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Somatic symptom disorder in primary care: A collaborative approach

The guidance presented here will help you to counsel patients and work with other caregivers in a biopsychosocial approach.

▶ THE CASE

James R* is a 30-year-old man who presented for a primary care walk-in visit due to dizziness, 2 days after he visited an emergency department (ED) for the same concern. He reported episodic symptoms lasting seconds to minutes, specifically when lying down. He said he had not fallen or experienced other physical trauma, did not have blurred vision or hearing loss, and was taking no medications. He also reported panic attacks, during which he experienced palpitations, trembling, paresthesia, and fear of dying. He stated that dizziness did not occur exclusively during panic episodes. His medical history was significant for hypertension; however, he reported significant anxiety related to medical visits. All home blood pressure readings he reported were within normal limits.

Upon examination, the patient had a blood pressure reading of 142/90 mm Hg and no evidence of nystagmus at rest. A neurologic exam was normal and a Dix-Hallpike maneuver reproduced subjective vertigo without nystagmus. Laboratory findings from the patient's ED visit were negative for troponin and drug use, and blood oxygenation levels were within normal limits. At the time of this current visit, an electrocardiogram was unremarkable, with the exception of some tachycardia.

The presumptive diagnosis was benign paroxysmal positional vertigo (BPPV). An Epley maneuver was performed in the clinic and resulted in minimal symptom improvement. The physician taught Mr. R how to perform the Epley maneuver himself, prescribed a short course of meclizine, and referred him to the integrated mental health care service to address his panic attacks and anxiety.

Over the next few months, Mr. R continued to report significant distress about the dizzy spells, which persisted even after performing the Epley maneuver, and he reported that the meclizine was causing worsening vertigo. He received an ear-nose-and-throat consultation and cognitive behavioral therapy (CBT)-based consultation/interventions. He also reported avoiding multiple activities due to concerns about his dizziness.

○ HOW WOULD YOU PROCEED WITH THIS PATIENT?

**The patient's name and other personally identifying information have been changed to protect his identity.*

Somatic symptom disorder (SSD) is characterized by one or more physical symptoms associated with "excessive thoughts, feelings, or behaviors that result in distress and/

or functional impairment.”¹ Individuals with SSD are preoccupied with symptom-related severity, experience high symptom-related anxiety, or devote significant time and energy to the symptoms or health concerns. With a diagnosis of SSD, physical symptoms experienced by the patient may or may not be medically explained. The same symptom need not be continuously present as long as the overall symptomatic presentation lasts 6 months or longer.

The specifier “with predominant pain” is used when pain dominates the presentation.¹ Estimated prevalence of SSD in primary care ranges from 5% to 35%.² The true scope of SSD is difficult to assess accurately since research tends to focus on medically unexplained symptoms, rather than excessive symptom-related concerns. Furthermore, terms such as “medically unexplained symptoms” and “functional syndromes” (including fibromyalgia and irritable bowel syndrome) are frequently used when describing SSD.³

One or more factors may contribute to unexplained symptoms: limitations of medical procedures and techniques, partial clinical information, patients’ inability to follow management recommendations, challenges in differential diagnostics, and access-to-care limitations preventing regular care and appropriate diagnostic work up.

■ **What’s important to remember** is that it’s the patient’s reaction to physical symptoms, rather than the presence of symptoms per se, that defines SSD.

CONSIDERATIONS IN THE DIFFERENTIAL DIAGNOSIS

When making a diagnosis of SSD, symptoms cannot:⁴

- be feigned or deliberately produced as in malingering or factitious disorder.
- result from physiologic effects of a substance (eg, intoxication, withdrawal, or adverse medication effects).
- constitute somatic delusions, as occur in psychotic disorders.
- constitute symptoms or deficits affecting voluntary motor or sensory function that are better explained by

neurologic, medical, or psychiatric conditions (consider conversion disorder).

