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cases, symptoms are typically diverse and relate to multiple bodily systems. Simply having physical symptoms does not merit a diagnosis of SSD, even if these symptoms are unexplained by physical disease. A diagnosis of SSD requires that additional features are present. These include excessive concern or preoccupation with the symp- toms, associated emotional distress, and maladaptive behaviour in relation to the symptoms such as the repeated and unnecessary seeking of medical attention. Patients with severe SSD are commonly very disabled, receive large amounts of unproductive medical atten- tion, and suffer iatrogenic harm. A related disorder is called conversion disorder (or functional neurological symptom disorder). This is similar to SSD, but in this disorder the patient's complaints include apparent loss of or change in a function, such as movement of a limb or impairment of vision. It also includes attacks that look like epileptic seizures but are not (so-called nonepileptic attacks), gait disorders, and other abnormal movements. Aetiology The aetiology of SSD is multifactorial. Predisposing factors for se- vere SSD include a family history, childhood neglect and abuse, and childhood experience of illness in the family. Symptoms may be associated with depression and anxiety. An ongoing interaction with medical services is probably a maintaining factor, with the patient increasingly developing the conviction that they are sick, even in the absence of medical evidence for this belief. The patient's life may become focused on care-seeking and disability, behaviour that may be reinforced by family members, partners, and others. Particularly important is the behaviour of doctors who may ex- acerbate the disorder. Ways in which this may happen are listed in Box 26.5.12.1. These iatrogenic factors are particularly important to consider, as even if we cannot always successfully treat a patient with severe SSD, we can at least avoid making the problem worse. Epidemiology Physical symptoms are extremely common in the general popu- lation, but only a few people experiencing them will seek medical attention, usually because of concern about the cause or because of severe discomfort or disability. The prevalence of SSD will vary by setting, but is more common in specialist clinics where it may account for 10–20% of consultations. Severe SSD, previously termed somatization disorder or Briquet's syndrome, in which there is a lifelong history of multiple symptoms and usually severe associated disability, is present in about 5% of medical patients. While only a small number of patients with SSD become inpatients, when this Box 26.5.12.1 Potential psychological iatrogenesis in somatic symptom disorder • Inadvertently exacerbating the patient's concern (e.g. by mentioning rare diseases or ordering unnecessary tests) • Dismissing the patient's complaints, which may lead them to reject the reassurance given • Giving inappropriate advice such as recommending excessive resting or unnecessary splints and supports, which may only serve to increase attention on the complaint and cause unwanted effects such as muscle weakness • Providing inappropriate disease focused pharmacological and sur- gical interventions, which may only generate further symptoms (e.g. abdominal surgery causing adhesions and opiate prescribing causing addiction)

 occurs it carries a high risk of iatrogenic harm, for example, from unnecessary surgery. Clinical features The main features of SSD are physical symptoms and the patient's concern about these. There may be no identifiable disease. If there is disease, the patient's concerns are markedly disproportionate, usu- ally focusing on the symptoms themselves and their distressing or disabling quality, although sometimes their main worry is about the possibility of undiagnosed serious disease that persists despite med- ical evidence to the contrary. Such patients may repeatedly seek re- assurance from doctors. SSD may be mild, moderate, or severe. In mild cases, there may only be one or two symptoms, such as pain and fatigue. In moderate cases, there may be multiple symptoms associated with distress and

disability, and often frequent and unproductive inter- actions with doctors. Patients with severe cases may have lifelong multiple symptoms and severe disability, for example, being wheelchair bound. For patients with severe SSD, pointers to the diagnosis may be apparent even before the consultation. The GP referral letter and medical records may note frequent attendance at medical services with a long history of numerous negative (and often repeated) investigations. There may also be a history of failed treatment with a record of multiple symptom-relieving medica- tions and even surgery. Differential diagnosis The differential diagnosis is from other medical and psychiatric conditions. Medical conditions The main medical differential is from symptoms that are entirely at- tributable to disease. It should be noted, however, that the identifi- cation of disease does not necessarily exclude SSD. For example, a high proportion of patients with nonepileptic attacks (attacks that look like epilepsy but are not associated with seizure activity in the brain) also have electroencephalogram (EEG) diagnosable epilepsy. The coexistence of SSD and a diagnosis of potentially fatal disease, for example, when the patient has both noncardiac chest pain and severe coronary artery disease, greatly increase the complexity of management. Other psychiatric disorders Other psychiatric disorders are associated with severe concern about physical symptoms. Anxiety disorders, especially panic disorder, can cause physical symptoms (breathlessness, paraesthesia, chest pain, and dizziness). Depressive disorder can also be the cause of troublesome physical symptoms, such as lethargy, sleep disturbance, pain, and weight loss. These symptoms may lead both the patient and their physician to erroneously conclude that they have a medical condition. It is important to diagnose anxiety and depression as they are relatively easily treated. Occasionally, concern about somatic symptoms may be delu- sional and part of a psychotic illness, for example, a patient who is unshakably convinced that a burning sensation in his head is due to tearing of his brain. Factitious disorder and malingering Patients with SSD suffer and should be differentiated from patients who construct medical presentations in order to deceive doctors. While such deliberate faking of symptoms and signs certainly oc- curs, it is unusual in routine clinical practice. Clues to its presence are observations or reports of markedly inconsistent behaviour (e.g. a patient who attends in a wheelchair but who is later seen walking briskly to their car or playing tennis). In such cases, if the patient’s apparent aim is the seeking of medical care and attention, the diag- nosis is that of factitious disorder, severe cases of which have been referred to as ‘Munchausen’s syndrome’. If the apparent aim is to seek other forms of benefit such as financial compensation or exemption from a duty or prosecution, the behaviour does not merit a psy- chiatric diagnosis: it is a form of dishonest behaviour, often called malingering. Clinical assessment The history and medical records are often critical to the diagnosis by documenting a history of consulting and negative investiga- tions. While the patient must be assessed for physical disease in the usual way, care should be taken about unnecessarily repeating or duplicating investigations. It is uncommon to miss serious physical disease if a careful clinical assessment is made. History The history should include not only questions about symptoms, but also questions about the patient’s fears and beliefs about the symp- toms, their emotional reaction to them, and how they cope. The his- tory of previous illness may reveal long-standing similar symptoms that have been extensively investigated. A full list of medications the patient takes is important; it may be a long and illogical one. Physical examination It is important to physically examine the patient. This may not only reveal unsuspected clinical signs suggesting disease, but also helps to reassure the patient that their complaints have been taken ser- iously and properly assessed. It may also reveal scars from many previous operations. In conversions disorder, positive findings on neurological examination help in making the diagnosis, for ex- ample, Hoover’s sign (demonstration of synergistic contraction, e.g. if a patient is asked to raise their right leg off the bed, they will

