A Case of Somatization in Schizoaffective Disorder: Comparison of *DSM-IV* to *DSM-5*

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Somatization is distressing somatic symptomatology in addition to the abnormal thoughts, feelings, and behaviors in response to these symptoms according to the *DSM-5*.[1,2] Wilhelm Stekel, a psychoanalyst, coined the term *somatization* in 1911 and used it to define the bodily expression of somatic neurosis or the process of neurotic conflicts presenting as physical symptoms.[3]

In the *DSM-5*, somatization disorder, pain disorder, and undifferentiated somatoform disorder were all merged into the new diagnosis somatic symptom disorder (300.82).[4] In the *ICD-10*, the disorder is mentioned in chapter F45.1.[5] It is normal to experience somatic symptoms from time to time, and most people can cope with them effectively. However, a disorder develops when an individual becomes overwhelmed by these concerns, and disproportionate and excessive thoughts, feelings, and behaviors are at the center of the perceived somatic symptoms.[4]

Case Report

A 56-year-old widowed unemployed White woman with a ninth-grade education was admitted under Florida Statute 394 civil involuntary order to the state hospital. Admission to the previous facility was due to bizarre psychotic and delusional behaviors and an earlier diagnosis of schizoaffective disorder. She was noncompliant with her medications and had a history of violent and aggressive behaviors (fight with resident and staff with police involved). She presented with psychotic, delusional, paranoid, and bizarre thoughts with off and on auditory hallucinations of voices telling her to attack people, but she reported no intention of doing the same. She also had visual hallucinations like the devil coming out of graves and flying objects. She had no suicidal or homicidal ideations, flashbacks or nightmares, seizure history, or allergies but did have a history of multiple suicide attempts and self-injurious behaviors (cut her left arm, jumped from the second floor, and cut her wrist 9, 2, and 1 years ago, respectively). She had a previous psychiatric history of mood swings, manic episodes, and repetitive requests for anxiety medication. She was diagnosed with schizoaffective disorder (*DSM-II* criteria) at age 16 years and had multiple psychiatric hospitalizations. She reported sexual abuse (at age 15 years) and physical abuse by a pimp 5 years ago. She had a previous medical history of diabetes mellitus, hypertension, hepatitis C, and chronic back and leg pain. She was a chronic alcoholic (since age 16 years), cocaine abuser (since age 18 years), and tobacco abuser for 35 years (2 packs/day until 5 months ago). As per legal records, she had previous charges for public drunkenness; battery on a law enforcement officer, disorderly conduct; cocaine possession; grand theft; and strong-arm robbery. She denied any current pending legal charges. She was put in an orphanage at birth and was raised by nuns, so her family history was unknown. She was married 1 time for 6 months; her husband died 9 years ago, and she had no children. She did housecleaning jobs. She received supplemental security income checks at the time. There was no military service history, and she enjoyed hobbies in her free time.

She was diagnosed according to *DSM-5* criteria with schizoaffective disorder (bipolar type), borderline personality disorder, cocaine abuse (in remission), and alcohol abuse (in remission), in addition to diabetes mellitus, unspecified viral hepatitis C without hepatic coma, and essential (primary) hypertension. Her psychopharmacologic management was on tablet haloperidol 10 mg twice/d, capsule diphenhydramine 50 mg twice/d, and tablet valproate 500 mg twice/d. During her stay, the patient often seemed anxious and made multiple somatic complaints, such as having stomach and back pain, to the nursing staff and requested as-needed medications, especially in the vicinity of a doctor. In meetings with the treatment team, she cried excessively, clutching her stomach, and complained of pain in her stomach, leg, and back, as well as pain while urinating and of being constipated. She reported that these symptoms had been present for the last 8 months or more. She believed she had a yeast infection in her stomach, tuberculosis, vaginal herpes, kidney problems, and difficulty sleeping. She would yell "please don't let me die" and would cry inconsolably. Repeated medical and physical examinations; urinalysis, urine culture, and kidney, ureter, and bladder x-ray for urinary complaints; magnetic resonance imaging and abdominal x-ray for abdominal complaints; and tuberculosis skin test results were all normal. Gynecology, family medicine, and orthopedic consultations were conducted and were all normal. She was started on tablet paroxetine 40 mg by mouth to manage the somatization. As the patient had weight loss associated

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with the depressive component of schizoaffective disorder, paroxetine was chosen among anxiolytic drugs for its weight gain effect.

At follow-up after 2 months, she started showing remarkable improvements of her somatic symptoms with pharmacologic treatment and psychotherapy. She reported the intensity of her pain was decreased, and she had fewer overall symptoms.

Discussion

The *DSM-IV* criteria for somatization disorder requires the presence of 4 pain symptoms, 2 gastrointestinal symptoms, 1 sexual symptom, and 1 pseudoneurologic symptom that are unexplained medically for several years. Our patient persistently (>8 months) complained of pain at 3 sites (stomach, leg, and back) and while urinating, 2 gastrointestinal problems (constipation and alleged yeast infection in stomach), and 1 sexual complaint (alleged vaginal herpes) but did not present with any neurologic symptoms. So, it is difficult to classify our patient under somatization disorder according to the *DSM-IV*. Additionally, the *DSM-IV* criteria fail to account for other symptoms (associated anxiety and lost sleep) and her unproportionate reaction to them (ie, inconsolable crying and yelling). Looking at the same case through the lens of the *DSM-5*, we see a clear picture of somatic symptom disorder with distressing symptomatology that significantly affected her daily functions, disproportionate reaction in the form of persistence of disturbing thoughts, and extreme anxiety about the perceived symptoms.