- be preoccupations with physical appearance flaws, as in body dysmorphic disorder.
- be accounted for by an anxiety disorder (eg, palpitations associated with panic attacks).

Illness anxiety disorder is also characterized by significant health-related concerns; however, physical symptoms are either mild or absent.

Possible causes of SSD are varied and complex, including genetic and biological factors, family dynamics, behavioral modeling/learning, personality traits, difficulties with emotional regulation, and awareness.⁵ Patients may present with ongoing requests for symptom explanations, feelings of helplessness, fear of having concerns dismissed, and low motivation for change.³

Aids in supporting a diagnosis of SSD

It’s not appropriate to rely solely on questionnaires to make the diagnosis of SSD. However, brief screening tools are a time-efficient way to capture patients’ experiences and perceptions.⁶ Along with other components of clinical evaluation, brief symptom screens can both support the diagnosis and help in longitudinal symptom assessment.

■ **Patient Health Questionnaire-15** (PHQ-15), developed for self-report screening in primary care, has desirable psychometric properties including appropriate internal reliability; convergent validity with measures of functional status, disability days, and symptom-related burden; and discriminant validity from measures of depressive symptoms.⁷ The PHQ-15 is an open access tool that is available in several languages. The respondent is asked to rate the extent of being bothered by a range of medical symptoms in the preceding 4 weeks. Total scores range from 0 to 30, with higher scores indicating greater symptom aggravation. Cutoffs of 5, 10, and 15 correspond to mild, moderate, and severe symptom levels.⁸

■ **Somatic Symptom Disorder - B Criteria Scale** (SSD-12) aims to capture SSD symptoms in line with *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) diag-



Ongoing elevated screening scores for anxiety and depression refractory to interventions may signal somatic symptom disorder.

➤ CBT is empirically supported as a treatment approach to medically unexplained symptoms and somatic symptom disorder.

nostic criteria. It assesses cognitive, affective, and behavioral aspects of SSD.⁹ The SSD-12 is copyrighted and its use requires registration and purchase. Cutoffs by age and gender are available. SSD-12 has demonstrated appropriate reliability and validity.⁹

■ **Structured Clinical Interview for DSM Disorders (SCID)**^{10,11} is perhaps the most rigorous differential diagnostic tool. However, SCID administration requires training and skill; time for administration and cost of the materials may be prohibitive in primary care.

Finally, SSD symptoms are highly associated with depression and anxiety. Ongoing elevated screening scores for anxiety and depression refractory to interventions may indicate the possibility of overlooked SSD. Furthermore, use of SSD screening tools with anxiety and depression screening tools can provide a more comprehensive picture of impairment, as well as symptom progress.

TREATMENT: AVOID A SPLIT APPROACH

Diagnosing and treating SSD can be challenging for physicians who focus on biomedically based approaches in patient care. Additional tests, studies, and prescriptions are likely to fuel (rather than pacify) patients' concerns, as such steps divert attention from the underlying psychological needs and mechanisms which maintain SSD. Avoid using a split biopsychosocial approach—ie, beginning the inquiry and treatment planning from a biomedical perspective, and then falling back on psychosocial formulation when treatment efforts have been ineffective. Such an approach leads to understandable patient dissatisfaction and can be interpreted by them as the caregiver suggesting that physical symptoms are “all in [their] head.”¹²

These 4 tips can help

1. Use a biopsychosocial formulation when initiating treatment. Be familiar with biopsychosocial factors in SSD and develop a narrative for discussing this formulation with patients. For example: “Mr. R, we are going to use the following [medical tests/studies/medications] to understand the cause of your symptoms and better manage them. We also

need to think about the role of stress and distress in your symptoms because these can also be at play with dizziness.” This may be particularly beneficial for a functional disorder, such as chronic pain. Incorporating patient education resources is an important step toward shared understanding (see Hunter Integrated Pain Service for chronic pain educational videos; www.tga.gov.au/chronic-pain-management-video-resource-brainman¹³).

