Somatic symptom disorder: Treatment

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INTRODUCTION

Somatic symptom disorder is characterized by one or more somatic symptoms that are accompanied by excessive thoughts, feelings, and/or behaviors related to the somatic symptoms [1]. In addition, the symptoms cause significant distress and/or dysfunction. The somatic symptoms may or may not be explained by a recognized general medical condition.

The diagnosis of somatic symptom disorder was introduced with publication of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) in 2013 [1]. In addition, DSM-5 eliminated the diagnoses of somatization disorder, undifferentiated somatoform disorder, hypochondriasis, and pain disorder; most of the patients who previously received these diagnoses are now diagnosed in DSM-5 with somatic symptom disorder.

This topic reviews the treatment of somatic symptom disorder. The epidemiology, pathogenesis, clinical presentation, course of illness, assessment, diagnosis, and differential diagnosis of somatic symptom disorder are discussed separately. (See "Somatic symptom disorder: Epidemiology and clinical presentation" and "Somatic symptom disorder: Assessment and diagnosis".)

TERMINOLOGY AND DSM-5

Somatic symptom disorder is a diagnosis that was introduced with publication of the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) in 2013 [1]. The clinical features and diagnostic criteria are discussed separately. (See "Somatic symptom disorder: Epidemiology and clinical presentation", section on 'Clinical presentation' and "Somatic symptom disorder: Assessment and diagnosis", section on 'Diagnostic criteria'.)

The DSM-5 diagnosis of somatic symptom disorder has largely consolidated and supplanted the diagnoses of somatization disorder, undifferentiated somatoform disorder, hypochondriasis, and pain disorder, which were included in the prior edition of the Diagnostic and Statistical Manual, Fourth Edition, Text Revision (DSM-IV-TR) and were collectively referred to as somatoform disorders [1-3]. The somatoform disorders were eliminated in DSM-5.

Most of the patients who previously received the DSM-IV-TR somatoform diagnoses are now diagnosed in DSM-5 with somatic symptom disorder [1,3]. As an example, the term hypochondriasis (table 1) in DSM-IV-TR described patients who misinterpreted one or more bodily symptoms and believed that they had a serious disease or were preoccupied with fear of a disease, despite appropriate medical evaluation and reassurance [2]. Among patients previously diagnosed with hypochondriasis, it is estimated that approximately 75 percent are subsumed under the DSM-5 diagnosis of somatic symptom disorder (if physical complaints are prominent) and 25 percent under the DSM-5 diagnosis of illness anxiety disorder (if physical complaints are minimal or nonexistent) [1]. Support for these estimates include a retrospective study of patients who initially received a DSM-IV diagnosis of hypochondriasis (n = 58); post-hoc application of DSM-5 criteria found that 76 percent met criteria for somatic symptom disorder and 24 percent met criteria for illness anxiety disorder [4]. Additional information about illness anxiety disorder, including its diagnostic criteria (table 2), is discussed separately. (See "Illness anxiety disorder: Epidemiology, clinical presentation, assessment, and diagnosis".)

A review by the workgroup that developed the DSM-5 diagnosis of somatic symptom disorder found that the construct, descriptive, and predictive validity of somatic symptom disorder were superior to the validity of the DSM-IV somatoform disorders [3]. In addition, inter-rater and test-retest reliability for somatic symptom disorder are good to very good.

Although the diagnosis of somatic symptom disorder has been criticized as overinclusive and fraught with the potential for false positives [5], it appears that somatic symptom disorder may be a more restrictive diagnosis than the DSM-IV-TR somatoform diagnoses that it replaced. A study of patients with symptoms that were deemed “medically unexplained” (n = 325) found that twice as many patients fulfilled diagnostic criteria for a somatoform disorder than for somatic symptom disorder (93 versus 46 percent) [6]. In addition, the diagnosis of somatic symptom disorder requires that patients exhibit excessive thoughts, feelings, or behaviors

related to the somatic symptoms, and thus identifies a group with greater mental impairment, compared with somatoform disorders [7].

The DSM-IV-TR somatoform disorders included the criterion that somatic symptoms were medically unexplained. However, the reliability for medically unexplained physical symptoms is poor [3,8] because it is difficult to prove that a symptom is medically unexplained (prove a negative) [1]. By contrast, DSM-5 somatic symptom disorder can be diagnosed in patients with known general medical disorders.

