CNS Spectrums (2016), **21**, 310–317.
doi:10.1017/S1092852915000760

REVIEW ARTICLE

The clinical inadequacy of the DSM-5 classification of somatic symptom and related disorders: an alternative trans-diagnostic model

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The *Diagnostic and Statistical of Mental Disorders*, Fifth Edition (DSM-5) somatic symptom and related disorders chapter has a limited clinical utility. In addition to the problems that the single diagnostic rubrics and the deletion of the diagnosis of hypochondriasis entail, there are 2 major ambiguities: (1) the use of the term "somatic symptoms" reflects an ill-defined concept of somatization and (2) abnormal illness behavior is included in all diagnostic rubrics, but it is never conceptually defined. In the present review of the literature, we will attempt to approach the clinical issue from a different angle, by introducing the trans-diagnostic viewpoint of illness behavior and propose an alternative clinimetric classification system, based on the Diagnostic Criteria for Psychosomatic Research.

Received 22 June 2015; Accepted 31 August 2015; First published online 28 December 2015

Key words: Clinimetric, Diagnostic Criteria for Psychosomatic Research, DSM-5, illness behavior, somatic symptom.

Introduction

Somatic symptoms disorder and other disorders with prominent somatic symptoms constitute a new category in *Diagnostic and Statistical of Mental Disorders*, Fifth Edition (DSM-5) called "somatic symptom and related disorders."[1] This category includes the diagnoses of somatic symptom disorder, illness anxiety disorder, conversion disorder, psychological factors affecting other medical conditions, factitious disorder, other specified somatic symptom and related disorder, and unspecified somatic symptom and related disorder.[1] According to the DSM-5, these disorders share as a common feature the prominence of somatic symptoms associated with significant distress and impairment.

We will critically examine this new classification, with special reference to its clinical flaws, and suggest an alternative trans-diagnostic approach based on the model of illness behavior.

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The DSM-5 Classification of Somatic Symptom and Related Disorders

The main diagnosis, somatic symptom disorder, requires one or more distressing somatic symptoms (criterion A) and excessive thoughts, feelings, and behaviors related to these symptoms or associated health concerns (criterion B). It is assumed (criterion A) that these patients bear excessive health concerns about such symptoms. The DSM-5 justified this choice with the need to de-emphasize the role of medically unexplained symptoms.

Criterion B was also justified by the need of including positive psychological features, which are a requisite for diagnosing a mental disorder. However, psychological symptoms related to medically unexplained symptoms do not necessarily involve excessive anxiety and thoughts about the seriousness of symptoms. The persistence of distressing somatic symptoms may induce demoralization and irritability rather than anxiety about the meaning of the symptoms. In addition, the evaluation of the disproportion of thoughts on the seriousness of symptoms, as well as of time and energy spent on them (criterion B), entail a wide variability in the clinician's judgment.[2]

The diagnosis of illness anxiety disorder is concerned with the preoccupation with having or acquiring a

serious illness. It is characterized by absence or low intensity of somatic symptoms and health-seeking or avoidant behavior that is judged to be maladaptive.[1] The definition does not include hypervigilance to bodily symptoms but mentions that "the individual is easily alarmed about personal health status." Thus, no insight specifiers have been introduced.[3] A potential problem is the lack of clarity inherent in the overlapping criteria of somatic symptom disorder and illness anxiety disorder. A broader problem is that illness anxiety disorder does not depend on the presence of somatic symptoms and clearly shares clinical characteristics with disorders in other groupings.[3] In addition, according to F diagnostic criterion, illness-related preoccupation is not better explained by another mental disorder (eg, somatic symptom disorder, panic disorder, generalized anxiety disorder). A potential problem, in this case, is related to the differential diagnosis. Avoidance and repetitive safety-seeking behaviors are, for instance, common in patients with obsessive-compulsive disorder[4] and body dysmorphic disorder.[5] Similarly, the most common prodromal symptoms of panic are illness phobia, health anxiety, or fear of disease.[6] Thus, the application of criterion F might reduce significantly the possibility of formulating this diagnosis and might let clinician forget that illness anxiety is a dimensional rather than a categorical construct.

