

Approach to the Patient with Multiple Somatic Symptoms



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KEYWORDS

• Somatic symptoms • Somatization • Depression • Anxiety • Collaborative care

KEY POINTS

- Patients with multiple and persistent physical symptoms are common in primary care.
- Collaboration with the patient is critical for effective management. Patients should be actively involved in setting treatment goals and deciding among therapeutic options.
- Screening and treatment of depression and anxiety disorders is a key component of management. Patients should be educated about how psychosocial stressors and somatic symptoms interact.
- Somatization can occur among patients with chronic medical conditions, such as cardiovascular disease or chronic obstructive pulmonary disease. Providers should avoid setting up a dichotomy between mental health and physical causation of symptoms.
- Twenty percent to 25% of patients with multiple somatic symptoms develop a chronic course of illness. Management should focus on improving functional status and avoiding unnecessary or invasive diagnostic tests and use of potentially addictive medications that increase the risk of iatrogenic complications.
- Patients with persistent somatic symptoms should have regular follow-up. Somatic symptom burden can be followed with a validated instrument, such as the 8-item Somatic Symptoms Scale.

INTRODUCTION

Patients with multiple somatic symptoms are common in primary care settings, in which more than half of all visits are for somatic complaints.¹ For some of the most common symptoms in primary care, such as chest pain, fatigue, dizziness, headache,

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and dyspnea, a medical diagnosis is not found in up to half of cases.² Patients with chronic and severe somatic symptoms have high levels of role impairment and spend more days in bed per month than patients with several major medical disorders.^{3,4} Patients with multiple and persistent somatic symptoms are also at risk for extensive investigations and referrals to specialists. Several studies have shown a strong relationship between somatization and excess health care costs resulting from high numbers of health care visits, repeated diagnostic testing, and costly treatments.⁵

Many patients with multiple somatic symptoms receive unnecessary and invasive somatic investigations, whereas psychological factors are insufficiently explored.⁶ In primary care settings, more than 70% of patients with major depression present with predominantly physical complaints rather than affective symptoms of depression.^{7,8} Kirmayer and Robbins⁵ found that most (73%) primary care patients with depressive or anxiety disorders presented exclusively with somatic symptoms. Compared with patients without psychiatric illness, those with anxiety and depressive disorders tend to have more somatic symptoms without identified disease and are more likely to be high users of health care resources.^{3,9–12}

There is also a strong correlation between the number of somatic symptoms and the likelihood of a depression or anxiety diagnosis.¹³ The higher number of somatic complaints in patients with comorbid depression or anxiety and chronic medical illness (compared with those with medical illness alone) might explain the increased diagnostic testing and higher medical costs that these patients incur.¹³ In addition to depression and anxiety, other risk factors for a chronic high number of somatic symptoms include childhood psychological abuse, education, being unmarried or widowed, and severity of medical illness.¹⁴

The category of somatoform disorders has been highly controversial since its introduction in the *Diagnostic and Statistical Manual of Mental Disorders, Third Edition* (DSM-III) 30 years ago. These disorders, such as somatization disorder and hypochondriasis, were difficult to diagnosis, and the diagnoses were not useful to primary care physicians and rarely used clinically. In DSM-IV, a key feature of somatoform disorders was the concept of medically unexplained symptoms. This concept was not well accepted by patients, and also ignored the fact that many cases of somatization occur in patients with comorbid psychiatric disorders and medical disorders. The comorbid psychiatric disorders often lead to amplification of medical symptoms in these patients.¹⁵

One of the most substantive changes in DSM-5 involves the replacement of several somatoform disorders, including somatization disorder, pain disorder and hypochondriasis, with somatic symptom disorder (SSD) (**Fig. 1**).

SSD is a category of disorders characterized by somatic symptoms that either are distressing or result in significant disruption of functioning, as well as excessive and disproportionate thoughts, feelings, and behaviors regarding those symptoms.¹⁶ To be diagnosed with SSD, the individual must be persistently symptomatic for at least 6 months. Moreover, the DSM-IV requirement that these somatic symptoms be medically unexplained has been eliminated, so individuals who meet criteria for SSD may or may not have a medically diagnosed condition. Rather, the diagnosis of SSD is based on the reporting of bothersome and persistent somatic symptoms accompanied by excessive psychological responses (**Box 1**). Hypochondriasis has also been eliminated as a disorder. Most patients with hypochondriasis now receive a DSM-5 diagnosis of SSD. Those with high health anxiety and minimal to no somatic symptoms are diagnosed with illness anxiety disorder (**Box 2**).