DSM-5 includes somatic symptom disorder in the category called somatic symptom and related disorders, which are diagnoses characterized by prominent somatic concerns, distress, and impaired functioning [1]. Patients with somatic symptom and related disorders typically present to primary care clinicians and general medical specialists rather than psychiatrists.

The World Health Organization's International Classification of Diseases – 10th Revision (ICD-10) still retains the term "somatoform disorders" as a category, as well as the specific diagnoses of somatization disorder, undifferentiated somatoform disorder, hypochondriacal disorder, and persistent somatoform pain disorder [9].

APPROACH TO THE PATIENT

Medical and psychiatric care of somatic symptom disorder combines strategies for patient management with specific therapeutic interventions. The primary care clinician generally plays the central role in managing these patients, and a psychiatrist or other mental health clinician may serve as a consultant and provide psychotherapy and/or pharmacotherapy, which can help some patients with the disorder.

The primary goal in managing somatic symptom disorder is to improve coping with physical symptoms, which includes reducing health anxiety and behaviors related to the symptoms, rather than eliminating the symptoms entirely [10,11]. As part of this goal, patients should try to improve occupational and interpersonal functioning.

Clinicians will obtain better outcomes by focusing upon caring rather than curing, and managing physical symptoms conservatively to avoid excessive and possibly harmful tests and treatments. In addition, patients need reassurance that their concerns about symptoms and illness have been heard and will receive appropriate evaluation. It's important that patients feel their concerns are understood and not dismissed as "all in their head." Management is thus patient-centered, emphasizing the patient rather than the diagnosis.

Additional information about the approach to the patient is reviewed in the context of discussing the diagnosis with the patient. (See "Somatic symptom disorder: Assessment and diagnosis", section on 'Discussing the diagnosis'.)

CHOOSING TREATMENT

We suggest that acute treatment of somatic symptom disorder proceed according to the sequence described in the subsections below. Patients initially receive initial therapy and progress through each step until they respond:

- Initial treatment – Primary care management with regularly scheduled visits that are not contingent upon active symptoms
- Treatment-resistant patients – The primary care clinician continues to meet regularly with the patient and also:
  - Discusses the case with a psychiatrist
  - Meets jointly with the patient and family members
  - Administers relaxation training
  - Provides formal psychoeducation
  - Prescribes antidepressants for patients with prominent comorbid symptoms of anxiety disorders, depressive disorders, or obsessive-compulsive disorder (OCD)
- Treatment-refractory patients – The primary care clinician continues to meet regularly with the patient and also refers the patient to a psychiatrist

There are few studies of somatic symptom disorder because it was introduced as a diagnosis in DSM-5, which was published in 2013 [1]. Somatic symptom disorder was derived in part from the somatoform disorders (diagnoses such as somatization disorder and hypochondriasis), which were eliminated from DSM-5. Most of the patients who previously received the somatoform diagnoses are now diagnosed in DSM-5 with somatic symptom disorder (see 'Terminology and DSM-5' above) [1]. Thus, treatment of somatic symptom disorder is based upon studies of somatoform disorders, as well as studies of “somatization,” which is a broad construct that has been used to describe patients with medically unexplained physical symptoms that cause distress and impairment, but is not a formal diagnosis in DSM-5.

Not all patients with somatic symptom disorder are ready for treatment. Some patients adamantly maintain that their symptoms are not disproportionate and refuse to believe that they have a psychiatric disorder; these patients may refuse to continue working with clinicians who do not share their view. We suggest that clinicians take a long-term perspective and let such patients know that the clinician is always available to provide treatment when the patient is ready.

Initial treatment — For patients with somatic symptom disorder, we suggest that primary care clinicians manage patients in the following manner, based upon multiple reviews [10-17]:

- Schedule regular outpatient visits (eg, every four to eight weeks) that are not contingent upon active symptoms.
- Establish a collaborative, therapeutic alliance with the patient.
- Acknowledge and legitimize the somatic symptoms – Clearly indicate that the symptoms are real.
- Explicitly set the goal of treatment as functional improvement, including activation and exercise.
- Communicate with specialists who are treating the patient – It is common for patients with somatic symptom disorder to consult one doctor after another ("doctor shopping").
- Evaluate for and treat diagnosable general medical diseases.
- Limit diagnostic testing and referrals to specialists. For patients who present with physical symptoms and have a low pretest probability of serious disease, diagnostic tests do little to resolve somatic symptoms and health anxiety. (See "Somatic symptom disorder: Assessment and diagnosis", section on 'Laboratory tests'.)
- Reassure patients that grave medical diseases have been ruled out – Although reassurance is helpful to many patients, it must be carefully dosed and targeted, and paired with acknowledging one's uncertainty about the cause of the symptoms. Facile or excessive reassurance may exacerbate disease fears or cause patients to feel that their clinician has not listened or taken their concerns seriously.
- Explain that the body can generate symptoms in the absence of disease, that psychological and social issues (eg, stress and conflicts) can affect the body, and that paying attention to a specific body part makes one more aware of sensations in that body part. In addition, educate patients about coping with physical symptoms. Coping may be

