New disorder risks mislabelling many as mentally ill

The new diagnosis of somatic symptom disorder, introduced in DSM-5, lacks specificity, says **Allen Frances**

The fuzzy boundary between psychiatry and general medicine is about to experience a seismic shift. The next edition of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM) is scheduled for release this May amid controversy about many of its new disorders. Among these, DSM-5 introduces a poorly tested diagnosis, somatic symptom disorder, that risks mislabelling many people as mentally ill.

The relation between psychiatry and the rest of medicine has been difficult to manage both for mental health practitioners and for primary care doctors, and this is even more problematic for patients caught inbetween. The boundary has never been clear cut or static but has shifted back and forth depending on new findings and fashions. The realm of psychiatry would shrink, and that of medicine would expand, whenever advancing science discovered a cause for a previously poorly understood presentation. The classic example of this is "general paresis of the insane," which went from psychiatry to neurology as soon as the spirochete was identified as the causal agent.

In DSM-5, "somatic symptom disorder" appears in a new section, "Somatic symptoms and related disorders," which replaces the "Somatoform disorders" section found in DSM-IV. This new category will extend the scope of mental disorder classification by eliminating the requirement that somatic symptoms must be "medically unexplained." In DSM-5, the focus shifts to "excessive" responses to distressing, chronic, somatic symptoms with associated "dysfunctional thoughts, feelings, or behaviors."

Somatic symptom disorder captured 15% of patients with cancer or heart disease and 26% with irritable bowel syndrome or fibromyalgia, and it had a high false positive rate of 7% among healthy people in the general population

The overinclusiveness of this diagnosis is suggested by the results of the DSM-5 field trial study reported by the somatic symptom disorder work group at the 2012 annual meeting of the American Psychiatric Association. Somatic symptom disorder captured 15% of patients with cancer or heart disease and 26% with irritable bowel syndrome or fibromyalgia, and it had a high false positive rate of 7% among healthy people in the general population.[1] The rate of psychiatric disorder among medically ill patients is unknown, but these rates seem high, and the burden of proof before introducing any new diagnosis is that it has a favourable risk to benefit ratio. Yet the proposed diagnosis is unsupported by any substantial evidence on its likely validity and safety and was strongly opposed by patients, families, caregivers, and advocacy organisations.[2]

The DSM-5 definition of somatic symptom disorder is loose. It requires only one bodily symptom that is distressing or disrupting to daily life, which lasts at least six months. It also requires one of the following psychological or behavioural responses: disproportionate thoughts about the seriousness of symptom(s); persistently high level of anxiety about symptom(s); or excessive time and energy spent on health concerns.[3] This is far looser than the (rarely used) definition of somatisation disorder in DSM-IV. This required a history of many medically unexplained symptoms before the age of 30 years that occurred over several years and which resulted in treatment being sought or psychosocial impairment. A total of eight or more medically unexplained symptoms were needed from four specified symptom groups, with at least four pain and two gastrointestinal symptoms.[4]

Previous DSM criteria have always included reminders to clinicians to rule out other explanations before concluding that any mental disorder is present. I suggested to the working group that similar reminders should be included this time and that before somatic symptom disorder is diagnosed clinicians should consider whether the health concerns are completely unrealistic or whether an underlying medical disorder might account for them. I also suggested that clinicians should consider whether symptoms might be caused by one of several mental disorders that often present with physical problems (such as depression, generalised anxiety, or panic disorder). The DSM-5 working group reviewed these suggestions and rejected them.

Misapplication of these catch-all criteria, especially in harried primary care practice, may result in inappropriate diagnoses of mental disorder and inappropriate medical decision making.[5] Millions of people could be mislabelled, with the burden falling disproportionately on women, because they are more likely to be casually dismissed as "catastrophisers" when presenting with physical symptoms.

A false positive diagnosis of somatic symptom disorder harms patients because it may result in any underlying medical causes being missed. It also subjects patients to stigma, inappropriate drugs, psychotherapy, and iatrogenic disease; disadvantages them in decisions relating to employment, education, and healthcare entitlements; skews their self perceptions and those of family and friends; and places parents of children with chronic illness at risk of accusation of "overinvolvement" or of maintaining "sick role behaviour."

Every diagnostic decision is a delicate balancing act between definitions that will result in too much versus too little diagnosis—the DSM-5 work group chose a remarkably sensitive definition that is also remarkably non-specific. This reflected a consistent bias throughout DSM-5 to expand the boundaries of psychiatric diagnosis with what I believe was insufficient attention to the risks of the ensuing false positive mislabelling.

The DSM-5 diagnosis of somatic symptom disorder is based on subjective and difficult to measure cognitions that will enable a "bolt-on" diagnosis of mental disorder to be applied to all medical conditions, irrespective of cause. ICD-11 (*International Classification of Diseases*, 11th revision) is now being prepared by some of the same people who worked on DSM-5.[6 7] Unless ICD-11 applies a higher standard of evidence and risk benefit analysis, it may repeat the mistake of casually mislabelling the physically ill as also mentally disordered.[8]

Clinicians are best advised to ignore this new category. When a psychiatric diagnosis is needed for someone who is overly worried about medical problems the more benign and accurate diagnosis is adjustment disorder.

