JEFFREY STAAB: Well, hello. I'm Dr. Jeffrey Staab from the Department of Psychiatry and Psychology at the Mayo Clinic in Rochester, Minnesota. And I'm here today to talk with you about somatic symptom disorders. So this is going to be the first of three connected talks on the somatic symptom disorders, looking at the new terminology that has come up in DSM-5 and the new concepts behind these disorders. I don't have any financial conflicts of interest. But I do want to thank the people that I work with here, my fellow psychologists and psychiatrists, our nurses, therapists, and our trainees. And a special thanks to the patients, who teach us as much as we teach them.

So we have a few goals for this presentation and the two that follow. We want to introduce the DSM-5 somatic symptoms disorders. This is a part of the manual that changed quite a bit from the DSM-IV. We also want to talk not just about the terminology, but about the concepts behind it. Talk a little bit more about diagnostic approaches, particularly for identifying functional disorders, illness anxiety, and somatic symptom disorder.

And also talk about treatment options, particularly how these changes really do alter the role that psychiatrists and psychologists can play in managing patients who have enigmatic physical symptoms. And then we'll review some specific treatment options that have been developed in the last few years.

So we want to start with the 20th century. And there was an important concept that developed in the latter half of the 20th century that really did move us forward, but also, if we don't move beyond that, could hold us back as we move into the years of the 21st century. So one of the core concepts was this idea of MUPS equals SAD. And what that means is medically unexplained physical symptoms are caused by somatization, anxiety, and depression. And this was a work of Kurt Kroenke and others who really showed that this overlapping triad of somatization, anxiety, and depression was responsible for a lot of the presentation of patients who would have symptoms that really didn't yield much to medical evaluations in primary care settings.

And so that was a nice way of introducing depression and anxiety into the differential diagnosis of the care of patients in primary care, and it also improved our ability to treat patients in consultation liaison psychiatry in the hospital. But it has had a consequence that we do need to move beyond, and that is that this sort of became a stress, anxiety, depression triad and mix, and there was not much differentiation.

So a lot of times patients were told that their symptoms were stress-related without details behind it in a way that could turn into a management strategy for them. And so while this concept was very important in introducing mood, anxiety, and somatic symptom problems into primary care and consultation liaison psychiatry, it also could potentially be an impediment to us if we don't move a bit beyond it, take the next steps now into the 21st century.

So here is our lineup in DSM-IV. So until May of 2013, when the DSM-5 came out, this was the section of somatic symptom disorders, or somatoform disorders, as it was called then. And so the name changed. And the name change not just to have a nice new term, but because we really did want to move the concept away from the presentation of an illness that looked sort of somatic but wasn't, to something that we could define by what it was.

And so in doing so, the first group of disorders on the list disappeared; they're no longer present in the DSM system. And that's because they're all based on the concept of medically unexplained physical symptoms. And that concept is partially-- not completely, but largely-- been eliminated from this somatic symptoms section of the manual. And we'll talk a little bit more about why that is in the subsequent talks.

There were some other changes that occurred too. Hypochondriasis was given the name of illness anxiety disorder. Again, not just a terminology change but a conceptual one. And conversion disorder, there were some back and forth between whether or not the term should be dropped in favor of functional neurologic symptoms, but in the end both were retained. So conversion disorder or functional neurologic symptom disorder.

There were some minor changes made in psychological factors in factitious disorder. And so this is the DSM-5 lineup, somatic symptom disorder with a pain subtype, illness anxiety disorder, and conversion or functional neurologic symptom disorder, along with a streamlined definition of psychological factors; factitious and the NOS categories were largely unchanged.

One important thing is that in the DSM-IV, all of these disorders were defined by what they weren't; namely, a person has physical symptoms but doesn't have a medical illness that explains it, and therefore they have a psychiatric disorder. So they were defined negatively by what they were not, rather than positively by what they were. And so the DSM-5 has really emphasized a couple of core disorders and identified the core features that we can determine by their presence as opposed to simply the absence of a medical explanation.

So the first of the disorders is somatic symptom disorder. And this is a focus of one or more physical symptoms that the patient finds distressing and functionally impairing. And that those-- that that distress, the amount of time and effort that the patient spends in thinking about and responding to their symptoms, is out of proportion to the kinds of medical problems that would produce those symptoms. Or, for that matter, psychiatric problems that would produce those symptoms. So the essential feature here is that the person is burdened by one or more physical symptoms. That those symptoms create a level of impairment that is both distressing and functionally impairing to the individual.

The second core disorder is illness anxiety disorder. A broader concept than hypochondriasis was in the DSM-IV. And here the essential feature is a persistent, excessive thoughts and feelings about having some sort of a physical illness. Also that the person is not easily reassured by negative evaluations. And there may not necessarily be many physical symptoms. So unlike somatic symptom disorder, in which there can be many physical symptoms that burden the patients, here it's the worry even about one symptom, that's the core feature. So the essential feature here is that preoccupation or fear about being ill.

Another really important concept here is that these two, or either one of them, can be present with or without a medical diagnosis. So we don't make these disorders just because a medical diagnosis isn't made, because someone could have illness anxiety and cancer, or could have illness anxiety with fears about cancer, but no evidence whatsoever of a malignancy. So there's not this either-or idea. That really wasn't truly part of DSM-IV, but in practice usually became that way.

OK. Conversion disorder also has a little bit of a change. Now this has been an evolution from DSM-III, to IV, to 5. But here we would have one or more symptoms of altered motor or sensory function. And this is where medically unexplained isn't completely gone; here we would say that those symptoms are not compatible with what we know about neurologic physiology or anatomy.

So the essential feature here is really that functional pattern of sensory or motor symptoms. There's still-- that incompatibility issue is retained. But an important feature that was that's not here is this idea that we have to find a psychological conflict or presumed trauma underlying the disorders. It's really the presence of the motor changes or the presence of the sensory systems themselves, and not their speculated or connection with past or present psychological difficulties that makes the diagnosis. And again, this can be present with or without other medical diagnoses. So someone can have, for example, epilepsy and a non-epileptic behavioral spell.

Now the writers of the ICD-11, which is now underway by the World Health Organization, are also making changes in this area. And there are some comparisons but also some differences that haven't yet been sorted out. So the diagnosis of somatic symptom disorder translates to the proposal for something called bodily distress disorder in the ICD-11. Illness anxiety was initially going to be part of the ICD-11, but it looks like the writers have sort of returned back to hypochondriasis as the diagnosis there. And then conversion disorder, interestingly, shows up in two places in the ICD-11 proposal. One in the neurologic disorders section-- which would be functional nervous system disorders-- and one in the psychiatric disorders section-- which are now called dissociative, as they were in ICD-10, or as they are in ICD-10.

So in conclusion about these changes in nomenclature and concepts, the move to somatic symptom disorders is really the next step in defining these disorders that manifest primarily with physical symptoms, and burden and preoccupation associated with them. The goal here is to define them positively-- and that's mostly been accomplished-- not negatively simply by what they're not.

So we're looking, as we do and other disorders, for an identifiable pattern of symptoms, not specifically just the absence of medical co-morbidity or morbidity. And we don't necessarily have to identify a psychological conflict that we presume is connected to those disorders. If it's there, fine, but it's not a necessary part of the diagnostic criteria. And this is the next step beyond the successes that we had with the SAD triad in the 20th century. There are comparable but not entirely identical, a change is occurring in the ICD-11 by the World Health Organization. Thank you all very much.