Primary care providers have a crucial role in the recognition and adequate treatment of patients with multiple somatic complaints. These patients can elicit powerful



Fig. 1. Somatic symptom disorder and illness anxiety disorder.

emotional reactions in physicians,^{17,18} which may result in less than optimal clinical care. Physicians often feel frustrated by patients' frequent complaints and dissatisfaction with treatment.¹⁹ Although physicians may think that their competence is challenged by their inability to find a medical cause for the symptoms, the patients may think that they are discredited and accused of fabricating their symptoms.

One of the biggest challenges in the primary care settings is to simultaneously address potential medical causes for physical symptoms while considering an associated mental health diagnosis. A major aim of this article is to enhance recognition of somatization and to describe treatment and management options that can lead to improvement in patient care.

SPECTRUM OF SEVERITY OF SOMATIC SYMPTOMS: A BIOPSYCHOSOCIAL APPROACH TO DIAGNOSIS AND MANAGEMENT

The 3 common types of somatization seen in primary care and management approaches to patients with these varying types of somatization are described in **Box 3**.

1. In primary care settings, it is common for patients to present with somatic symptoms related to temporary stressors. For example, symptoms such as headache or back pain could be triggered or amplified in the context of a job loss, divorce,

Box 1

Somatic symptom disorder

- One or more somatic symptoms associated with distress and impairment
- Excessive thoughts, feelings, and behaviors in response to somatic symptoms
- Somatic symptom does not have to always be present but must be persistent (at least 6 months)

Adapted from American Psychiatric Association. Diagnostic and statistical manual of mental disorders. 5th edition. American Psychiatric Association; 2013. p. 309–27.

Box 2**Illness anxiety disorder**

- Persistent preoccupation with having a serious illness (at least 6 months)
- Very high levels of health anxiety
- Complete absence of somatic symptoms, or if any somatic symptoms are present, they are very mild
- Excessive health-related behaviors (eg, constantly checking for signs of illness) or maladaptive avoidance (eg, avoids a visit to the doctor's office)

Adapted from American Psychiatric Association. Diagnostic and statistical manual of mental disorders. 5th edition. American Psychiatric Association; 2013. p. 309–27.

or interpersonal difficulties. Resolution of these acute somatic symptoms requires minimal treatment or occurs after stressors resolve, and there are typically no long-term adverse consequences and minimal functional impairment. According to Kroenke and Jackson,²⁰ in patients presenting to a general medicine clinic with physical symptoms, 70% of patients reported improvement within 2 weeks. The few patients who fail to improve often have even more severe symptoms at 3 months, and in 1 study²⁰ were twice as likely to be fearful about the prospect of an undiagnosed severe medical illness.

2. Although most patients with stress-related somatic symptoms improve within several weeks of seeing a health care provider, approximately 20% to 25% of patients suffer from chronic or recurrent symptoms that are often present at 5-year follow-up.^{21–23} Patients with a longer duration of symptoms are likely to fall into the other 2 common types of somatization: relapsing/remitting episodes of somatization associated with acute or recurrent anxiety and depressive episodes or chronic somatization, which is largely covered by the DSM-5 term somatic symptom disorder. The relapsing/remitting form of somatization is characterized by episodes of somatic symptoms associated with repetitive psychosocial stressors (eg, marital conflicts, job difficulties), anxiety and depression episodes, and substantial impairment in daily functioning (**Box 4**).

Early accurate diagnosis is important to prevent progressive negative consequences such as job loss, marital problems, and financial problems. Delays in diagnosis and intervention for this condition can lead to worsening affective and anxiety symptoms and high medical costs as a result of multiple specialist visits and medical testing. The case outlined in **Box 5** shows some of the key features of relapsing/remitting somatization associated with an anxiety disorder.