improved with teaching the process of cognitive restructuring, in which patients are asked about one of their symptoms and what they fear is wrong, are then asked to suggest alternative explanations for the symptom, and finally asked to determine which explanation is most likely.

- Assess and treat patients for comorbid psychiatric disorders; as an example, effective treatment of comorbid anxiety disorders and depressive disorders is likely to make a difference. Anxiety and depressive disorders appear to be common in somatic symptom disorder. (See "Somatic symptom disorder: Epidemiology and clinical presentation", section on 'Comorbid psychopathology'.)

- Taper and discontinue unnecessary medications, especially those that are potentially addictive; however, this is best attempted after establishing a good clinician-patient relationship.

- Pursue clues offered by patients that they are struggling with psychosocial problems or prior life events such as sexual abuse. However, clinicians should avoid prematurely pushing patients who are reluctant to discuss these problems, and some patients may never want to talk about their occupational or interpersonal problems.

A key part of management is to regularly schedule outpatient visits with the primary care clinician, so that symptoms are not required for the patient to receive clinical attention [10,11]. This is less stressful for the patient and clinician than symptom-driven visits, avoids reinforcing the sick role, and enables clinicians to provide reassurance on the basis of focal physical examinations and to remain vigilant for the same diseases that can befall any patient. The visit interval depends upon the individual patient. The goal is to find the right interval that avoids inappropriate emergency visits or telephone calls. It is reasonable to initially schedule visits every one to two months. For patients who improve, the schedule can be tapered. Patients should be encouraged to consult their primary care clinicians before going to the emergency department in between outpatient appointments; emergency department visits often lead to multiple unnecessary tests.

Crisis calls must be managed firmly so that the multiple chronic or recurrent symptoms do not elicit excessive evaluation. The clinician must be supportive but firm, and adhere to the agreed upon schedule of visits for recurrent problems.

Randomized trials indicate that when diagnostic testing is warranted, brief educational interventions can help patients accept negative test results and thus help clinicians reassure patients [18,19]. These interventions can be administered before or after the test, and may be as simple as an information sheet.

Clinicians should emphasize functioning and coping [20]. The focus of treatment should be rehabilitation and the restoration and maintenance of functioning at work, home, and in social circles. Clinicians should encourage patients to take an active role in treatment by working on specific, realistic, incremental goals that include observable behaviors. This will help to discourage patients from assuming the sick role. One example of a useful treatment plan is a graduated exercise program.

Metaphors can help to engage patients in treatment [10]. Those symptoms which are not amenable or resistant to medical or surgical intervention can be compared to a radio channel that cannot be changed. The patient needs to gain greater control over the volume knob and the sensitivity of the antenna (ie, identify any factors that increase or decrease symptoms).

When malingering is suspected (ie, somatic symptoms are amplified to pursue a tangible benefit such as a prescription for opioids or disability benefits), probes may help clarify the patient's aims. As an example, the clinician may inquire, "Is there something in particular you were hoping to get today?" [21].

Structure of visits — Caring for patients with somatic symptom disorder requires time to listen to the patients [11]. This should occur at regularly scheduled office visits not contingent upon complaint, so that patients can voice concerns without feeling the need to make telephone calls or emergency visits. Based upon our clinical experience, we think that such visits will save time in the long run.

New somatic symptoms and current stressors should be explored at these visits. Different aspects of symptoms should be discussed, including [14]:

- Somatic – Location, severity, and duration, as well as associated symptoms.
- Cognitive – Patient's thoughts and expectations about the symptoms.
- Emotional – Patient's feelings about the symptoms.
- Behavioral – Have the symptoms interfered with occupational, social, or recreational activities?

