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Brief Report

Canadian Emergency Physician Attitudes Toward Somatic Symptom and Related Disorders

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Abstract: Background: Somatic symptom disorder (SSD) involves physical symptoms that cannot entirely be explained by an organic medical cause, accompanied by persistent thoughts, feelings and behaviours relating to one's health. SSD is common yet underdiagnosed in emergency departments (EDs). This study aimed to assess emergency physician (EP) readiness, attitudes and perceptions toward diagnosing SSD and explore demographic trends. **Methods**: In total, 1339 Canadian EPs were invited to respond to a survey collecting demographic information and assessing attitudes toward SSD in four domains: perceptions of SSD, attitudes toward patients, diagnostic confidence, and physician–patient communication. Data were analyzed using *t*-tests and ANOVA to determine associations with demographic information. **Results**: Of the 96 survey respondents, 75 met the eligibility criteria. In total, 44% estimated that emotional stress was the primary cause of symptoms in 11–20% of their patients. Most felt that SSD was underdiagnosed and that effective therapies exist. Concerns included medico-legal implications, managing patients' emotions, and potential negative reactions to non-organic diagnoses. Most respondents felt prepared and confident broaching the diagnosis. More experienced EPs felt that there was time to broach the topic of SSD, while rural EPs were less concerned about patient offence than urban counterparts. **Conclusions**: EPs recognize SSD as common and underdiagnosed, acknowledging its diagnosis as part of their role. Challenges identified include managing patients' emotions, time constraints, and reliance on only diagnosing SSD once an organic etiology is excluded. Training pathway, experience, and practice setting impact perceptions and attitudes around SSD. The findings suggest opportunities for improving SSD care through targeted interventions, communication training, and enhanced diagnostic education.

Keywords: somatic symptom disorder; somatization; survey; emergency medicine; medically unexplained symptoms

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Academic Editor: Raimundas Lunevicius

Received: 18 February 2025
Revised: 5 March 2025
Accepted: 10 March 2025
Published: 16 March 2025

Citation: Wells, J.H.; Town, J.M.; Campbell, S.G. Canadian Emergency Physician Attitudes Toward Somatic Symptom and Related Disorders. *Emerg. Care Med.* **2025**, *2*, 14. https://doi.org/10.3390/ecm2010014

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1. Introduction

Various terms are used to describe physical symptoms and accompanying problematic thoughts, feelings and behaviours that are not believed to primarily have a medical cause, including somatoform disorder, medically unexplained symptoms, somatization and functional syndromes. The Diagnostic and Statistical Manual of Mental Disorders 5 (DSM-5-TR) uses the term 'somatic symptom disorder' (SSD) to describe physical symptoms lasting over six months that cannot entirely be explained by an organic medical cause, accompanied by persistent thoughts, feelings and behaviours relating to one's health [1]. Pain is the most frequently reported symptom, but others can include shortness of breath, muscle tension

and gastrointestinal or sexual dysfunction. The DSM-5-TR emphasizes that the way in which a patient interprets and presents their symptoms is a defining characteristic of SSD, rather than simply the presentation of symptoms in the absence of a clearly defined medical issue. Namely, the patient may present with concerns out of proportion to their symptoms, including a high level of anxiety regarding their symptoms, and devote significant time and energy to their symptoms [1].

Emotional or psychologically based symptoms are believed to occur in 18.5% of adult and 13% of pediatric emergency department (ED) visits, after excluding cases with physical trauma [2,3]. Despite this prevalence, SSD diagnosis is often delayed or missed and SSD has low clinical regard amongst ED physicians and nurses [4].

In a survey of over 1700 primary care physicians (PCPs) conducted by Lehmann et al., barriers to the diagnosis of SSD included the demand to relieve symptoms as well as the desire to rule out physical disease [5]. The situation regarding emergency physician (EP) attitudes and perceptions of SSD has yet to be evaluated.