Box 3**Subtypes of somatization**

1. Acute somatization
 - Temporary production of physical symptoms associated with transient stressors
2. Relapsing somatization
 - Repeated episodes of physical symptoms associated with repetitive stressors and anxiety or depressive episodes
3. Chronic somatization
 - Nearly continuous somatic focus, perception of ill health, development of disability

Box 4		
A comparison between relapse/remitting and chronic somatization		
	Acute	Chronic
	Anxiety/Depression	Anxiety/Depression
	Somatization	Somatization
Childhood history	Normal	Neglect, abuse
		Multiple losses
Job history	Stable	Poor to unstable
Intimate relationships	Stable, long-term	Unstable, abusive
		Multiple partners

3. The chronic subtype of somatization is often characterized by a history of multiple and persistent somatic symptoms associated with a high level of functional impairment. When diagnostic evaluations fail to fully show the cause for their suffering, these patients often seek additional diagnostic assessment and studies or self-medicate with alcohol, illicit drugs, or chronic opioid pain medications. Extensive diagnostic testing and medical/surgical procedures may also increase the risk of iatrogenic injury, further increasing the costs associated with chronic and persistent somatic symptoms.

Several risk factors have been associated with chronic and severe somatic symptoms, including childhood neglect or sexual abuse, chaotic lifestyle, a history of alcohol and substance use, poor work history, and tumultuous relationships. In addition to higher rates of comorbid chronic medical illness and psychiatric disorders, chronic and severe somatization has also been associated with the presence of axis II disorders. According to Rost and colleagues,²⁴ avoidant, paranoid, self-defeating, and obsessive-compulsive are the most common personality disorders identified. Among personality traits, high levels of neuroticism and harm avoidance are associated with a higher number of somatic symptoms as well with axis II personality disorders.^{25,26}

The case described in **Box 6** shows some of the key features of chronic somatization.

Complex biological, psychological, and environmental factors play a significant role in patients with multiple somatic symptoms. The identification of factors that contribute to the initiation, maintenance, or exacerbation of symptoms can help the physician understand the patient as a person and enhance the therapeutic alliance

Box 5
Key features of relapsing/remitting somatization associated with an anxiety disorder
Mrs S, a 35-year-old woman, married with 2 children, presented with an 8-week history of muscle tension, intermittent heart palpitations, and dizziness. Over the previous 2 weeks, Mrs S had presented twice to the emergency room with chest pain, palpitations, sweating, and shortness of breath. Workup over the last 2 months, including routine blood chemistries, blood cell count, calcium concentration, thyroid-stimulating hormone, electrocardiography, treadmill, and Holter monitor, had shown no signs of cardiovascular abnormalities. In the last week, she had had to leave work twice when the anxiety became intolerable. Physical examination showed a healthy, tense woman with normal vital signs. She took no medications and denied using alcohol or drugs. She reported that she had been under a lot of stress because of marital problems since her husband had lost his job 2 months previously.

Box 6**Case showing some of the key features of chronic somatization**

Ms T was a 42-year-old divorced woman with recurrent severe abdominal pain, fatigue, and disturbed sleep. After a viral respiratory infection, she presented with worsening fatigue and nausea. Her multiple physical complaints began after a litigious divorce when she began suffering from tension headaches and legs that became “weak” at times. In the last 2 months, she had gone to the emergency room (ER) 3 times for acute pain and was hospitalized once. Over the previous 2 years, she had undergone extensive investigations, including abdominal radiography, abdominal ultrasonography, esophagogastroduodenoscopy, and colonoscopy, all of which were normal. Past medical history showed negative exploratory laparotomy 1 year previously, multiple previous ER visits for migraines, and 2 back surgeries. She had a history of recurrent depressive symptoms, for which she had never been prescribed antidepressant medication or been referred for psychotherapy. She also had a history of domestic violence. She was on disability for chronic back pain. In the last year, she had received care from 3 different physicians. When you refused to prescribe opioids, she started yelling at you “You think that it is all in my head... you’re fired.”

with the patient. When health care providers use this approach, patients are not set up to perceive their problems as either physical or mental, and the pitfall of assuming that symptoms have only a psychological basis is avoided. A biopsychosocial approach is also consistent with the new DSM-5 diagnosis of SSD, a multidimensional descriptive system that underlines the patient’s difficulties coping with distressing somatic symptoms and emphasizes the contribution of biological and psychosocial factors in the development of somatic symptoms.^{27,28}