In conversion disorder, the essential feature is neurological symptoms that are incompatible with neurological pathophysiology.[1] The DSM Fourth Edition (DSM-IV) criterion B concerning the presence of psychological factors preceding the initiation or the exacerbation of symptoms was removed in DSM-5. This choice seems to be inconsistent with the proposal to de-emphasize the role of medically unexplained symptoms and to include positive psychological features in the diagnoses. According to the suggested criteria, each patient with medically unexplained symptoms or deficits of voluntary motor or sensory function may satisfy the diagnosis of conversion disorder. However, about 30% of outpatients who attend neurological facilities have symptoms not explained by medical findings.[7] In addition, the proposed diagnosis of conversion disorder might depend on the accuracy of the medical examinations. Certain symptoms may be prodromes of an illness that manifests itself at a later stage.[8]

The essential feature of psychological factors affecting other medical conditions is the presence of clinically significant psychological or behavioral factors that adversely affect a medical condition by increasing the risk for suffering, death, or disability.[1] These factors are poorly specified and add little to the diagnostic process.

The diagnosis of factitious disorder embodies persistent problems related to illness perception and identity.[1] However, its discussion is beyond the scope of this review.

Other specified somatic symptom and related disorders and unspecified somatic symptom and related disorders include conditions for which some, but not all, of the criteria for somatic symptom disorder or illness anxiety disorder are met.[1]

The DSM-5 removed the diagnosis of hypochondriasis. The majority of patients with DSM-IV hypochondriasis would be subsumed under the diagnosis of somatic symptom disorder and the remaining part under the diagnosis of illness anxiety disorder.[1] Those with somatic symptom disorder are characterized by the presence of distressing somatic symptoms, while, in patients with illness anxiety disorder, somatic symptoms are absent or, if present, are mild. The presence of somatic symptoms is the differential feature between the 2 diagnoses. Thus, the distinctive features of hypochondriasis, which include preoccupation, anxiety, bodily hypervigilance, and avoidance behaviors, were lost.[9] In addition, both in somatic symptom disorder and illness anxiety disorder, disease conviction is virtually neglected and the diagnostic criteria are more representative of health anxiety than disease phobia.

Clinical Inadequacy of the DSM-5 Classification

In addition to the problems that the single diagnostic rubrics and the deletion of the diagnosis of hypochondriasis entail, there are major clinical flaws in the classification system concerned with somatic symptom and related disorders.

There are 2 major ambiguities that may result in misleading clinical indications. One is concerned with the use of the term "somatic symptom." Even though the DSM-5 attempts to avoid the centrality of medically unexplained symptoms that occurred in the DSM-IV and acknowledges the potential occurrence of these clinical phenomena in established medical disorders, its use of the term "somatic symptoms" reflects an ill-defined concept of somatization, as the tendency to experience and communicate psychological distress in the form of physical symptoms and to seek medical help for them.[10] Anything that could not be explained by organic factors, with special reference to laboratory investigations, is thus likely to fall within the domains of somatization. For instance, conversion disorder is also named functional neurological symptom disorder. Its B diagnostic criterion states "clinical findings provide evidence of incompatibility between the symptom and recognized neurological or medical conditions,"[1] and its C criterion states "the symptom or deficit is not better explained by another medical or mental disorder."[1] Thus, the DSM-5 maintains the misleading organic/functional dichotomy, which is based on the assumption that if organic factors cannot be identified, there should be psychiatric reasons that may be able to fully explain the somatic

https://doi.org/10.1017/S1092852915000760 Published online by Cambridge University Press