The primary aim of this study is to assess Canadian Eps' preparedness, attitudes and perceptions toward diagnosing SSD in the ED and secondarily to identify demographic trends associated therein. The relevance of these aims is highlighted by the current primary care shortage in Canada, where an estimated one in five individuals do not have a family physician, thus increasing the likelihood of patients with SSD presenting to the ED [6].

2. Materials and Methods

A voluntary and anonymous national survey was emailed to a list of 1339 EPs supplied by the Canadian Association of Emergency Physicians. Participants were excluded if they did not actively practise emergency medicine. Ethics approval was obtained from Dalhousie University on July 28 2023 (REB # 2023-6757).

Following Lehmann et al., the survey comprised two sections: one collecting demographic data (Figure A1) and a second divided into four domains, (1) EP perceptions of SSD, (2) attitudes toward patients, (3) diagnostic confidence, and (4) physician–patient communication (Figure A2) [5].

The survey was distributed on 16 October 2023, with reminders after two and four weeks, and closed on 17 November 2023.

A flow chart of the study is presented in Figure 1.

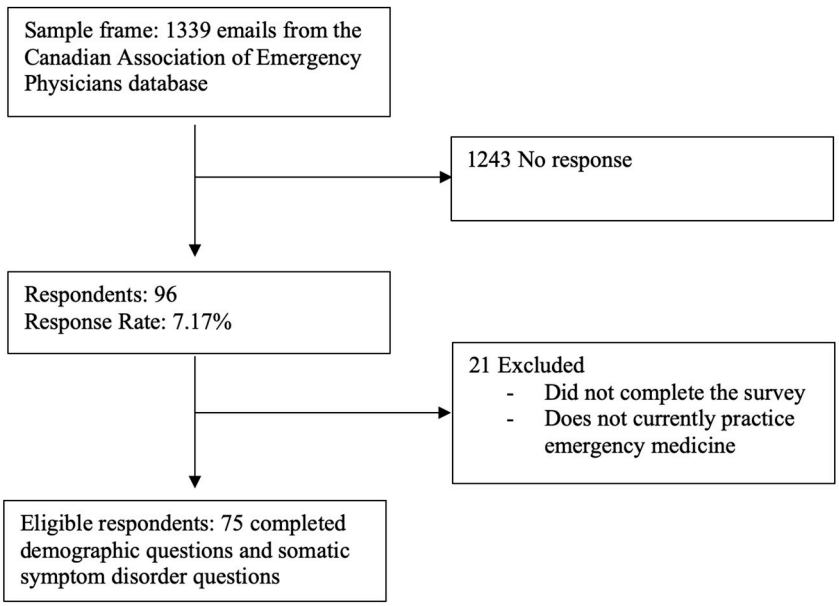


Figure 1. Study flow chart.

Statistical Analysis

Mean values and standard deviations for all 18 questions were calculated and responses were analyzed for associations with demographic information. A *t*-test was used for two-category demographics, and ANOVA was used for those with three or more categories, all at a 95% confidence interval. Bonferroni tests were conducted when necessary. Responses with fewer than six options (e.g., question 8) were scaled for comparison.

3. Results

In total, 96 participants completed the survey, of which 75 were deemed eligible.

Demographic information of the participants is presented in Table 1. Over half were male, with 53.3% trained as Fellows of the Royal College of Physicians of Canada (FRCPC), 37.3% with a certification in the College of Family Physicians (CCFP) and an additional certification in emergency medicine (CCFP (EM)), 6.7% with a CCFP alone, and 2.7% falling under 'other'. About one-quarter had less than 10 years of experience, 32% had 10–20 years of experience, 29.3% had 21–30 years of experience and 12% had over 30 years of experience. Practice settings included urban/suburban areas (80%) and small town/rural settings (20%). Most (58.7%) practised in an academic health centre, and the remainder practised in community hospitals. The majority (69.3%) served a mixed patient demographic, while 25.3% served adults only and 5.3% served pediatric cases only.

Table 1. Personal and practice characteristics of participants, *n* = 75.

