risks for the individual.
4. The factors influence the underlying pathophysiology, precipitating or exacerbating symptoms or necessitating medical attention.
C. The psychological and behavioral factors in Criterion B are not better explained by another mental disorder (e.g., panic disorder, major depressive disorder, posttraumatic stress disorder).
Specify current severity:
• **Mild:** Increases medical risk (e.g., inconsistent adherence with antihypertension treatment).
• **Moderate:** Aggravates underlying medical condition (e.g., anxiety aggravating asthma).
• **Severe:** Results in medical hospitalization or emergency room visit.
• **Extreme:** Results in severe, life-threatening risk (e.g., ignoring heart attack symptoms).

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PROMOTING HOLISTIC CARE

The well-tested DSM-5 criteria for somatic symptom disorder remove overlap and confusion from previous editions and encourage comprehensive assessment of patients for accurate diagnoses and holistic care.

The DSM-IV criteria included a large number of disorders that overlapped and made it difficult for primary care providers to effectively isolate the problem plaguing their patients. Because those diagnosed with somatic symptom disorder are primarily seen in general medical settings as opposed to psychiatric settings, the criteria in DSM-5 clarify confusing terms and reduce the number of disorders and subcategories, making the criteria more useful to nonpsychiatric care providers. To ensure that the new criteria would indeed help clinicians better identify individuals who need care, scientists tested the somatic symptom disorder criteria in actual clinical practices during the DSM-5 Field Trials. Somatic symptom disorder's diagnostic reliability performed very well in these field tests.

Comprehensive assessment of patients requires the recognition that psychiatric problems often cooccur in patients with medical problems. While DSM-IV was organized centrally around the concept of medically unexplained symptoms, DSM-5 criteria instead emphasize the degree to which a patient's thoughts, feelings, and behaviors about their somatic symptoms are disproportionate or excessive. The new narrative text for somatic symptom disorder notes that some patients with physical conditions, such as heart disease or cancer, will indeed experience disproportionate and excessive thoughts, feelings, and behaviors related to their illness, and that these individuals may qualify for a diagnosis of somatic symptom disorder. This in turn may enable them to access treatment for these symptoms. In this sense, somatic symptom disorder is like depression; it can occur in the context of a serious medical illness. However, diagnosis of somatic symptom disorder still requires clinical training, experience, and judgment based on guidance such as that contained in the DSM-5 text to ensure proper recognition of when a patient's thoughts, feelings, and behaviors are indicative of a mental disorder that can benefit from focused treatment.

This change in emphasis removes the mind-body separation implied in DSM-IV and encourages clinicians to make a comprehensive assessment and use clinical judgment rather than a check list that may arbitrarily disqualify many people who are living with both somatic symptom disorder and another medical diagnosis from getting the help they need.