Clinics in Dermatology (2017) **35**, 246–251

ELSEVIER

Clinics in Dermatology

Somatic symptom disorder in dermatology

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Abstract Somatic symptom disorder (SSD) is defined by the prominence of somatic symptoms associated with abnormal thoughts, feelings, and behaviors related to the symptoms, resulting in significant distress and impairment. Individuals with these disorders are more commonly encountered in primary care and other medical settings, including dermatology practice, than in psychiatric and other mental health settings. What defines the thoughts, feelings, and behaviors as abnormal is that they are excessive, that is, out of proportion to other patients with similar somatic symptoms, and that they result in significant distress and impairment. SSD may occur with or without the presence of a diagnosable dermatologic disorder. When a dermatologic disorder is present, SSD should be considered when the patient is worrying too much about his or her skin, spending too much time and energy on it, and especially if the patient complains of many nondermatologic symptoms in addition. The differential diagnosis includes other psychiatric disorders, including depression, anxiety disorders, delusions of parasitosis, and body dysmorphic disorder.

This paper describes SSD and its applicability in dermatologic practice, with illustrative cases.

Somatic symptom disorder

The distinguishing characteristic of somatic symptom disorder (SSD) lies in the way the patient presents, interprets, and responds to the symptoms rather than to the somatic symptoms themselves. As a result, the diagnostic criteria for SSD include disproportionate emotional, cognitive, and behavioral manifestations, key to defining the disorders.[1–4]

The creation of SSD is due to the changes that occurred from DSM-IV to DSM-5.[1,2] In DSM-IV, psychiatric conditions primarily presenting in medical settings with physical symptoms were grouped together as the "somatoform disorders," which included somatization disorder, hypochondriasis, pain disorders, and conversion disorder. The authors of DSM-5 recognized the overlap between the somatoform disorders and a lack of clarity about the boundaries of these DSM-IV diagnoses. DSM-5 sought to reduce the total number of disorders, as well as their subcategories, to make diagnosis more straightforward for nonpsychiatric physicians encountering patients with these symptoms. Patients who previously would have been found to have somatization disorder and most of those with hypochondriasis or pain disorders now have the new diagnosis of SSD.

The change is not just semantic but conceptual. Previous (DSM-III, DSM-IIIR, and DSM-IV) criteria emphasized the centrality of medically unexplained symptoms in diagnosing somatoform disorders. DSM-5 removed this requirement for several reasons. The reliability of determining that a somatic symptom is medically unexplained is limited, and grounding a diagnosis in the absence of an explanation is problematic and reinforces mind-body dualism. A mental disorder diagnosis should not be made solely, because a medical cause for

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http://dx.doi.org/10.1016/j.clindermatol.2017.01.010
0738-081X/

Table 1 Diagnostic criteria for somatic symptom disorder

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:

a. Disproportionate and persistent thoughts about the seriousness of one's symptoms
b. Persistently high level of anxiety about health or symptoms
c. 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).

physical signs and symptoms cannot be shown. In addition, the presence of a medical diagnosis does not exclude the possibility of a comorbid mental disorder. A psychiatric diagnosis should be based primarily on the presence of abnormal psychologic symptoms and signs.

The new (DSM-5)[1] classification defines the major diagnosis of SSD on the basis of positive symptoms, namely, distressing somatic symptoms *plus* abnormal thoughts, feelings, and behaviors in response to these symptoms, rather than an absence of a medical explanation for the somatic symptoms. What defines the thoughts, feelings, and behaviors as abnormal is that they are excessive, that is, out of proportion to other patients with similar somatic symptoms, and that they result in significant distress and impairment.

Some mental disorders, including major depressive disorder or panic disorder, may initially manifest with primarily somatic symptoms. Such diagnoses may account for the somatic symptoms, or they may be comorbid with one of the somatic symptom and related disorders. The somatic component adds severity and complexity to depressive and anxiety disorders and results in higher severity, functional impairment, and even refractoriness to traditional treatments. The criteria for SSD are shown in Table 1. The prevalence of SSD is unknown, but in the general adult population it may be around 5-7%. Women tend to report more somatic symptoms.

Several factors contribute to somatic symptom and related disorders, including genetic and biologic vulnerability, early traumatic experiences, and learning, as well as cultural/social norms that devalue and stigmatize psychologic suffering compared with physical suffering. Variations in symptom presentation are often due to the interaction of many factors within cultural contexts that influence how a person may identify or classify sensation, interpret illness, and seek medical help. SSD occurs across the age spectrum.[5]

The core features of SSD are multiple somatic symptoms (or one severe symptom) that are distressing and result in significant impairment: Worrying too much about the somatic symptoms, plus spending too much time and energy on them. In dermatology practice, the somatic symptoms may be entirely focused on the skin, with pruritus or pain being most common, or the cutaneous symptoms may accompany other symptoms, such as headache, back pain, fatigue, gastrointestinal symptoms, chest pain, shortness of breath, and paresthesias.

In addition to multiple symptoms, SSD patients often present vague and inconsistent histories expressing dissatisfaction with previous care received. They are often viewed as "difficult patients." The symptoms and related concerns often dominate the patient's life, and psychosocial functioning declines. Many patients engage in excessive self-monitoring to reassure themselves, for example, checking their skin frequently or repeatedly measuring blood pressure and pulse. Patients with SSD often seek remedies through complementary/alternative practitioners, and consume vitamins, over-the-counter remedies, and fad diets. Many patients devote excessive amounts of time on the Internet reading about medical diseases and treatments.

SSD can occur with or without a general medical illness that can "explain" their somatic symptoms. When such an illness is present (eg, psoriasis), SSD can be diagnosed when the patient's cognitive-emotional-behavioral response to the skin disease is clearly excessive compared with most other patients with that same skin disorder of similar severity. Patients with