symptomatology. In addition, it neglects the fact that the presence of a nonfunctional medical disorder does not exclude, but indeed increases, the likelihood of psychological distress and abnormal illness behavior.[11] This old logic that, if it is not organic, it should be psychiatric is reinforced by the fact that these diagnostic categories are defined as psychiatric, and exclusion criteria for other psychiatric disorders are endorsed. George Engel[12] was very critical on the disease concept of functional medical disorder or medically unexplained symptoms. For instance, he regarded the view that irritable bowel syndrome is caused by psychological influences as an oversimplification.[12] It clashes with the nature of psychosomatic medicine itself, which is a comprehensive, interdisciplinary framework for the assessment of psychosocial factors affecting individual vulnerability, course, and outcome of any type of disease; the holistic consideration of patient care in clinical practice; and the specialist interventions to integrate psychological therapies in the prevention, treatment, and rehabilitation of medical disease.[13] For instance, a very recent investigation outlined how patients with functional dyspepsia[14] present with stable increased cerebral cannabinoid-1 receptor availability: the "organicity" then just depends on the type of investigative methods.

A second major source of confusion in the DSM-5 classification system is given by the fact that it makes reference to abnormal illness behavior in all diagnostic rubrics, but it never provides a conceptual definition for it. Pilowsky[15] characterized abnormal illness behavior as the persistence of a maladaptive mode of experiencing, perceiving, evaluating, and responding to one's own health status, despite the fact that a doctor has provided a lucid and accurate appraisal of the situation and management to be followed (if any), with opportunity for discussion, negotiation, and clarification, based on adequate assessment of all relevant biological, psychological, social, and cultural factors. Its formulation takes into account the role of the patient–doctor interaction in determining illness behavior. If a patient was not provided adequate information about his/her medical condition and management to be followed, and develops overwhelming anxiety about his/her health, is a psychiatric diagnosis warranted? Is a problem caused by the patient or by an inadequate patient–doctor interaction?

We will thus attempt to approach the clinical issue from a different angle–the unifying viewpoint of illness behavior.

Illness Behavior

The DSM-5 does not define the concept of "illness behavior." Mechanic and Volkart[16] defined illness behavior as "the ways in which given symptoms may be differentially perceived, evaluated, and acted (or not acted) upon by different kinds of persons." Subsequently, Mechanic[17] provided the following specification: "Illness behavior refers to the varying ways individuals respond to bodily indications, how they monitor internal states, define and interpret symptoms, make attributions, take remedial actions and utilize various sources of informal and formal care." In addition, illness behavior "shapes the recognition of illness, the selection of patients into care, the degree of compatibility between patient and physician attributions, patterns of health practice and adherence with medical advice, and the course of illness and the treatment process"[17](p. 1208).

The simple fact that, in the presence of certain physical symptoms, some persons immediately seek medical help while others wait a long time before consulting a physician determines the likelihood of early recognition of a life-threatening disease and its prompt treatment and prognosis.[18] In addition, once the symptoms of a medical disease are experienced by a person, or he/she has been told by a doctor that he/she is ill even if symptoms are absent, this disease-related information gives rise to psychological responses that are likely to influence the course, therapeutic response, and outcome of a given illness episode. Illness behavior is one of the factors that demarcates major prognostic and therapeutic differences among patients who otherwise seem to be deceptively similar since they share the same diagnosis.[18] Thus, illness behavior is a core characterization in psychosomatic medicine and provides an explanatory model for clinical phenomena that do not find room in customary taxonomy.

Abnormal illness behavior may also be associated with psychiatric disorders. When agoraphobia is accompanied by panic attacks, hypochondriacal fears and beliefs tend to occur and remit upon treatment of the agoraphobia.[19] When agoraphobia is not accompanied by panic attacks, illness denial prevails and explains why these patients are unlikely to seek treatment.[20]

According to recent reviews of the literature,[18,21] illness behavior may vary greatly according to illness-related, patient-related, and doctor-related variables and their complex interactions. Important lines of research have been concerned with illness perception, frequent attendance at medical facilities, healthcare-seeking behavior, treatment-seeking behavior, delay in seeking treatment, and treatment adherence.[18,21] A number of dimensional instruments have been developed for identifying the features of illness behavior, but they are of limited use to the practicing clinician.[18] The question is when a certain manifestation of illness behavior is worthy of clinical attention.