There is some evidence that genetic factors play a role in the development of somatic symptoms, and that SSD reflects complex relationships among genetic factors, somatic symptoms, anxiety, and depression.^{29–31} The history of SSD can start in early life. A childhood history of chronic illness or abnormal illness behavior, or the presence of a family member with a chronic illness seems to predispose to somatization later in life.^{32,33} Childhood adversity, such as neglect and sexual and physical abuse has been associated with a greater risk of both psychological and somatic problems as an adult. Several studies have suggested an association between childhood and adult trauma experiences and increased somatic symptom reporting in adults.^{34–37}

The model proposed by Walker and colleagues (the P-P-P [predisposing, precipitating, perpetuating] model) is a valuable tool to understanding and guiding management of these challenging patients.³⁸ This 3-stage model includes biological, psychological, and social factors with a role in the initiation, maintenance, or exacerbation of symptoms (**Table 1**).

- Predisposing factors make individuals more vulnerable to disease. Examples of predisposing factors for SSD include chronic illness during childhood, childhood adversity, family of origin modeling of abnormal illness behavior, poor coping ability, comorbid medical illness, and psychiatric illness.

Table 1**Predisposing, precipitating, and perpetuating factors**

Predisposing	Precipitating Factors	Perpetuating
Chronic childhood illnesses	Medical illness	Chronic stressors
Childhood adversities	Psychiatric disorder	Maladaptive coping skills
Comorbid medical illness	Social and occupational stress	Negative health habits
Lifetime psychiatric diagnosis	Changes in social support	Disability payments
Poor coping ability		

- Precipitating factors are stressors or elements of a patient's life that have a chronologic relationship with the onset of the symptoms or precipitate a crisis. They can include medical illness, psychiatric disorder, losses or changes in important relationships, change in employment or financial status, traumatic events for the individual or community, and changes in social support.
- Perpetuating factors that maintain the patient's current difficulties include medical illness, maladaptive coping strategies, lack of social support, social isolation, ongoing financial problems, opiate medication dependence, and legal issues related to the symptoms. Katon and colleagues⁸ have labeled psychosocial factors that perpetuate illness "illness maintenance systems."

PSYCHIATRIC DISORDERS AMONG PATIENTS WITH SOMATIC SYMPTOMS

Up to 20% of patients presenting for a primary care visit report significant depressive symptoms, and 5% to 10% meet diagnostic criteria for major depression.³⁹ Depression is characterized by changes in mood accompanied by somatic and cognitive changes.¹⁶ When patients with depression seek care from their health care provider, their chief complaint is often somatic rather than emotional.⁴⁰ In an international multicenter study of more than 1000 patients,⁷ 69% of patients with depression reported only somatic symptoms as the reason for their visit. In addition to fatigue and sleep disturbances, nonspecific musculoskeletal complaints and gastrointestinal problems can be the presenting symptoms of depression. Depressed patients with general aches and pains make 20% more visits to their health care provider each year than those without such aches and pains.⁷ The presence of multiple pain symptoms (eg, back pain, headache, abdominal pain) increases the risk for comorbid depression by at least 2-fold.^{41,42}

Primary care providers do not recognize depression in about 50% of depressed patients.⁴³ In particular, a diagnosis of depression can be missed when the physician is focused on finding a cause for the physical symptoms and the patient is not asked questions that could show psychiatric comorbidity. Despite high rates of depression in primary care, making an accurate diagnosis is complicated by several factors. Stigma regarding mental illness and mental health treatment can make patients reticent about expressing feelings of sadness and more comfortable reporting somatic symptoms. In addition, a somatic presentation of depression is more common in patients who do not have an ongoing relationship with the physician.⁷ Without a trusting relationship, self-disclosure of psychological complaints is less likely. Another barrier to an accurate diagnosis is that depression, anxiety, and medical conditions often coexist, complicating the clinical picture. A cross-sectional survey of the associations among depression, anxiety, and multiple somatic symptoms in 15 primary care centers found considerable overlap.