I thank Suzy Chapman, patient advocate, Poole, UK, of Dx Revision Watch, for valuable comments and suggestions.

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Competing interests: AF will publish two books that include references to DSM-5 (*Saving Normal* and *Essentials of Psychiatric Diagnosis*).

References are in the version on bmj.com.

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- News: More psychiatrists attack plans for DSM-5 (*BMJ* 2012;344:e3357)
- Personal view: The psychiatric oligarchs who medicalise normality (*BMJ* 2012;344:e3135)

FROM THE FRONTLINE **Des Spence**

Doctor in the house

Like many doctors of a certain generation, I've made many thousands of house calls. I've been barked at by pit bulls and chihuahuas. Taken lifts full of graffiti, vomit, urine, and wine bottles. Walked up blacked out stairwells using the torch of my auriscope to guide me, the crunch of used syringes under foot. Met countless police officers and seen death in every manifestation.

And announced death to screams, cries, sobs, or hysterical laughter. Detained patients under the Mental Health Act at 3 am. Stood on blood, pus, and excrement soaked nylon carpets. Conducted mouth to mouth resuscitation. Driven in the middle of the night through rain and snow. Suppressed my fear and steadied my hand to inject penicillin while watching the rash of meningococcal septicaemia. Assessed psychotic, myopic, sociopathic, and alcoholic patients. All with no lone worker status and no risk assessment. I've been pushed to the edge professionally, emotionally, and physically.

The aspiration to deliver "holistic care" . . . is mere lip service without home visits

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I've done what I could, and I did my best. No *Dr Kildare* or *ER*, but real hand to hand medical combat. House calls gave insight and made me a doctor in practice, not just on paper.

But house calls are losing favour. Practices sometimes refuse them, and the once common regular visits made to older people are long gone. Domiciliary visits by consultants seem all but extinct. House calls are considered inefficient and even risky on health and safety grounds. Increasingly we see patients only on our own consulting room turf, sanitised and controlled. Doctors seem to live separate, distant, parallel lives, with a decreasing knowledge of the communities we serve. Yet you learn so much from house calls. You see how people live and the practical problems they face; you meet families, neighbours, and home helps. You get to understand the limitations of healthcare in the context of people's social situations. You glean something of patients' personal lives from family photos, music, and pictures. But most of all, doctors learn to cope.

The aspiration to deliver "holistic care," with an understanding of people's psychological, physical, social, and spiritual needs, is mere lip service without home visits. And the goal for more patients to die at home, to limit hospital admissions, and to improve communication is not achievable without a willingness to see patients at home. The house visit is at the heart of medicine, with doctors seen and connected to the area. While we waste billions on pointless health service initiatives, we miss the obvious. We should encourage doctors to visit patients in their homes. This is simple, effective, important yet undervalued medical care.

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THE BEST MEDICINE **Liam Farrell**

A curious case of childhood obesity

Finding the magic cottage was tricky. I asked directions from a sulky young girl in a red hoodie. "Get lost," she said, "I'm morphing awkwardly into adulthood. Subtext too subtle for you?"

I summoned the great god Pan. He was adjusting his loincloth, which was revealingly and impressively askew. "Sorry, can't stay," he smirked, "A wood nymph just called around; comprendez?"

I eventually tracked down the cottage by the pricking of my thumbs—and satnav. Reality was on holiday, shacked up somewhere with the laws of physics.

I stepped inside, accidentally squashing a pixie. It was your average magic cottage—ancient crone, gingerbread furniture, a couple of goblins molesting a squirrel—except for an expensive flat screen television and Sky box.

"Sure you're a real witch?" I asked suspiciously. She handed me a certificate. "Member of the Royal College of Witches and Chiropractors," it stated.

"Unbelievable," I said.

"Yeah," she said, "Even fairytale creatures know chiropractic is a crock of . . ." She stopped. "Oi, you!" she shouted out the window, "Scram, or I'll set the dogs on you."

"That Terry Pratchett again," she explained, "Always snooping round."

Two really fat kids lounged on an Ikea settee, stuffing themselves with doughnuts as big as my head.

"I'm worried about Hansel and Gretel's weight," she said.

"Plenty of exercise, a balanced diet . . ." I began.

"No, doctor," she said, "I need to beef them up, poor little things." Hansel belched loudly and pungently in agreement.

"What have you been feeding them?" I asked.

"The very best," she said, "Home cooked, organic, and all." I lifted a supersize McDonald's Happy Meal wrapper. "So what's this?" I accused.

Build a witch a fire and she's warm for a day, throw her in the fire and she's warm for the rest of her life

She looked embarrassed: "The new cooker was being installed, so we had to order in." The traditional oven, I noted, had been replaced by an enormous Aga.

Cometh the hour, cometh the doc; stories have their own atavistic power, and I understood my obligations. "Very country kitchen chic," I said, "Show me how it works."

House proud, she bent down to twiddle the knobs. I shoved her inside and, in tribute to Spinal Tap, turned it up to 11. Build a witch a fire and she's warm for a day, throw her in the fire and she's warm for the rest of her life.

At least we won't need the Liverpool care pathway, I thought.

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