Familiarity with the patient allows judicious evaluation of new symptoms. Patients with somatic symptom disorder, as with all patients, remain at risk for developing new and potentially serious general medical conditions [17]. After any comorbid general medical conditions are identified and properly treated, clinicians can express empathy for the patient's persistent somatic symptoms, health anxiety, and excessive time and energy devoted to the symptoms, and shift the focus away from the physical symptoms and toward better coping.

For patients with an established diagnosis of somatic symptom disorder who regularly present with multiple somatic symptoms, it may be helpful to ask patients at the beginning of the visit to select one symptom to discuss [17]. Clinicians can focus patients in this manner while at the same time acknowledging that the patient has multiple symptoms and worries.

A physical examination should be performed at each visit, at least in the initial period (eg, first several months) of patient management, and at any visit when the patient has a new somatic symptom [14,22].

It may be tempting to use diagnostic tests and specialty consultations for the sole purpose of reassuring the patient; however, negative findings rarely provide lasting reassurance [23], and excessive evaluation risks additional complications and "incidentalomas" [24]. A study of 420 audiotaped general practice consultations with patients with unexplained symptoms revealed that doctors were more likely to propose investigations, as well as physical interventions and referrals to specialists, than respond to patient cues about psychological needs [25]. Additional information about the futility of laboratory tests in this setting is discussed separately. (See "Somatic symptom disorder: Assessment and diagnosis", section on 'Laboratory tests'.)

Although clinicians can use self-report instruments to provide measurement based care, the use of such instruments is not standard practice. None of the applicable instruments was specifically developed for somatic symptom disorder, and no one instrument assesses all of the various aspects of the disorder, including the type of distressing somatic symptom, the presence of disproportionate thoughts and high levels of anxiety about the symptom, and whether the patient devotes excessive time and energy to the symptoms. Available instruments include the Patient Health Questionnaire – 15 Item (PHQ-15) (table 3), Somatic Symptom Scale-8 (see "Somatic symptom disorder: Assessment and diagnosis", section on 'Screening'), and Whiteley Index (table 4); these are discussed in the context of screening for somatic symptom disorder. (See "Somatic symptom disorder: Assessment and diagnosis", section on 'Screening'.)

Treatment-resistant patients — For treatment-resistant patients with somatic symptom disorder who do not respond satisfactorily to initial treatment, we suggest that primary care clinicians continue initial treatment and in addition, discuss the case with a psychiatrist, meet with the patient and family, and administer relaxation training, psychoeducation, and antidepressants.

Discuss the case with a psychiatrist — Based upon reviews as well as our clinical experience, discussing the case with a psychiatrist or other mental health specialist may help primary care clinicians manage patients with somatic symptom disorder who do not respond to initial

therapy [26]. This consultation does **not** entail referring the patient to meet with the psychiatrist because referrals are often not necessary for treatment resistance. In addition, many patients object to a psychiatric referral; patients may feel misunderstood and think that their primary care clinician has dismissed their somatic symptoms as “all in their heads.” Patients may also fear that the clinician is abandoning them.

The case discussion is akin to collaborative care, which integrates psychiatric treatment into primary care practices. The primary care clinician and psychiatrist examine case notes to review the patient’s clinical features and verify that somatic symptom disorder is the correct diagnosis. (See "Somatic symptom disorder: Epidemiology and clinical presentation", section on 'Clinical presentation' and "Somatic symptom disorder: Assessment and diagnosis", section on 'Diagnostic criteria'.)

In addition, the initial treatment with regularly scheduled visits (see 'Initial treatment' above) is discussed to ensure it is properly administered; as an example, primary care clinicians may inadvertently reinforce the patient’s illness by ordering unnecessary laboratory tests. In addition, the consultant may help the clinician detect clues offered by patients that they are struggling with psychosocial problems. The number and frequency of meetings between the primary care clinician and the consultant depends upon the severity of illness and the patient’s progress.

The consultant can also assist primary care clinicians in speaking with patients about the quality of the doctor-patient relationship, which is often problematic. Patients with somatic symptom disorder often feel ignored by and speak disparagingly of their clinicians, who in turn are often frustrated by “difficult” patients. Addressing the relationship focuses upon the process of the patient and clinician working together, rather than just the specifics of the patient’s symptoms. As an example, the clinician can ask patients to candidly describe their expectations about treatment and their feelings about the quality of care that they are receiving.

