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For Medical Professionals

DSM-5 redefines hypochondriasis

The newly approved Diagnostic and Statistical Manual of Mental Disorders (DSM-5) contains many revisions, but few are as sweeping as those involving somatoform disorders. In the updated edition, hypochondriasis and several related conditions have been replaced by two new, empirically derived concepts: somatic symptom disorder and illness anxiety disorder. They differ markedly from the somatoform disorders in DSM-IV.

To meet the criteria for somatic symptom disorder, patients must have one or more chronic somatic symptoms about which they are excessively concerned, preoccupied or fearful. These fears and behaviors cause significant distress and dysfunction, and although patients may make frequent use of health care services, they are rarely reassured and often feel their medical care has been inadequate.

Patients with illness anxiety disorder may or may not have a medical condition but have heightened bodily sensations, are intensely anxious about the possibility of an undiagnosed illness, or devote excessive time and energy to health concerns, often obsessively researching them. Like people with somatic symptom disorder, they are not easily reassured. Illness anxiety disorder can cause considerable distress and life disruption, even at moderate levels.

Freeing patients and doctors

The new classifications have been criticized as overly broad and likely to lead to increased mental health diagnoses in the medically ill. But Jeffrey P. Staab, M.D., of Mayo Clinic in Minnesota, who participated in the somatic symptom disorder field trials, argues that the opposite is the case.

"People who have reasonable health concerns will not get the diagnosis," he says. "By eliminating the concept of medically unexplained symptoms, the DSM-5 criteria prevent the

easy assumption of a psychiatric diagnosis in patients who present with medical symptoms of unclear etiology."

He points out that thousands of patients were diagnosed with stress ulcers before the discovery of Helicobacter pylori. "There are many examples of false assumptions because we couldn't identify a medical problem. Now, the whole concept of medically unexplained symptoms is gone. This is a profoundly fundamental change."

Dr. Staab adds that it is a change welcomed by patients. "Health anxiety and body vigilance are much more understandable to patients when they realize they can have these things despite what their medical doctor finds. During the field trials, we found it much easier to engage patients if we identified what the problem was instead of what it was not," he says.

He argues that the new constructs are liberating for physicians, too. "Under the old scheme, we never knew if we had done enough. When we couldn't find the cause of certain symptoms, there was always the fear that we simply hadn't searched long enough or hard enough. Now we can acknowledge that a patient's preoccupation with physical symptoms is higher than normal, whether there is a diagnosis or not. It is one of the biggest changes in talking with patients with a set of psychiatric problems in 25 years."

The change has been long in coming, Dr. Staab says. "It has taken two decades of research to redefine hypochondriasis. This is not just something people came up with. But now we can identify these symptoms in a positive way and can help patients modify them."

Indeed, the new diagnostic criteria allow a different approach to treatment. Most psychiatrists assume that some sort of trauma, tragedy or conflict in the past is driving health-anxious fears and behaviors, Dr. Staab says. "And if we can't find it, and the patient can't find it, it can become a speculative wild goose chase for trauma. Trauma is more likely in these patients, but if we don't find a history of trauma, we can look at stress, and if we don't find that, we can still talk about exaggerated preoccupations with health and help patients reset and reframe that without digging around in the past."

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