naturally tense the extensors of their left leg as they do so; if they don't, then they are not making a genuine effort, and Hoover's sign is positive). Observations during the consultation The patient with severe SSD may be disproportionately disabled, even being pushed in a wheelchair or using braces. The patient may moan or rub the affected bodily parts, as if to emphasize their

 suffering. The patient's partner may be seen to behave in a solicitous way in keeping with the disproportionate disability. Investigations A balance must be struck between the risk of missing disease and the iatrogenic psychological harm that can result from overinvestigation. It is good practice to check if any investigation has been performed recently before ordering it again. Review of medical records It is especially important to obtain and review all the medical re- cords. These may indicate many previous assessments and investiga- tions, as well as failed treatments. They may also document a pattern of referral to many different specialists. Management The general principles of management are outlined in Box 26.5.12.2. Acknowledging, reassuring, and explaining The starting point of effective management is to make it clear to the patient that you accept the reality of their suffering and do not think they are imagining their symptoms. The patient then needs reassuring that there is no evidence they have an unpleasant disease, followed by a positive diagnosis and a credible explanation for their symptoms and practical plan. Providing reassurance The provision of appropriate reassurance is an important part of the medical consultation. To be effective it must be based on the patient's specific concerns, not those of the doctor, hence it is important to ask the patient what they are worried they have before reassuring them that they do not have it. Many patients report the physical examination as particularly re- assuring. A detailed explanation of what any investigations show can also help, including showing the patient any relevant images. While it is unwise to state categorically to any patient that they have no disease, it can help to explain that the probability they have the disease that they fear is very low, and why. Beware, however, of the patient who repeatedly asks for reassurance about the same dis- ease; they may have health anxiety disorder, a condition that is per- petuated by repeated reassurance-seeking. Giving a diagnosis and explanation Patients benefit from a positive diagnosis, and the failure to offer one may set them off on an unhelpful search. However, the diag- nosis given must be appropriate. The term 'functional symptoms' (symptoms that reflect a reversible change in bodily function rather than fixed 'structural disease') may be useful here. This diagnosis can then be elaborated with an explanation of what may have caused the symptoms. While our understanding of the aetiology of SSD is imperfect, we do have some evidence as described in the previous section on aetiology. Explanations that include both psychological and biological factors and emphasize which of these factors are po- tentially reversible set the scene for treatment (see next). It is worth noting that overly simplistic explanations for symp- toms are probably unhelpful. On the one hand saying that the symp- toms are 'just psychological' or 'all in the mind' is likely to offend the patient and to reduce their confidence in you and your suggested management plan. On the other hand, colluding with beliefs that their symptoms indicate an untreatable disease (such as chronic Lyme disease) when they do not is also likely to make the patient unwilling to accept appropriate treatment and to promote unneces- sary invalidity. Giving practical advice After the diagnosis and explanation, a positive plan of action that specifies both what the patient can change and what the doctor will do is required. The patient can be advised how to change any potential illness- perpetuating behaviours (e.g. by becoming more active and not searching for illnesses on the internet). The doctor can offer to provide accurate information about the illness, review their pro- gress and if appropriate prescribe (e.g. an antidepressant drug) and refer (e.g. to physiotherapy or specialist psychology). Writing specifically to the patient, as well as to the general practitioner to summarize

the conclusions of the medical assessment and the pro- posed plan of action usefully reinforces these messages, which may otherwise be forgotten, and gives the patient something to show family members. Antidepressant drug treatment The so-called antidepressant drugs have been found to be of some benefit in SSD. While they are most likely to be helpful when the patient is depressed or anxious, they can also reduce symptoms such as pain in patients who are not depressed or anxious. However, an observed high drop-out rate from treatment emphasizes the need for careful explanation and follow-up to ensure adherence. For these drugs to be accepted by the patient, a clear explanation of why they are being prescribed is required. One of the following two ap- proaches is suggested: the first is to explain that the term ‘antidepres- sant’ is a misnomer and that the drugs are actually broad-spectrum agents of proven value for symptoms such as difficulty sleeping and pain, as well as for depression. The second is to be explicit that they are being prescribed for depression or anxiety, but to emphasize that these psychological problems are an entirely understandable reac- tion to the distressing somatic symptoms. Box 26.5.12.2 Management principles for somatic symptom disorder • Exclude disease, but avoid unnecessary investigation or medical referral • Tell the patient that you accept and sympathize with their complaint(s) • Give the patient a positive diagnosis and explanation • Encourage a return to normal functioning • Consider prescribing antidepressant drugs with appropriate explanation • Consider referral to specialist liaison psychiatry or psychology

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