Family meeting — Based upon our clinical experience, there are several reasons to involve family members in managing treatment-resistant somatic symptom disorder. Family members can help clinicians better understand the patient's symptoms and emotional and behavioral response to them. In addition, genuine concern leads family members to unintentionally reinforce the patient's problematic behaviors. Difficulties with specific family functions and processes such as communication and problem solving may also exacerbate the patient's illness. Family members may be struggling to cope with the patient's illness and may require help for themselves. Information about family meetings and therapy is discussed separately. (See "Overview of psychotherapies", section on 'Family therapy'.)

Relaxation training — Relaxation training may be useful for somatic symptom disorder, based upon indirect evidence. A randomized trial compared relaxation training with cognitive-behavioral therapy (CBT) in 89 patients with somatization [27]. Treatments were administered over three sessions by primary care nurses or physician assistants in primary care clinics. Relaxation training sessions each lasted 30 minutes and included progressive muscle relaxation and diaphragmatic breathing. CBT sessions each lasted 60 minutes and included counseling regarding symptom amplification, cognitive distortions, and misunderstandings about medical care; patients who did not respond to three sessions of CBT received six additional sessions. Both treatment groups improved from baseline, and follow-up at 6 and 12 months showed that improvement was comparable for relaxation training and CBT. Some forms of CBT for somatization include relaxation as a component of treatment [28].

Psychoeducation — Education may be beneficial in somatic symptom disorder because it has been effective for treating patients with related disorders. In one study, primary care clinicians treating 70 patients with somatization disorder all received a consultation letter offering treatment recommendations [29]. Patients were then randomly assigned to receive eight group therapy sessions focused upon education or to treatment as usual. The experimental group reported better physical and mental health, and over a one-year period generated 52 percent less health care costs.

Antidepressants — For patients with treatment-resistant somatic symptom disorder, plus prominent symptoms of anxiety disorders, depressive disorders, or OCD (eg, charting bowel movements), we suggest add-on treatment with antidepressants, based upon randomized trials in patients with somatoform disorders and medically unexplained symptoms [30,31]. However, adding a medication may exacerbate somatic symptom disorder by causing adverse effects (ie, other somatic symptoms) that become another source of complaint and concern.

Reasonable antidepressant options for somatic symptom disorder include selective serotonin reuptake inhibitors (SSRIs), serotonin-norepinephrine reuptake inhibitors, and low-dose tricyclics (table 5). Antidepressants should be initiated at low doses and increased slowly as tolerated to achieve a therapeutic dose, because the somatic sensitivity and health anxiety in patients create a low threshold for perceiving side effects. In patients who are reluctant to try an antidepressant because of a general sensitivity to side effects, clinicians should start with the lowest possible dose. As an example, clinicians can prescribe citalopram or nortriptyline 10 mg/day, or duloxetine 20 mg/day, for the first week and then titrate the dose every four weeks as needed and tolerated.

Indirect evidence supporting the use of antidepressants for somatic symptom disorder includes systematic reviews of randomized trials in which antidepressant medication was prescribed for

somatoform disorders and medically unexplained symptoms [30-32]. Examples include the following:

- A 1999 meta-analysis of 94 randomized trials (n >6500 patients) compared antidepressants (primarily tricyclics) with placebo and found a large benefit for treating unexplained symptoms and unexplained symptom syndromes [33]:
  - Improvement occurred more than three times as often with antidepressants than placebo (odds ratio 3.4, 95% CI 2.6-4.5).
  - The number needed to treat was three (ie, treatment of approximately three patients with antidepressants yielded a beneficial response in one additional patient that would not have occurred with placebo).
- In a 2014 systematic review that included several meta-analyses of randomized trials, the primary findings included the following [14,34]:
  - A meta-analysis of three trials (n = 243 patients), lasting 8 or 12 weeks, compared second-generation antidepressants (escitalopram, fluoxetine, or venlafaxine) with placebo and found that improvement of somatoform disorders was greater with antidepressants, and the clinical effect was large. In addition, improvement of depressive symptoms and functioning was greater with antidepressants, and discontinuation of treatment due to adverse effects was comparable for antidepressants and placebo.
  - A meta-analysis of three trials (n = 177) found that improvement of somatoform disorders was comparable for second-generation antidepressants and tricyclics.
  - A meta-analysis of two trials (n = 107) compared SSRIs alone (citalopram or paroxetine) with SSRIs plus antipsychotics (paliperidone or quetiapine), and found that improvement of somatoform disorders was greater with combination treatment, and the clinical benefit was large. In addition, discontinuation of treatment due to adverse effects was comparable for the two groups.
- A subsequent 10-week randomized trial compared imipramine with placebo in 120 patients with somatic symptoms that involved multiple organ systems, caused distress or substantial disability, and lasted at least two years [35]. Patients with comorbid anxiety disorders or depressive disorders were excluded. Imipramine was started at 10 mg/day for one week and then titrated to 25 to 75 mg/day. Improvement occurred in more patients who received imipramine than placebo (53 versus 25 percent). Although moderate or