75% of depressed patients had comorbid anxiety, somatization or both; 57% of the patients with anxiety had comorbid depression, somatization; or both and 54% of the patients with somatization had comorbid depression, anxiety or both.⁴⁴

Among primary care patients with chronic medical conditions, depression has been associated with decreased self-care, poor adherence to medical treatment, and also amplification of somatic symptoms.⁴⁵ In a review of 31 studies involving 16,922 patients, Katon and colleagues¹³ evaluated the impact of depression and anxiety on somatic symptom reporting in patients with chronic medical conditions, such as diabetes, pulmonary disease, heart disease, and arthritis. In patients with chronic medical illness, those with comorbid depression or anxiety reported more medical symptoms, even after controlling for the severity of the medical disorder. Other studies⁴⁶ have suggested that among patients with diabetes, the severity of diabetic

symptoms is more strongly associated with depressed mood than with glycosylated hemoglobin levels or number of diabetes complications.

Anxiety disorders are the most common mental disorders in the general population and occur at least as commonly among primary care patients as depression. As many as one-third of primary care patients have significant anxiety symptoms; and anxiety disorders can be as disabling as depression.⁴⁷ Moreover, depression and anxiety co-occur up to 50% of the time.⁴⁸ Anxiety disorders can be difficult to diagnose, because anxiety can be a symptom of another psychiatric disorder, an expression of the patient's response to a medical illness, a medication side effect or secondary to a general medical condition, withdrawal from alcohol, or a symptom of drug use.⁴⁹ For example, patients with generalized anxiety disorder (GAD), one of the most common mental disorders in primary care, typically present with nonspecific somatic symptoms, such as headaches, muscle aches, fatigue, and gastrointestinal symptoms. A myriad of somatic symptoms are also present in patients with panic attacks (eg, palpitations, chest pain, dizziness, and diaphoresis). Anxiety disorders can confuse the clinical picture, and multiple anxiety disorders can occur in the same patient (panic disorder and posttraumatic stress disorder [PTSD]). Sometimes, the physical manifestations of anxiety can lead to multiple diagnostic procedures, including invasive procedures, and iatrogenic complications.

Psychiatric comorbidity in patients presenting with somatic complaints should be suspected in the following scenarios:

- The number of physical symptoms is a powerful predictor of psychiatric comorbidity, because the likelihood of coexisting depression or anxiety increases with the number of physical symptoms.¹²
- The risk for coexisting depression is doubled when patients present with 2 or more pain symptoms.⁵⁰
- When somatic symptoms remain unexplained after a thorough medical workup, there is an increased probability of a psychiatric comorbidity.^{21,51}
- Frequent clinic visits and high use of health care services is a predictor of psychological distress.³⁷

Several investigators have identified important clinical factors that predict depression and anxiety disorders in primary care patients presenting with physical complaints.^{3,4,52} In a study of 500 patients presenting to a general medicine walk-in clinic with physical symptoms as the main complaint,³ 4 clinical predictors significantly increased the possibility of a depressive or anxiety disorder: recent stress, total number of somatic symptoms (with or without explained cause), poor self-reported health status, and symptom severity. A follow-up study⁵² supported these findings, suggesting that the strongest predictors of an underlying mental disorder were recent stress, 5 or more physical symptoms, or poor health.

The S4 model (symptom count, stress, severity, and self-rated health) proposed by Jackson and Kroenke may help the physician recognize the need for exploration of psychological symptoms by acting as an excellent tool for identification of patients who might be at risk for an underlying mental health disorders. The model can also improve patient care by helping a busy family practitioner to target those high-risk patients and come to an accurate diagnosis.

Items in the S4 model include:

1. Stress recently (last week) (yes/no)
2. Symptom count (checklist of 15 common somatic symptoms); scored as positive if more than 5 symptoms

3. Self-rated overall health poor or fair on a 5-point scale (excellent, very good, good, fair, poor); scored as positive for fair or poor responses
4. Self-rated severity of symptoms from 0 (none at all) to 10 (unbearable) scale; scored as positive for responses greater than 5

The presence of any of these 4 predictors seems to increase the likelihood of an underlying depressive or anxiety disorder at least 2-fold to 3-fold.