	Level	**Responses**
Gender	Male (%)	44 (58.7)
	Female (%)	31 (41.3)
Training Path	FRCPC (%)	40 (53.3)
	CCFP (EM) (%)	28 (37.3)
	CCFP (%)	5 (6.7)
	Other (%)	2 (2.7)
Years Spent Practising Emergency Medicine	>10 years (%)	20 (26.7)
	10–20 years (%)	24 (32)
	21–30 years (%)	22 (29.3)
	>31 years (%)	9 (12)
Geographic Population Served in Practice Setting	Urban/Suburban (%)	60 (80)
	Small Town/Rural (%)	15 (20)
	Geographically Isolated/Remote	0
	Cannot Identify a Primary Geographic Location	0
Primary Work Setting	Community Hospital (%)	31 (41.3)
	Academic Health Centre (%)	44 (58.7)
	Private Office/Clinic	0
	Prefer Not to Answer	0
Primary Patient Demographic	Adult Only (%)	19 (25.3)
	Pediatric Only (%)	4 (5.3)
	Mixed (%)	52 (69.3)

Figure 2 shows the average responses to Section 2 (Figure A2) of the survey. Questions 8 and 9 are not included in this figure as the responses to these are not on a Likert scale. In question 8, when asked about the proportion of patients whose symptoms were

thought to be primarily caused by emotional stress, 44% indicated 11–20%, while 40% indicated less than 10%. In response to question 9, 90% of respondents felt that SSD was occasionally, often, or very frequently missed rather than over-diagnosed. For all other questions, a mean response above 3.5 indicated agreement on average and a mean response below 3.5 indicated disagreement, with scores closer to 6 showing stronger agreement and those closer to 1 showing stronger disagreement.