severe adverse events occurred more often with imipramine than placebo (55 versus 20 percent of patients), discontinuation of treatment due to adverse events was comparable for the two groups (6 and 5 percent). The most common side effects of any intensity with imipramine were dry mouth, dizziness, nausea, diaphoresis, sleep disturbances, and constipation.

One of the most common physical symptoms in somatic symptom disorder is pain, and antidepressants are an established treatment for chronic non-cancer pain.

Treatment-refractory patients — For treatment-refractory patients with somatic symptom disorder who do not respond satisfactorily to initial treatment, as well as next step interventions for treatment-resistant patients, we suggest that primary care clinicians continue initial treatment and in addition, refer the patient to a psychiatrist or other mental health clinician experienced in diagnosing and treating somatic symptom disorder. Ideally, the consultant is the same psychiatrist with whom the primary care clinician discussed the case. (See 'Treatment-resistant patients' above.)

Many patients balk at seeing a psychiatrist, and because of the referral, may feel that the primary care clinician does not understand them [11]. The clinician should offer the referral in such a way that the patient does not feel stigmatized or dismissed (see 'Approach to the patient' above). The willingness of patients to accept a psychiatric referral will likely depend in part upon their conviction that the primary care clinician will not abandon them. It can be helpful to tell patients, “I will continue to be your doctor, but I can do a better job with input from a colleague.” In addition, patients may be more inclined to accept referrals if they are told that the psychiatrist has experience in treating somatic symptom disorder and that the referral does not mean that the patient is “crazy.”

Although many patients with somatic symptom disorder are reluctant to accept a psychiatric referral, even a single (first) visit with the consultant may be acceptable and prove useful [11]. In addition, if patients find the one-time consult helpful, they may consent to additional, ongoing treatment with the psychiatrist, including pharmacotherapy and/or psychotherapy.

Single consultation — The psychiatrist should attempt to accomplish several tasks during the first visit, and perhaps only interview with the patient. Some of these tasks overlap with what occurred when the case was previously discussed with the primary care clinician, but meeting directly with the patient improves the ability of the psychiatrist to complete the tasks, which include the following:

- Verify the diagnosis of somatic symptom disorder

- Review the use and outcome of initial treatment with regularly scheduled visits, as well as next step treatments (see 'Initial treatment' above and 'Treatment-resistant patients' above)

- Assess the patient for comorbid psychopathology (eg, anxiety disorders and depressive disorders) and for psychosocial problems

- Discuss the nature of the relationship between the patient and primary care clinician and explore problems that the patient may hesitate to divulge directly to the primary care clinician

  Following the visit, the consultation note (letter) to the primary care clinician includes the primary diagnosis, any secondary diagnoses, and treatment recommendations as warranted. As an example, the recommendations may include changes in how the primary care clinician is conducting the regularly scheduled visits or administering antidepressants.

Indirect evidence suggests that even a one-time consultation can improve outcomes. A systematic review of six randomized trials (total n = 449 patients with somatization) compared usual care with a one-time consult, and found that the consult reduced the severity of somatic symptoms, improved physical and social functioning, and decreased medical costs [36].

Psychiatric treatment — Patients may present with treatment-refractory somatic symptom disorder plus prominent symptoms of anxiety disorders, depressive disorders, or OCD, and consent to ongoing, adjunctive treatment administered by the psychiatrist. For these patients, we suggest that the psychiatrist administer antidepressant medications if the primary care clinician lacks the requisite training or expertise to prescribe antidepressants [11]. As an example, the primary care clinician may have prescribed an initial antidepressant trial that was not successful, and prefer that the psychiatrist manage the pharmacotherapy component going forward. The choice, administration, and efficacy of antidepressants is discussed elsewhere in this topic. (See 'Treatment-resistant patients' above.)