MANAGEMENT RECOMMENDATIONS

Our approach to management of patients with somatic symptoms is based on the effective methods supported by published evidence and also on our experience working with primary care providers. First, an overview is presented of general strategies, and then, specific recommendations tailored to the severity of the patient's symptoms and comorbidities are made.

General Principles of Management

Engagement and building a sound therapeutic alliance with the patient

In the management of the patient presenting with somatic complaints, empathy is essential for the development of a strong therapeutic relationship with the patient.⁵³ This alliance is strengthened when the physician listens carefully, encourages the patient to describe their symptoms, and explores the meaning of each symptom for the patient.⁵⁴ The patient not only feels understood but also feels reassured that their concerns are taken seriously. As described by Coulehan and colleagues,⁵⁵ building empathy entails asking patients to tell you more about their problem (such as "What has this been like for you?," "How has all of this made you feel?"), clarifying (such as "Let me see if I've gotten this right..."), and communicating your understanding to the patient ("I can imagine that must be...").

Biopsychosocial history and physical examination

In the first phase of clinical assessment, a detailed history and physical examination are powerful tools to enhance engagement, to rule out serious or treatable medical conditions, and to guide test selection and treatment. However, when doctors focus primarily on physical symptom relief, they can miss clues about the reason for the visit and miss the opportunity to explore the patient's perspective of the symptoms and associated psychosocial stressors.^{56,57} The BATHE technique is an excellent tool for engaging a patient while simultaneously assessing psychosocial factors. This technique consists of asking 4 specific questions: the patient's background, affect (the feeling state), the most troubling problem, and how the patient is handling the situation (**Box 7**). The questions are followed by an empathic response.⁵⁸

It is also important to elicit the patient's exploratory model of their illness.⁵³ This process includes what the patient thinks might be causing the symptoms, how the illness

Box 7

The BATHE technique

B: Background: "What is going on in your life?" and "What brings you in today?"

A: Affect: "How do you feel about that?"

T: Trouble: "What bothers you the most about this situation?"

H: Handling: "How are you handling that?"

E: Empathy: "That must be very difficult for you"

or symptoms have affected their lives and their family, what their expectations are for investigations, and what they expect from treatment.⁵⁹

Diagnostic evaluation to rule out medical illness

Diagnostic tests are selected based on the history and physical examination. However useful diagnostic tests are, they seldom have 100% sensitivity and specificity in identifying the cause of a disease, and uncertainty often remains, with negative results. As more tests are performed, finding a chance abnormality is always a possibility, and the doctor's fear of angering the patient or missing a serious condition can trigger unnecessary extensive investigations.

Although care must be taken to provide appropriate investigation for signs or symptoms, a recent meta-analysis⁶⁰ suggested that physicians overestimate the value of diagnostic testing on reassurance. Moreover, in this meta-analysis, tests for symptoms with a low risk of serious illness had no impact on decreasing illness anxiety. Although it is important to provide reassurance that a serious illness is unlikely, explaining the results and acknowledging the patient's frustration at not finding a specific cause for their symptoms may be more important. When doctors reassure patients without providing a clear explanation for symptoms, these symptoms may even be exacerbated.⁶¹

Educate patients how psychosocial stressors and symptoms interact

Instead of performing an exhaustive search for a mysterious illness, it may be helpful to gradually move from investigating somatic symptoms to exploring social or psychological distress, which may amplify or prolong the symptoms. However, premature inquiry about depression or anxiety can trigger negative reactions in some patients and may damage rapport. In patients with a higher risk based on your objective elements, including psychiatric disorders in the primary differential diagnosis often makes for an easier transition to a more detailed discussion when a reasonable workup is negative. A useful strategy is to explain how stress and symptoms interact and how physical illness and emotional problems often co-occur. Addressing the connection between how the brain and body interact can help restore hope in an individual who is suffering and feels powerless to control them.

Specific Management Strategies

For patients with recurrent somatic symptoms in whom acute anxiety and depression are the likely cause or a major contributor to the somatic presentation, screening for psychiatric comorbidity is recommended.