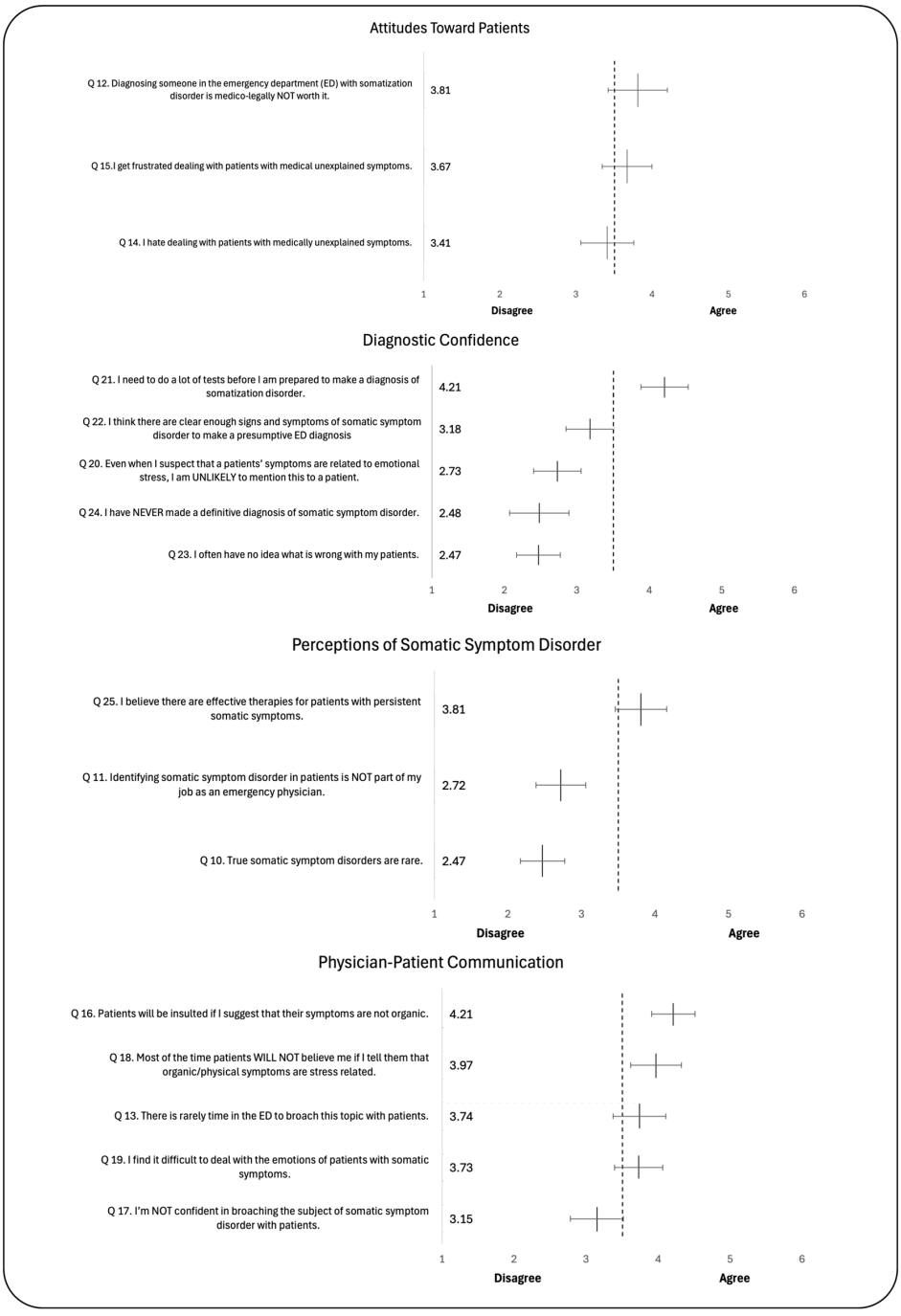


Figure 2. Mean responses to questions in Section 2 (Figure A2) of the survey. Questions are subdivided into four domains and ordered from highest average level of agreement to highest average level of disagreement. Mean responses are displayed beside the statement. The value 3.5 is represented by the dotted reference line. The closer the mean is to 6, the stronger the agreement. The closer the mean is to 1, the stronger the disagreement. Error bars represent 95% confidence intervals.

Significant statistical tests relating demographic information from Section 1 (Figure A1) to responses in Section 2 (Figure A2) are displayed in Figure 3. Demographic associations with significance include male respondents being more likely than females to express the belief that there are clear enough signs and symptoms of SSD to make a presumptive ED diagnosis. Participants with a FRCPC certification were on average more likely than those with a CCFP(EM) to claim to never have made a definitive diagnosis of SSD. Participants with 10–20 years of experience were more likely than those with >30 years of experience to believe that there is rarely time in the ED to broach this topic with patients. Those with <10 years of experience were least likely to have made a definitive diagnosis of SSD. Respondents in urban/suburban settings were significantly more likely than those in rural/small town settings to believe patients would be insulted if a non-organic origin of their symptoms was suggested.

