

New categories of bodily stress syndrome and bodily distress disorder in ICD-11

Novas categorias de síndrome de estresse corporal e transtorno de estresse corporal na CID-11

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“Somatization” has long been considered as one of the greatest riddles in Health Care. All versions of the International Classification on Diseases (ICD) and the Diagnostic and Statistical Manual of Mental Disorders (DSM) released in the last 30 years differ when classifying patients with physical complaints associated with emotional distress. These differences demonstrate that, in spite of the improvement in our knowledge on how the brain potentially interferes with body function, we still have a long way ahead before we can truly understand the processes (and there may be several) that ultimately result in this phenomenon. However, scientific progress away from the traditional Cartesian perspective towards a more integrated biopsychosocial model¹ has produced advances not only in clinical practice, but also in how disorders are classified. The new version of ICD-11, particularly its special version for Primary Care, introduces some major changes with the new categories of bodily stress syndrome (ICD-11-PC)² and bodily distress disorder (ICD-11) that are different from the categories of somatic symptom disorders from DSM-5.

Primary Care is concerned with helping people in the early stages of symptom development and disorder where the strong influence of social and family context can be easily tracked³. This has always been a challenge for ICD and DSM in primary care since these taxonomic systems, designed by experts in more severe disorders, support a more category-based approach for the classification of disorders instead of a dimensional approach. Presenting physical symptoms while under emotional distress can be considered normal⁴ up to a certain degree, but these symptoms are also related to life stress, anxiety and depression. Additionally, they are a core feature of the “functional syndromes” that are found in different medical specialties such as fibromyalgia, irritable bowel syndrome, tension headaches and others^{5,6}. These symptoms have been previously named as medically unexplained symptoms (MUS) but this denomination cannot be considered a classification category, being more adequately described as a working hypothesis in everyday clinical work⁷. The category of Bodily Stress Syndrome in ICD-10-PC has now emerged as a new alternative to better understand, define and help managing these patients in primary care.

However, patients present with a continuum of severity of physical symptoms associated with emotional distress, especially those attending mental health services, including General Hospitals. This continuum points to one aspect that is present in those patients with more severe problems (and much less common in primary care): cognitive symptoms involving excessive preoccupations about health, and their association with increased functional

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impairment. Both ICD-11 with “bodily distress disorder” and DSM-5 with “chronic somatic symptom disorder” emphasize the importance of hypochondriac/health preoccupation cognitions as the basis for considering the presence of one of these mental disorders.

Perhaps, the current classifications are not, in fact, completely different but merely focus on different patients presenting in distinct levels of care and viewed through different lenses – those of the specialist or the family doctor. They may represent parts of the same phenomenological continuum that goes from cultural patterns of presenting emotional distress to severely impaired and difficult to treat patients with prevalent convictions of being severely ill in organic terms. However we do not know if this is the case. Multiple (and different) processes may play a part in the problems we see at different levels of care.

What is clear is that understanding the processes by which “somatization” develops requires us to embrace a conceptual model encompassing biological, psychological (including mental disorders, stressful life events and social support networks) and social (such as social deprivation) determinants. This is the ongoing challenge we face today, whenever we deal with the interface of Psychiatry and

General Medicine in health promotion, disease prevention and clinical care.

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