Screening for depression and anxiety

Considering the well-documented overlap of depression, anxiety, and somatic symptoms (SAD triad), one of the most important steps in the evaluation of patients with SSD is screening for psychiatric disorders, especially depression and anxiety. The Patient Health Questionnaire-9 (PHQ-9) can be used as a diagnostic tool for major depressive disorder, to monitor response to treatment, or to guide treatment.⁶² The 7-item GAD scale (GAD-7) is a reliable, valid, and easy-to-use self-report questionnaire for evaluating the presence and severity of 1 of 4 anxiety disorders: panic, generalized anxiety, social phobia, and PTSD. Once a patient scores 10 or more on the GAD-7, follow-up questions are needed to diagnose which of these specific disorders are present.

Evaluate somatic symptom burden

The 8-item Somatic Symptoms Scale (SSS-8), an abbreviated version of the PHQ-9, was recently developed as a brief, patient-reported measure of the severity of somatic

symptoms. The SSS-8 may facilitate the diagnosis of SSD and may be helpful to monitor somatic symptom burden and guide treatment.⁶³

Treatment of comorbid psychiatric disorders

A comprehensive discussion of effective treatment of depression and anxiety is beyond the scope of this article. However, it is important for physicians treating patients with SSD to be aware that both medication and cognitive-behavioral therapy (CBT) have proven effectiveness in treating depression and many anxiety disorders.⁶⁴ Therefore, when a depressive or anxiety disorder is diagnosed, the physician should consider both psychopharmacologic treatment and psychotherapy as treatment options.

There is increasing evidence that both antidepressant and CBT are valuable treatment modalities for patients who present with multiple somatic complaints, whether the symptom has a medical explanation or not.^{65–67} Antidepressants may be helpful in relieving chronic pain symptoms, independent of the presence of a comorbid psychiatric disease.⁶⁵ The serotonin-norepinephrine reuptake inhibitors, such as venlafaxine and duloxetine, have been found mostly effective in treating neuropathic pain.⁶⁸ There is increasing evidence that dual-acting antidepressants that modulate both norepinephrine and serotonin receptors may ameliorate other somatic symptoms as well.^{69–71} It is important to optimize the management of pain that commonly co-occurs with depression, because this can improve treatment outcomes and quality of life.⁷² Some studies have shown that although the burden of physical symptoms diminishes significantly in the first month of selective serotonin reuptake inhibitor (SSRI) treatment, patients with moderately severe pain at the start of treatment are 2-fold less likely to respond to antidepressant treatment.^{73,74} Given the negative consequences associated with opioid therapy, physicians should avoid prescribing opioid analgesics. Some of the problems related to opioid therapy include frequent visits to the emergency room for opioid prescriptions, misuse to self-medicate, and development of tolerance and addiction.

CBT has the strongest and most consistent evidence for its efficacy among different psychotherapeutic modalities.^{66,75} In a review of 13 randomized controlled trials (RCTs) of treatment modalities for somatoform disorders, Kroenke showed that CBT was effective in most studies (supported by 11 of 13 RCTs).⁷⁵ A recent meta-analysis including 10 randomized and 6 nonrandomized trials suggested that psychotherapy for more severe forms of somatoform disorder that were treated in secondary and tertiary care was more effective than usual treatment with respect to reduction of physical symptoms and functional impairment (eg, life satisfaction, interpersonal problems, maladaptive cognitions and behavior).⁷⁶ One of the cases described earlier shows this clinical approach.

In treating patients with chronic somatic symptoms, the main goal is not to cure the disease but to improve function and help the patient cope more effectively with symptoms. It is also important to convey that the primary care provider will continue to collaborate with the patient to alleviate suffering and distress from their symptoms (**Box 8**).

The second clinical vignette shows some of these familiar problems encountered by primary care providers (**Box 9**).

In addition to the guidelines discussed earlier, the following strategies are recommended^{77–80}:

- Schedule time-limited regular appointments (eg, every 4–6 weeks) rather than erratic appointments to address complaints

Box 8**Treatment: essential concepts and goals**

- Collaborate with patient to help reduce distress from symptoms
- Explain that although there may not be a reason for their symptoms, you will work together to improve their functioning as much as possible
- Educate patients how psychosocial stressors and symptoms interact
- Avoid comments like “Your symptoms are all psychological” or “There is nothing wrong with you medically”
- Avoid the temptation to order unnecessary, repetitive, or invasive investigations
- Educate the patient on how to cope with their symptoms instead of focusing on a cure
- Involve and collaborate with the patient in setting treatment goals.