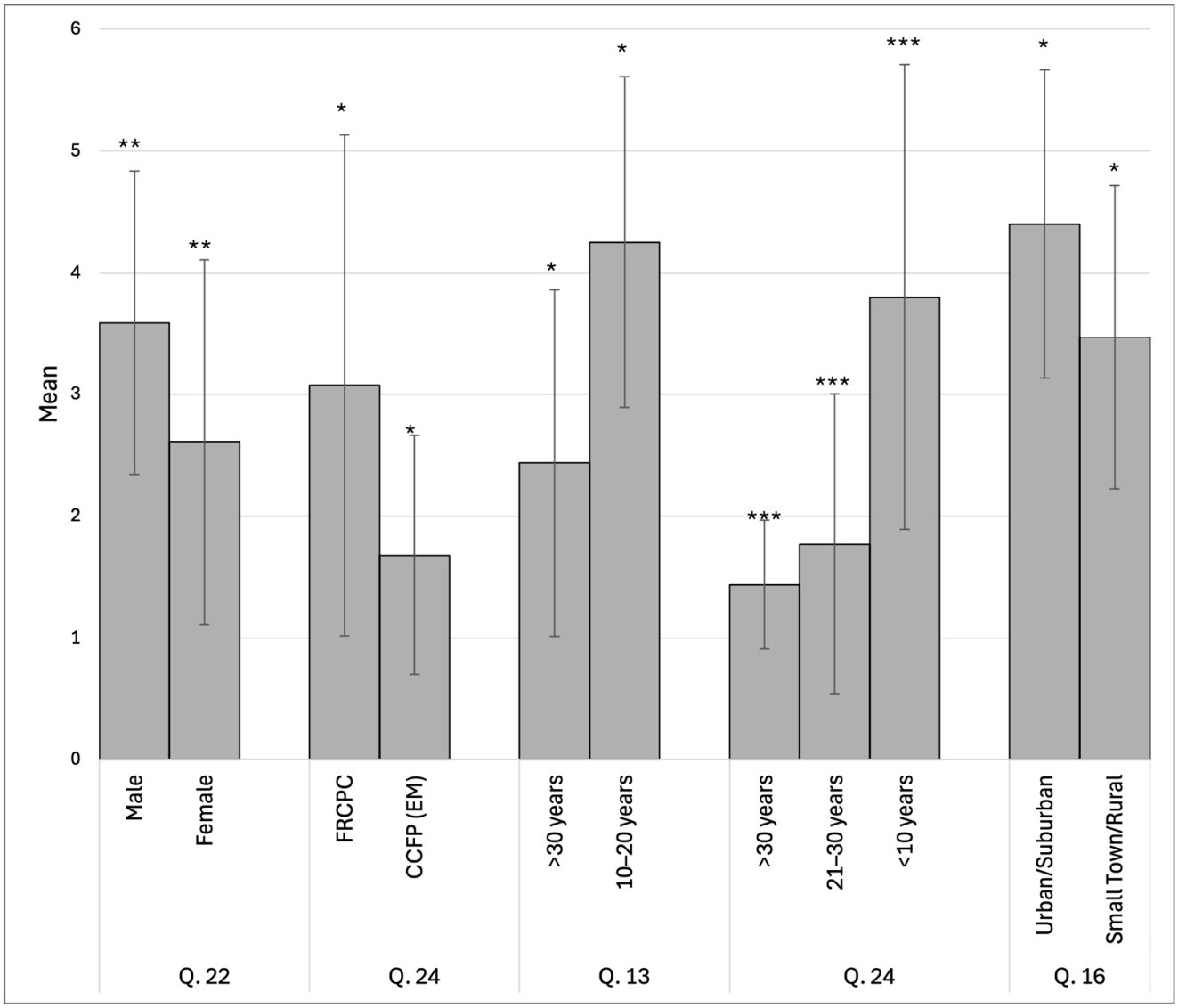


Figure 3. Bar graph showing mean responses in Section 2 (Figure A2) of the survey when significant differences existed based on demographic variables collected in Section 1 (Figure A1). Only significant differences are shown. Question number is indicated on the x axis along with the demographic variable. Error bars represent the standard deviation. * $p < 0.05$ ** $p < 0.01$ *** $p < 0.001$.

4. Discussion

This study aimed to evaluate EPs' attitudes and comfort in managing patients with suspected SSD and identify demographic factors associated with their responses.

Most respondents felt that SSD is common and underdiagnosed, acknowledged the existence of effective therapies to treat SSD and acknowledged their role in diagnosing it. Respondents perceived the need for extensive testing before diagnosis. While this is understandable considering the imperative in EM to consider acutely life-threatening diagnoses, male respondents were more likely to believe there are clear enough signs of SSD to make a presumptive diagnosis.

