SOMATIC SYMPTOM AND RELATED DISORDERS

Somatic Symptom Disorder

SSD

DSM-5-TR 300.82 | ICD-10-CM F45.1

Distressing somatic symptoms accompanied by excessive thoughts, feelings, and behaviors about health, persisting 6 months or longer.

PREVALENCE	TYPICAL ONSET	SEX RATIO	COURSE
~5-7% of general adults	Before age 30; often teens	Roughly 10:1 female:male	Chronic; high utilization

CLINICAL PICTURE

- Patients present with pain, fatigue, gastrointestinal, or neurologic complaints that are genuinely experienced, with or without a medical explanation.
- Health worry dominates daily life: symptoms are catastrophized, time and energy go to appointments, and reassurance produces only very brief relief.
- The clinical hallmark is the psychological response rather than the absence of disease, so documented medical illness does not exclude the diagnosis.
- High utilization is typical, with repeated imaging, specialist referrals, and emergency visits that yield negative or incidental findings.
- Frustration accumulates on both sides as patients feel dismissed and clinicians feel manipulated, steadily eroding the therapeutic relationship.
- Function narrows over time as work, activity, and social roles are avoided in an effort to protect against symptom exacerbation.

DIAGNOSTIC CRITERIA AT A GLANCE

- One or more somatic symptoms cause distress or significant disruption of daily life, which is the entry requirement for the diagnosis.
- Excessive thoughts, feelings, or behaviors related to those symptoms are required, and only one of three specified features must be present.
- Those features are disproportionate and persistent thoughts about seriousness, persistently high health anxiety, and excessive time and energy devoted to symptoms.
- The symptomatic state persists longer than 6 months, although any individual symptom may come and go across that period of time.
- Specify with predominant pain, specify persistent course, and rate severity as mild, moderate, or severe by the number of features met.

NEUROBIOLOGY & PHYSIOLOGY

- Central sensitization amplifies nociceptive signaling, and insula, anterior cingulate, and somatosensory cortex show heightened response to identical stimuli.
- Impaired descending inhibition through serotonergic and noradrenergic pathways explains the efficacy of SNRIs and tricyclics in pain-predominant cases.
- Predictive processing models frame symptoms as overweighted interoceptive priors that persist despite repeatedly disconfirming sensory input.
- HPA axis dysregulation and low-grade systemic inflammation are reported, frequently linked to childhood adversity and cumulative chronic stress load.
- Twin studies suggest modest heritability near 25-30%, with genetic loading shared with anxiety and depressive disorders rather than disorder-specific.
- Comorbid fibromyalgia, irritable bowel syndrome, and chronic fatigue share the same central amplification substrate and often coexist in one patient.

PSYCHOLOGICAL MECHANISMS

- Somatosensory amplification directs attention inward, so ordinary bodily noise such as peristalsis or ectopic beats is detected and interpreted as pathology.
- Catastrophic misinterpretation converts benign sensations into evidence of serious disease, which then drives checking and reassurance-seeking behavior.
- Reassurance and testing relieve anxiety only briefly and negatively reinforce the checking cycle, guaranteeing the next round of escalation.
- Alexithymia and early illness learning, whether childhood illness, parental modeling, or adversity, shape the somatic idiom used to express distress.
- Secondary gain through the sick role, disability status, or family attention maintains the behavior without any conscious deception by the patient.

DIFFERENTIAL & COMORBIDITY

- Illness anxiety disorder involves fear of having a disease with minimal or absent somatic symptoms, whereas this diagnosis requires distressing symptoms.
- Functional neurological disorder shows positive incompatibility signs such as Hoover sign and is a separate diagnosis with its own criteria.
- Factitious disorder and malingering both involve intentional production or feigning of symptoms, which somatic symptom disorder explicitly does not.
- Exclude occult medical disease proportionally, with particular attention to multiple sclerosis, lupus, porphyria, thyroid disease, and early malignancy.
- Depression, anxiety disorders, and personality disorders co-occur in over half of cases, and suicide risk rises with comorbid depression and chronic pain.

Treatment EVIDENCE-BASED MANAGEMENT

PHARMACOLOGIC

- No medication is FDA-approved for this disorder, so treatment targets comorbid depression and anxiety, which often reduces symptom preoccupation.
- **Duloxetine 60 mg/day** or venlafaxine XR helps pain-predominant presentations by restoring descending inhibition; monitor blood pressure and nausea.
- Low-dose tricyclics such as **amitriptyline 10-50 mg** at bedtime help pain, sleep, and bowel symptoms, but watch anticholinergic burden in older adults.
- **SSRIs** are reasonable when health anxiety is prominent; start at half the usual dose since these patients are highly sensitive to side effects.
- Actively avoid opioids and benzodiazepines, which worsen long-term outcome through hyperalgesia, tolerance, and dependence in this population.

PSYCHOTHERAPY

- **CBT** is the best-supported treatment across 8-16 sessions, targeting catastrophic appraisals, checking, reassurance-seeking, and activity avoidance.
- **Mindfulness-based** approaches and **ACT** reduce symptom-related distress and improve function without requiring that symptoms be eliminated first.
- Reattribution work links symptoms to stress physiology in a way that validates the lived experience rather than declaring the problem psychological.
- **Psychodynamic interpersonal therapy** shows benefit in trials for functional somatic syndromes, especially when relational trauma is prominent.
- Graded activity and pacing rebuild function first, with symptom reduction following later, rather than waiting for symptoms to resolve before moving.

ADJUNCT & SUPPORTIVE

- Assign a single primary care clinician who provides brief, regularly scheduled visits that are deliberately uncoupled from symptom escalation.
- Set the shared goal as improved function and coping rather than cure or a unifying diagnosis, and document that agreement in writing early on.
- Limit new investigations to clear clinical indications, since each negative workup tends to increase rather than reduce long-term health anxiety.
- Track severity with the **PHQ-15** plus the **SSD-12** or **Whiteley Index** to document change objectively and give visits a clear structure.
- Exercise, sleep regulation, and physical therapy improve pain and fatigue, and multidisciplinary pain programs help refractory presentations.

CLINICAL PEARLS

- The symptoms are real; the diagnosis rests on the response to them, not their cause.
- Regular brief scheduled visits beat reactive visits driven by symptom crises.
- Every negative test buys hours of relief and weeks of fresh worry.

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NOTE

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