- Perform a brief physical examination at each visit to address new symptoms or health concerns
- Avoid unnecessary diagnostic tests unless objective evidence of a disease is present
- Treat comorbid psychiatric disorders and alcohol and substance abuse problems
- Minimize polypharmacy, tapering and discontinuing medications with high potential for abuse (eg, narcotic agents, sedatives)
- Prescribe regular dosing of pain medications and avoid as needed analgesics (especially opiates)
- Encourage mobility to prevent physical deconditioning (eg, physical therapy, regular exercise)

Psychiatric consultation and the role of collaborative care model

Referral to a psychiatrist consultant can be perceived as abandonment by the patient or invalidation of their symptoms. Patients are more likely to accept a referral when the provider underscores how the consultation will help both the patient and the doctor to find other ways to alleviate suffering and improve coping with illness. A follow-up visit with the primary care physician after the psychiatric consultation is recommended to discuss recommendations for further treatment. Patients with more severe somatization, or those who have not responded to trials of 1 or 2 medications, who require combination therapy, or who have had intolerable side effects, may benefit from a psychiatric referral.

Box 9**Familiar problems encountered by primary care providers**

Mrs S had symptoms typical of panic disorder. The initial evaluation of a patient presenting with somatic symptoms and anxiety should include a history and physical examination, an evaluation of the potential role of medications and substances, and screening diagnostic tests (eg, routine blood chemistries, thyroid-stimulating hormone [TSH] level, electrocardiogram). TSH level is recommended for patients with new-onset anxiety disorders. Because patients with panic disorder often present with somatic complaints, and most are fearful of having a serious condition, such as a heart attack, an important step after the clinical diagnosis is made is to discuss with the patient their fears of medical illness and expectations of medical testing and treatment. Mrs T felt relieved when you reassured her that with appropriate treatment her symptoms could be controlled. You discussed that both CBT and antidepressant medication have been shown in controlled trials to be equally effective.⁸¹ The patient agreed to a trial of an SSRI and her anxiety symptoms improved when she returned 2 weeks later.

Patients are more likely to accept mental health treatment when it is provided as part of primary care treatment. There is an increasing body of research on how to integrate mental health treatment into primary care as a collaborative care model of treatment, in which mental health professionals work together with providers in the primary care setting. A meta-analysis of 79 randomized trials of collaborative care depression and anxiety interventions in primary care⁸¹ found that depression and anxiety outcomes were improved for up to 2 years compared with usual care approaches. Integration of mental health treatment into primary care may improve the care of patients with somatic symptoms and increase physician satisfaction.

SUMMARY

In primary care settings, patients frequently present with multiple somatic complaints, which can be associated with significant distress and functional impairment. When these somatic complaints are related to acute psychosocial stressors, the somatic symptoms resolve relatively rapidly in most cases, usually without any specific treatment. However, in 20% to 25% of cases, these symptoms can recur or become chronic and can be associated with high use of medical services and increased risk of iatrogenic complications. Risk factors for chronic multiple somatic symptoms include childhood abuse and neglect, childhood illness, and co-occurring psychiatric illness.

These conditions can be effectively managed in primary care, and primary care providers should use a biopsychosocial approach. Collaboration and education are key at every point in management, and patients should be actively involved in setting treatment goals. Patients should also be screened with brief validated instruments for current depression or anxiety disorders, because these frequently occur in patients with multiple somatic complaints. It is critical for primary care providers to remember that somatization can also occur among patients with chronic medical conditions. Distinctions between physical and mental phenomena can make patients feel the need to choose one or the other explanation, and often interfere with the therapeutic alliance. It is more helpful to educate patients about how psychosocial stressors and somatic symptoms interact. Education and regular scheduled visits are central to the management of these patients. Evidence-based treatments should be provided for depression or any anxiety disorder that is identified. There is also increasing evidence that these treatments (antidepressant medications, CBT, exercise, and collaborative care) are also effective for improving functioning and decreasing somatic symptom burden.

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