In addition, for all patients with treatment-refractory somatic symptom disorder, we suggest that the psychiatrist or another mental health clinician administer psychotherapy, based upon indirect evidence from randomized trials in patients with somatoform disorders or somatization. We prefer CBT because it has been more widely studied than other types of psychotherapy [11,28,37-40]. However, reasonable alternatives to CBT include psychodynamic psychotherapy, supportive psychotherapy, family therapy, and stress management. All of these psychotherapies can be provided in a primary care or psychiatric setting [39]. Study results from

randomized trials suggest that for CBT, individual and group formats are each superior to usual care, and that individual CBT is superior to group CBT [41,42].

Clinicians should anticipate that roughly 70 to 90 percent of patients with somatic symptom disorder will decline psychotherapy:

- Among more than 5700 general medical outpatients who screened positive for hypochondriasis (a type of somatoform disorder) and were offered treatment with CBT or usual care in a randomized trial, nearly 70 percent refused to participate [43].
- In an observational study, CBT was offered to more than 400 patients who visited their primary care clinician more than once per month for at least two years (excluding appointments for routine monitoring and patients with established serious illnesses) [44]. Only 7 percent agreed to treatment.

Guidelines for administering short-term (eg, 5 to 12 sessions) psychotherapy to patients with somatic symptom disorder include [45]:

- Clearly explain the structure of the treatment plan
- Teach meaningful skills relevant to daily life
- Training in these skills should continue until they are mastered in the therapist's office
- Patients need to practice these skills outside of the office
- Clinicians should attribute improvement to the patient's increased skills

CBT directs patients to re-examine their health beliefs and expectations, to look at how the sick role affects their symptoms, and to change dysfunctional thoughts (engage in cognitive restructuring) [20]. In addition, behavioral techniques are used to improve role functioning and minimize sick role behaviors; these techniques include response prevention, systematic desensitization, progressive muscle relaxation, and graduated exercise programs. A practical guide for providing CBT is shown (table 6) [46,47]. The use of CBT is limited when patients are unable to rationally discuss their illness perceptions and beliefs [48], or when patients are wedded to the sick role because of secondary gain (eg, missing work, disability payments, or obtaining prescription drugs).

Evidence supporting the use of psychotherapy for somatic symptom disorder includes randomized trials:

- A 12-week trial evaluated a CBT program consisting of 12 text modules [49]. The trial included patients with either somatic symptom disorder (n = 114) or illness anxiety disorder (n = 18) who were randomly assigned to one of four treatments: internet CBT with therapist guidance (e-mail-like communication), internet CBT with no therapist support, bibliotherapy (hardcopy of the CBT text modules), or a waiting list. Improvement of health anxiety was greater in each group that received CBT, compared with the wait list controls. In addition, the clinical benefit of CBT was large, and follow-up at six months showed that improvement was durable. Each form of CBT provided comparable improvement.

- A second 12-week trial examined treatment of health anxiety in patients with somatic symptom disorder and/or illness anxiety disorder (n = 86) [50]. Patients were randomly assigned to either a six-lesson, clinician-guided internet-delivered CBT program or a control condition that included written material about anxiety, as well as clinician contact by e-mail and telephone. Clinically significant improvement of health anxiety occurred in more patients who received internet-delivered CBT than in controls (84 versus 34 percent). In addition, improvement of depression, generalized anxiety, and functioning was greater with CBT.

Indirect evidence supporting the use of psychotherapy for somatic symptom disorder includes meta-analyses of randomized trials in patients with somatoform disorders and somatization:

- A meta-analysis of 10 randomized trials (n = 1081 patients) compared psychotherapy with usual care or a waiting list control group [14,39]. Improvement of somatic symptoms was superior with psychotherapy, and the clinical effect was small to moderate. Posttreatment assessments for up to one year indicated that improvement with psychotherapy was durable. However, heterogeneity across studies was moderate. In addition, discontinuation of treatment was 7 percent greater in patients treated with psychotherapy than controls (relative risk 1.07, 95% CI 1.01-1.14).

  The psychotherapy in 6 of the 10 trials was CBT. A subgroup analysis compared CBT with usual care in 593 patients and found a small to moderate advantage for CBT, which was maintained beyond one year posttreatment. However, heterogeneity across studies was substantial, and discontinuation of treatment was 7 percent greater with CBT than usual care.

- Another meta-analysis included a different set of 10 randomized trials, as well as 6 observational studies, and compared psychotherapy (primarily CBT or psychodynamic therapy) with usual care in 1438 patients [51]. The mean length of physical symptoms was >8 years, and the median length of treatment for both groups was nine weeks.