The Diagnostic Criteria for Psychosomatic Research

The Diagnostic Criteria for Psychosomatic Research (DCPR) were introduced in 1995 by an international

https://doi.org/10.1017/S1092852915000760 Published online by Cambridge University Press

group of investigators.[22] The rationale was to expand the traditional domains of the disease model by translating psychosocial variables that derived from psychosomatic research into operational tools.

The DCPR are a set of 12 psychosomatic syndromes whose prognostic role in the development, course, and outcome of medical diseases, regardless of "organic" or "functional" nature, was documented by a large body of literature. Seven of them refer to the concept of abnormal illness behavior: persistent somatization, conversion symptoms, anniversary reaction, disease phobia, thanatophobia, health anxiety, and illness denial (Table 1). Four syndromes (ie, alexithymia, type A behavior, demoralization, and irritable mood) can be considered affective disturbances that are qualitatively different from the conventional manifestations of mood and anxiety disorders that have been observed in clinical psychiatry (Table 2).

The DCPR syndrome of functional somatic symptom secondary to a psychiatric disorder acknowledges the hierarchical relationship between functional somatic symptoms and psychiatric disorders. Symptoms of autonomic arousal frequently may be a consequence of psychiatric disorders, and high co-occurrence rates between DSM-IV somatoform disorders and both anxiety and mood disorders have been documented.[23,24]

TABLE 1. Main characteristics of the DCPR concerning abnormal illness behavior

Hypochondriasis: Fears of having, or the idea that one has, a serious disease based on the person's misinterpretation of bodily symptoms lasting at least 6 months. Resistance to appropriate medical reassurance is the distinctive feature, which clearly differentiates hypochondriasis from other related manifestations of abnormal illness behavior.

Health anxiety: Generic worry about illness, concern about pain and bodily preoccupations, tendency to amplify somatic sensations of less than 6 months' duration. Worries and fears readily respond to appropriate medical reassurance, even though new worries may ensue after some time.

Disease phobia: A persistent, unfounded fear of suffering from a specific disease, with doubts remaining despite adequate examination and reassurance. Fears tend to manifest themselves in attacks rather than in chronic worries as in hypochondriasis; panic attacks may be associated. The object of fears does not change with time. Duration of symptoms exceeds 6 months.

Thanatophobia: Attacks with the sense of impending death and/or conviction of dying soon, even though there is no objective medical reason for such fear. Marked and persistent fear and avoidance of news which that reminds the patient of death (e.g., funerals, obituary notices); exposure to these stimuli almost invariably provokes an immediate anxiety response.

Persistent somatization: A functional medical disorder (e.g., fibromyalgia, esophageal motility disorders, irritable bowel syndrome, neurocirculatory asthenia, urethral syndrome), whose duration exceeds 6 months, causing distress or repeated medical care or resulting in impaired quality of life. Additional symptoms of autonomic arousal and exaggerated side effects from medical therapy are present, indicating low sensation or pain thresholds and high suggestibility.

Conversion symptoms: One or more symptoms/deficits affecting voluntary motor/sensory function, characterized by lack of anatomical or physiological plausibility; and/or absence of expected physical signs or laboratory findings; and/or inconsistent clinical characteristics. If symptoms of autonomic arousal or a functional medical disorder are present, conversion symptoms should be prominent, causing distress or repeated medical care or impairing quality of life. At least 2 of the following features are present: ambivalence in symptom reporting; histrionic personality features; precipitation of symptoms by psychological stress, the association of which the patient is unaware; history of similar physical symptoms experienced by the patient or observed in or wished on someone else.

Anniversary reaction: Symptoms of autonomic arousal/functional medical disorder/conversion symptoms causing distress or repeated medical care or resulting in impaired quality of life. Symptoms began when the patient reached the age or on the occasion of the anniversary when a parent or very close family member developed a life-threatening illness or died. The patient is unaware of such an association.

Illness denial: Persistent denial of having a physical disorder and of the need of treatment (e.g., lack of compliance, delayed seeking of medical attention), as a reaction to the symptoms, signs, diagnosis or medical treatment of a physical illness. The patient has been provided a lucid and accurate appraisal of the medical situation and management to be followed.