2. Combine education about pathophysiology with patient-centered interviewing. Significant SSD symptom improvements were noted following a single 30-minute educational session, while motivational interviewing techniques were used to probe patients' concerns.²

3. Maintain professionalism and good clinical practice. Consider SSD a medical matter and address it accordingly: explore concerns fully, provide evidence-based responses, communicate empathy, and employ objective management strategies.¹⁴

4. Do not overlook the value of the relationship. A recent systematic review concluded that the relationship between the patient and care provider was central to the success of the interventions for symptom reduction.¹⁵

■ **A controversial approach.** Pharmacotherapy for SSD is controversial. While several trials of antidepressants and St. John's wort have been positive and some authors have stated that all classes of antidepressants are effective for SSD, others maintain that questions regarding dosing, treatment duration, and sustainability of improvement have not been sufficiently addressed in research.^{16,17}

Coordination of care issues

Primary care continues to be the de facto mental health system, and specialty services may be unavailable or declined by patients.¹⁸ CBT delivered in person or online is empirically supported as a treatment approach to medically unexplained symptoms and SSD.^{17,19-22}

A recent meta-analysis of randomized controlled trials published by Jing and colleagues²³ reported that CBT was effective for SSD symptom reduction, and that treatment gains were maintained 3 to 12 months post treatment. However, concerns about the prac-

tical implementation of CBT in primary care were raised because CBT was not shown to be effective in improving social functioning or reducing the number of medical visits. Symptom improvement was maximized with longer durations of treatment (> 10 sessions) and greater session lengths (> 50 minutes). Additionally, Abbass and colleagues²⁴ brought up several methodologic (sampling and analysis) concerns related to Jing et al's work.

Overall, CBT's effect sizes are small, and patients who are open to biopsychosocial explanations for their symptoms and to receiving psychological services may differ from most patients seen in primary care practices.²¹ Furthermore, mental health providers may hesitate to diagnose SSD because they are concerned about missing a somatic illness.³ Therefore, when coordinating care with mental health providers, it may be beneficial to discuss the treatment approach, assess familiarity with the SSD diagnosis, and closely coordinate and collaborate on the treatment plan.

While physicians cannot be expected to function as psychotherapists, an understanding of CBT and techniques for SSD treatment can be beneficial. Integrated mental health services may hold promise in addressing SSD in primary care. Onsite availability of a behavioral health provider competent in providing evidence-based care can target SSD symptoms and support both patients and physicians.

▶ THE CASE

Mr. R's treatment course included multiple primary care appointments (scheduled and walk in), ED visits, and specialist visits (ENT/vestibular rehabilitation). He sought care as symptoms intensified, lasted longer, or occurred in new circumstances. He reported persistent fear of the symptoms and anxiety that serious medical causes had been overlooked. He also described distress associated with vertigo and his anxiety sensitivity (anxiety about being anxious).

The behavioral health consultant (BHC; psychologist) and physician talked to the patient about the biopsychosocial antecedents of his condition and the factors that perpetuate the anxiety and stress response. The BHC described the fight/flight/freeze response to the patient and explained its role in the physi-

ologic stress response associated with somatic symptoms and panic. Educational materials (videos and handouts) were also provided to the patient to further illustrate these concepts. The BHC also discussed the role of interoceptive and situational avoidance and active coping (eg, engaging in safe activities); taught the patient relaxation and grounding techniques; and used cognitive disputation aimed at challenging catastrophic symptom interpretations.

The BHC and the patient's physician established joint treatment goals that included improving functioning, promoting active coping, and decreasing distress associated with symptoms. After the initial medical and BHC visits, both vertigo and anxiety symptoms appeared to abate somewhat, but symptoms have been ongoing and distress and impairment have been variable. The patient's family physician and BHC continue to work with him to optimize the care plan and treatment goals.

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