Improvement of physical symptoms and functioning was superior with psychotherapy than treatment as usual, and the clinical benefit was small to moderate. In addition, the benefits of psychotherapy persisted at follow-up (mean length of posttreatment follow-up was 11 months).

Other indirect evidence supporting the use of psychotherapy, especially CBT, for somatic symptom disorder includes randomized trials in patients with hypochondriasis, a specific type of somatoform disorder [52-55].

Patients with somatic symptom disorder may not respond to initial therapy with regularly scheduled visits and to all next step treatments, or may decline referral to a psychiatrist. For these patients, we suggest that primary care clinicians continue to meet regularly with patients. Even when the course is chronic, our clinical experience suggests that it is possible for clinicians to develop and maintain relationships with patients, and help them to eventually relinquish some of their somatic symptoms, improve their psychosocial functioning, and rely less upon interventions that are not indicated, including diagnostic tests, medications, and treatment by medical specialists. At a minimum, clinicians can help some patients from inadvertently harming themselves by soliciting and receiving unnecessary tests and procedures [22].

COMORBID PSYCHOPATHOLOGY

Major depression or panic disorder are commonly comorbid in patients with somatic symptom disorder and should be treated as they would when occurring separately. Somatic symptoms and related abnormal thoughts, feelings, and behaviors are likely improve when the comorbid disorder is treated with appropriate pharmacotherapy [56]. (See "Management of panic disorder with or without agoraphobia in adults" and "Unipolar major depression in adults: Choosing initial treatment".)

SUMMARY AND RECOMMENDATIONS

- Somatic symptom disorder is characterized by one or more somatic symptoms that are accompanied by excessive thoughts, feelings, and/or behaviors related to the somatic symptoms. In addition, the symptoms cause significant distress and/or dysfunction. The somatic symptoms may or may not be explained by a recognized general medical condition. (See 'Terminology and DSM-5' above.)

- The primary goal in managing somatic symptom disorder is to improve coping with physical symptoms, which includes reducing health anxiety and behaviors related to the

symptoms, rather than eliminating the symptoms entirely. As part of this goal, patients should try to improve occupational and interpersonal functioning. Clinicians will obtain better outcomes by focusing upon caring rather than curing. (See 'Approach to the patient' above.)

- For initial treatment of patients with somatic symptom disorder, we suggest that primary care clinicians schedule regular outpatient visits that are not contingent upon active symptoms, rather than scheduling visits contingent upon active symptoms (**Grade 2C**). Key elements of the visits include the following:
  - Establish a therapeutic alliance with the patient
  - Legitimize the somatic symptoms, communicate with specialists who are treating the patient
  - Evaluate for and treat diagnosable general medical diseases and comorbid psychopathology
  - Limit tests and referrals
  - Reassure patients that grave medical diseases have been ruled out
  - Explain that the body can generate symptoms in the absence of disease
  - Slowly discontinue unnecessary medications
  - Pursue clues offered by patients that they are struggling with psychosocial problems

  (See 'Initial treatment' above.)

- The primary care visits are structured to discuss different aspects of the physical symptoms, including their location, severity, and duration; the patient's thoughts, expectations, and feelings about the symptoms; and whether the symptoms interfere with occupational or social activities. In addition a physical examination is typically performed. (See 'Structure of visits' above.)

- For treatment-resistant patients with somatic symptom disorder and prominent symptoms of anxiety disorders or depressive disorders who do not respond satisfactorily to initial treatment, we suggest antidepressants (**Grade 2B**). For all treatment-resistant patients, it is advisable that primary care clinicians continue initial treatment and in addition, discuss the case with a psychiatrist, meet with the patient and family, administer

relaxation training, provide psychoeducation, and prescribe antidepressants if the patient also has prominent symptoms of anxiety disorders or depressive disorders.

- Treatment-refractory somatic symptom disorder, which does not respond satisfactorily to initial treatment and next step interventions, is managed by continuing initial treatment and referring patients to a psychiatrist experienced in diagnosing and treating the disorder. Although many patients are reluctant to accept a psychiatric referral, even a single (first) visit with the consultant may be acceptable and prove useful. Patients who consent to ongoing adjunctive treatment with the psychiatrist are treated with antidepressant medications if they have prominent symptoms of anxiety disorders or depressive disorders. In addition, psychotherapy, especially cognitive-behavioral therapy, is often effective for all patients with somatic symptom disorder; however, many patients decline psychotherapy. (See 'Treatment-refractory patients' above.)

Topic 110022 Version 7.0

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