TABLE 2. Clinical manifestations of psychological factors affecting medical conditions

Allostatic overload: The presence of a current identifiable source of distress in the form of recent life events and/or chronic stress; the stressor is judged to tax or exceed the individual's coping skills when its full nature and circumstances are evaluated. The stressor is associated with 1 or more of the following manifestations, which have occurred within 6 months after the onset of the stressor: psychiatric symptoms according to the DSM classification,; psychosomatic symptoms according to the DCPR classification,; significant impairment in social or occupational functioning or in psychological well-being.

Demoralization: A feeling state characterized by the patient's consciousness of having failed to meet his/her own expectations (or those of others) or being unable to cope with some pressing problems. The patient experiences prolonged and generalized (at least 1-month duration) feelings of helplessness or hopelessness or giving up. The feeling closely antedated the manifestations of a medical disorder or exacerbated its symptoms.

Irritable mood: Irritable mood may be experienced as brief episodes, in particular circumstances, or as prolonged and generalized. It requires an increased effort of control over temper or results in irascible verbal or behavioral outbursts. The experience of irritability is always unpleasant for the individual, and overt manifestation lacks the cathartic effect of justified outbursts of anger. The feeling elicits stress-related physiologic responses that precipitate or exacerbate the symptoms of a medical disorder.

Type A behavior: At least 5 of the following 9 characteristics are present: excessive involvement in work and other activities subject to deadlines; steady and pervasive sense of time urgency; motor-expressive features indicating sense of being under the pressure of time (e.g., rapid and explosive speech, abrupt body movements, tensing of facial muscles); hostility and cynicism; irritable mood; tendency to speed up physical activities; tendency to speed up mental activities; intense desire for achievement and recognition; high competitiveness. The behavior elicits stress-related physiologic responses that precipitate or exacerbate the symptoms of a medical condition. The behavior does not occur in the course of manic or hypomanic syndromes.

Alexithymia: At least 3 of the following 6 characteristics are present: inability to use appropriate words to describe emotions; tendency to describe details instead of feelings; lack of a rich fantasy life; thought content associated more with external events than with fantasy or emotions; unawareness of the common somatic reactions accompanying the experience of a variety of feelings; occasional but violent and often inappropriate outbursts of affective behavior.

https://doi.org/10.1017/S1092852915000760 Published online by Cambridge University Press

The DCPR have been widely used in medical[25,26] and psychiatric[27] settings. They have undergone extensive validation, as summarized in a monograph that also includes a semistructured clinical interview for their assessment.[26] Excellent inter-rater reliability, construct validity, and predictive validity for psychosocial impairment and treatment outcome were found.[26,28]

A recent review of the literature highlighted how the DCPR system can be clinically useful for subtyping medical patients, identifying subthreshold or undetected syndromes, evaluating the burden of medical syndromes, predicting treatment outcomes, and identifying risk factors.[25] Data from a cross-sectional assessment using DSM-IV and DCPR in 1,560 patients recruited from different medical settings[29] yielded 3 clusters: (1) comprised one-third of patients and was characterized by a 5–8% rate of DSM-IV disorders and no DCPR syndromes; (2) comprised one-quarter of patients and was characterized by only the presence of DCPR irritability, and (3) comprised about 40% of patients and was characterized by the predominance of DCPR somatization and DSM mood/anxiety disorders.

An Alternative Clinimetric Classification System

There is clinical need to identify the manifestations of abnormal illness behavior that impair quality of life and interfere with appropriate management in both medical and psychiatric diseases. The term "clinimetrics," introduced by Feinstein,[30] indicates a domain concerned with the measurement of clinical issues that do not find room in customary clinical taxonomy. Such issues include psychosocial variables that deserve clinical attention.[31,32] In the framework of clinimetrics, Feinstein defined the concept of comorbidity as referring to any "additional co-existing ailments" separated from the primary disease, even in the case this secondary phenomenon does not qualify as a disease per se.[33] Feinstein[34] also remarked that, when making a diagnosis, thoughtful clinicians seldom leap from a clinical manifestation to a diagnostic end-point instead of using clinical reasoning, which goes through a series of "transfer stations" where potential connections between presenting symptoms and pathophysiological processes are drawn. Unfortunately, in psychiatric assessment, comorbidity is limited to psychiatric diagnoses, and disturbances are generally translated into diagnostic end-points. Clinicians tend to rely exclusively on "hard data," diagnoses, excluding "soft information," additional co-existing ailments, although this soft information can be reliably assessed and is fundamental for an adequate psychosomatic assessment.