The patient could not have been diagnosed with somatization according to *DSM-IV* criteria[6] but is a clear case of somatization using the *DSM-5*.[4] The *DSM-III* and *DSM-IV*[7–9] focused more on counting and cataloging symptoms labeled as medically unexplained. This was an effective and more objective method of diagnosing somatization but led to conflicts over the doctors' and patients' varying perspectives of legitimacy and "reality" of the symptoms. The *DSM-5* incorporated the new perspective of focusing on the positive criteria such as presence of distressing thoughts, feelings, and behaviors associated with somatic symptoms instead of negative criteria like absence of a medical reason or explanation for the symptomatology. The *ICD-11* category 6C20 bodily stress disorder adopted a similar approach of focusing on presence of associated psychological symptoms rather than absence of identifiable organic cause for a medically unexplained symptom.[9]

Even before the *DSM-5*, the psychiatric community was already exhibiting unrest regarding the existing classifications for medically unexplained symptoms and somatoform disorders, with each making its own suggestions for modifications.[10–13] They desired a unified approach for medical and psychogenic causes for symptomatology, as a bodily symptom could have both components at the same time with an existing medical ailment with a psychological exaggeration,[13] similar to our case. The *DSM-5* criteria were a step up from the *DSM-IV*[14–16] but still leave a lot to be desired, as further specifications for its ruling-in criteria are needed to be clearer and free of jargon.[14–18] We are eagerly waiting for such changes to be reflected in the sixth edition of the *DSM*.

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REFERENCES

1. Escobar JI, Dimsdale JE. Somatic Symptom and Related Disorders. In Sadock BJ, Sadock VA, and Ruiz P, eds. *Kaplan & Saddock's Comprehensive Textbook of Psychiatry*. 10th ed. 1835–1836; 2017.
2. Lipowski ZJ. Somatization: the concept and its clinical application. *Am J Psychiatry*. 1988;145(11):1358–1368.
3. Marin C, Carron R. The origin of the concept of somatization. *Psychosomatics*. 2002;43(3):249–250.
4. American Psychiatric Association. *Diagnostic and Statistical Manual of Psychiatric Disorders*. Fifth Edition. Washington, DC: American Psychiatric Association; 2013.
5. World Health Organization. *International Statistical Classification of Diseases and Related Health Problems*. Tenth Revision. Geneva: World Health Organization; 1992.
6. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*. Fourth Edition. Washington, DC: American Psychiatric Association; 1994.
7. American Psychiatric Association. *Diagnostic and Statistical Manual of Psychiatric Disorders*. Third Edition. Washington, DC: American Psychiatric Association; 1980.
8. Smith RC, Gardiner JC, Lyles JS, et al. Exploration of *DSM-IV* criteria in primary care patients with medically unexplained symptoms. *Psychosom Med*. 2005;67(1):123–129.
9. World Health Organization. *International Statistical Classification of Diseases and Related Health Problems*. Eleventh Revision. Geneva: World Health Organization; 2019.
10. Mayou R, Kirmayer LJ, Simon G, et al. Somatoform disorders: time for a new approach in *DSM-V*. *Am J Psychiatry*. 2005;162(5):847–855.
11. Fava GA, Wise TN. Issues for *DSM-V*: psychological factors affecting either identified or feared medical conditions: a solution for somatoform disorders. *Am J Psychiatry*. 2007;164(7):1002–1003.
12. Sharpe M, Mayou R, Walker J. Bodily symptoms: new approaches to classification. *J Psychosom Res*. 2006;60(4):353–356.
13. Fava GA, Fabbri S, Sirri L, et al. Psychological factors affecting medical condition: a new proposal for *DSM-V*. *Psychosomatics*. 2007;48(2):103–111.
14. Sharpe M. Somatic symptoms: beyond "medically unexplained." *Br J Psychiatry*. 2013;203(5):320–321.
15. van der Feltz-Cornelis CM, van Houdenhove B. *DSM-5*: van somatoforme stoornissen naar "somatic symptom and related disorders." (*DSM-5*: from "somatoform disorders" to "somatic symptom and related disorders") *Tijdschr Psychiatr*. 2014;56(3):182–186.
16. Mayou R. Is the *DSM-5* chapter on somatic symptom disorder any better than *DSM-IV* somatoform disorder? *Br J Psychiatry*. 2014;204(6):418–419.
17. Claassen-van Dessel N, van der Wouden JC, Dekker J, et al. Clinical value of *DSM IV* and *DSM 5* criteria for diagnosing the most prevalent somatoform disorders in patients with medically unexplained physical symptoms (MUPS). *J Psychosom Res*. 2016;82:4–10.
18. Scamvougeras A, Howard A. Somatic symptom disorder, medically unexplained symptoms, somatoform disorders, functional neurological disorder: How *DSM-5* got it wrong. *Can J Psychiatry*. 2020;65(5):301–305.