Table 1 outlines the clinical spectrum of illness behavior that can be based on specific criteria. It includes hypochondriasis from the DSM-IV classification and other DCPR syndromes. Retaining hypochondriasis is important, since psychotherapeutic strategies had been developed and validated in randomized controlled trials.[35–40] They were targeted to address resistance to reassurance, which is the key characteristic of hypochondriasis, and often entails significant clinical benefits. Anxiety is indeed present in hypochondriasis, but it is not the main feature.[41] Not surprisingly, when the broad and ill-defined concept of illness anxiety (which does not differentiate between hypochondriasis and health anxiety, as depicted in Table 1) became the source of a randomized controlled trial using similar cognitive behavior strategies, there were no significant benefits in quality of life and health costs.[42]

"Health anxiety" includes a variety of worries and attitudes concerning illness and pain which are less specific than hypochondriasis and disease phobia that respond to medical reassurance. It frequently occurs among consultation-liaison psychiatry patients (21–34.6%).[28,43]

Disease phobia and thanatophobia may be components of a hypocondriacal syndrome, yet they may also occur independently. Disease phobia differs from hypochondriasis for 2 characteristics of fear: specificity and longitudinal stability (fears concern a specific disease and are unlikely to be moved on another disease or organ system) and phobic quality (fears tend to manifest themselves in attacks rather than in constant worries as in hypochondriasis).[44] Noyes *et al*[45] also pointed out that disease phobia often results in the avoidance of internal and external illness-related stimuli, while hypochondriasis usually leads to reassurance-seeking or checking behaviors. Disease phobia is less frequent than health anxiety in medical samples, yet it was found in 19% of consultation-liaison psychiatry patients.[28,43]

Persistent somatization may occur regardless of the functional/organic dichotomy. For instance, it occurred in 21% of patients with endocrine disorders[46] and in 33.7% of patients with functional gastrointestinal disorders.[47]

The DCPR defined conversion symptoms were formulated according to Engel's[48] criteria (see Table 1) in terms of abnormal illness behavior.[2,49] In a sample of 1498 patients from various medical settings, DCPR conversion symptoms were found in 4.5% of subjects, while DSM-IV conversion disorder in only 0.4%.[49]

The anniversary reaction is a special form of somatization or conversion and is not rare, having a prevalence of 3.6% in medical patients from different medical settings.[49]

Illness-denying abnormal illness behavior has been ignored by nosography, even though it may entail important clinical manifestations, such as counterphobic behavior or delayed help-seeking behavior for physical symptoms.[50] DCPR illness denial includes patients who do not acknowledge the presence or the severity of their

illness. In healthy subjects, illness denial may concern one's own vulnerability to life-threatening diseases, resulting in unsafe health habits or non-attendance to preventive screenings.[2] The DSM-5 included "poor adherence" as an example of psychological factors affecting medical condition (PFAMC) interfering with the treatment of a general medical condition. However, poor adherence is not necessarily a consequence of illness denial, since it also may be the result of memory impairment or lack of understanding of the physician's prescriptions.[2] DCPR illness denial was found in 9.5% of women with breast cancer[51] and 4.6% of cardiac recipients.[52]

Another set of clinimetric information can provide specification to the vague DSM-5 category of psychological factors affecting medical conditions (Table 2).

Allostatic overload occurs when the cost of chronic exposure to stress-related fluctuating and heightened neural or neuroendocrine responses exceeds the coping resources of an individual.[53] It is characterized by fatigue, psychic anxiety, irritability, and initial insomnia.[53]

The definition of demoralization integrates Frank's[54] demoralization syndrome and Schmale and Engel's giving up–given up complex.[55] DCPR studies report a very low prevalence of 2–5% in healthy participants and a high prevalence in the medically ill.[56] Demoralization and major depression can be differentiated on clinical grounds; they may occur together or independently, and major depressive disorders do not necessarily involve demoralization.[56]

The syndrome of irritable mood is based on Snaith and Taylor's[57] definition. Irritability may be part of other psychiatric syndromes, it is always unpleasant for the individual, and its overt manifestation lacks a cathartic effect.[57] Prevalence rates of about 10–15% were found in different medical settings.[2]

Type A behavior is derived from the "specific emotional complex" observed in patients with heart diseases in the late 1950s.[58] It has been recognized in those at risk of coronary heart disease,[59] but was also found in 10.8% of patients with non-cardiac diseases, suggesting the need to extend its assessment to other medical settings.[60]

Alexithymia characterizes patients who have difficulties in describing feelings and differentiating them from bodily sensations, a poor fantasy life, and an "operative" way of thinking.[61,62] It seems linked to an increased risk and a worsened outcome of several medical conditions, such as cardiovascular diseases, cancer, and gastrointestinal disorders.[63–65] Alexithymia was also significantly associated with substance abuse, disordered eating,[64] and altered immune responses to stress.[66] Several methods have been developed to measure it.[67]

Guidi *et al*[68] found that the DCPR-based proposal allows the identification of psychological factors meaningful for the illness course in the proportion of 3:1, as compared with the new proposed DSM-5 diagnostic criteria for somatic symptom disorders, when applied to patients with heart failure. Most of the patients with somatic symptom disorders (61.5%) were diagnosed with the poorly defined PFAMC category, whereas the DCPR-based classification yielded a better specification of these psychological factors.

Conclusion

The DSM-5 seems to capture only a narrow part of the information necessary for the clinical process and to neglect important features concerning psychological factors affecting medical conditions and abnormal illness behavior. The new DSM-5 classification of somatic symptom and related disorders, although it has introduced substantial modification in diagnostic criteria, does not seem to meet the basic requirements of clinical utility in the field of psychosomatic medicine and the identification of the psychological factors that influence the course of medical disorders.[25]

In 1960, George Engel[69] criticized the concept of disease: "The traditional attitude toward disease tends in practice to restrict what it categorizes as disease to what can be understood or recognized by the physician and/or what he notes can be helped by this intervention. This attitude has plagued medicine throughout its history and still stands in the way of physicians' fully appreciating disease as a natural phenomenon" (pp. 471–472). The inadequacy of this concept of disease particularly applies to the DSM-5. Fava *et al*[32] have outlined an assessment strategy that is beyond the restrictive concept of disease. A satisfactory psychosomatic assessment should have a particular reference to the role of stress, thus early and recent life events, chronic stress, and allostatic load should be carefully evaluated. Similarly, a number of factors (eg, healthy habits, psychological well-being) were shown to be implicated in the modulation of individual vulnerability to disease.

As to the high prevalence of medically unexplained symptoms, it has been suggested that it is not that certain disorders lack an explanation, but rather it is our assessment that is inadequate in most of the clinical encounters.[31] Assessment of illness behavior is a truly trans-diagnostic process and may identify issues that can be, in most cases, addressed by the physician through the provision of medical information and explanation (eg, in relation to the beliefs of patients about their illness). In a minority of cases, they can be managed by structured interventions such as psychotherapy. A systematic appraisal of individual illness behavior and the provision of appropriate responses by the physician may contribute to improving medical outcomes.[18,70,71]

The current DSM-5 classification of somatic symptom and related disorders may be a source of misleading

https://doi.org/10.1017/S1092852915000760 Published online by Cambridge University Press

clinical assumptions and needs to be integrated with, if not substituted by, a trans-diagnostic assessment of illness behavior.

Disclosure

The authors do not have an affiliation with or financial interest in any organization that might pose a conflict of interest.

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https://doi.org/10.1017/S1092852915000760 Published online by Cambridge University Press