EPs' concerns about missing organic disease and meeting patient expectations to alleviate symptoms match those of PCPs described by Lehmann et al. [5]. Respondents in our study acknowledged that patients might not accept non-organic diagnoses, and that time constraints and managing patient's emotions are challenging. They also expressed concerns about the medico-legal implications of SSD diagnoses. Although our surveys were not identical, EPs appear to experience greater frustration and difficulty dealing with emotions in this population than PCPs [5]. This may be due to the more familiar and trusting relationships between PCPs and their patients, and due to the higher levels of stress associated with acute presentations. Other studies have indicated low clinical regard for disorders of medically unexplained symptoms [4]. While our results support this, some EPs do report confidence broaching SSD with patients.

CCFP(EM)-trained EPs were more likely to report having made a diagnosis than FRCPC physicians. This difference may be explained by a CCFP(EM) physician's greater exposure to SSD patients in primary care training, and by the possibility that FRCPC-trained EPs are more likely to work in higher-acuity EDs, thus having an appropriately higher index of suspicion for acute life-threatening illness.

Physicians with >30 years of experience were more likely to believe there is time in the ED to broach this topic. This finding may align with the suggestions by Chao-Jui et al.: that experienced physicians spend more time interacting with patients [7]. Greater experience also correlated with the likelihood of having made a SSD diagnosis, potentially reflecting the increased familiarity with and likelihood of encountering SSD given the length of clinical time.

Rural physicians were less concerned than urban-based physicians about insulting patients by suggesting a non-organic diagnosis, possibly due to differences in physician–patient relationships. One study comparing communication styles of urban and rural physicians found that rural physicians may generally ease patient anxiety and increase patient trust more than urban physicians [8].

Our study suggests that there is room for improvement in EPs' diagnostic confidence in SSD and the role for education on communication techniques to minimize the likelihood of patients feeling insulted. This may include structured communication techniques, encouragement of empathy and reassurance that organic illnesses have been adequately considered, with adherence to established guidelines for the treatment of SSD [9,10]. EPs' awareness of effective SSD treatments suggests that there would be greater willingness to make referrals for further assessment and treatment if services were more readily available. Examples of ED-based psychology clinics demonstrating effectiveness in treating SSD are reported in the literature [11].

Limitations of this study include the small sample size, affecting its generalizability. The survey was shortened to encourage participation and reminders were sent; nevertheless, the response rate was disappointing. There was likely selection bias amongst those who responded. This survey likely selected EPs more interested in or aware of SSD, and perhaps those with a more favourable perception thereof. Data on awareness of SSD amongst EP are

sparse, though a study amongst physicians in Sweden found that 71% of physicians across various specialties were aware of the diagnosis but only 7% were aware of the diagnostic criteria [12]. To align with the survey of Lehmann et al., most survey statements were framed negatively, which may have influenced responses.

5. Conclusions

EPs recognize that, while ruling out life-threatening illness is crucial, SSD is common and underdiagnosed. They believe effective therapies exist and see SSD as a legitimate ED diagnosis. However, they remain concerned that patients may react negatively to non-organic explications, reported struggling with managing patient's emotions, and reported that there is often a lack time to address the diagnosis. Opportunities remain to improve care for SSD and reduce the associated suffering.

Author Contributions: Conceptualization, J.H.W. and S.G.C.; data curation, J.H.W.; formal analysis, J.H.W., J.M.T. and S.G.C.; funding acquisition, J.H.W.; investigation, J.H.W.; methodology, J.H.W. and S.G.C.; project administration, J.H.W.; resources, J.H.W.; supervision, S.G.C.; visualization, J.H.W.; writing—original draft, J.H.W.; writing—review and editing, J.H.W., J.M.T. and S.G.C. All authors have read and agreed to the published version of the manuscript.

Funding: We received financial support in the form of a CAD 5000 bursary from the Dalhousie University Faculty of Medicine Ross Stuart Smith RIM Summer Studentship.

Institutional Review Board Statement: This study was conducted in accordance with the Declaration of Helsinki and approved by the Ethics Committee of Dalhousie University (REB # 2023-6757, 28 July 2023).

Informed Consent Statement: Informed consent was obtained from all subjects involved in the study.

Data Availability Statement: The raw data supporting the conclusions of this article will be made available by the authors upon request.

Conflicts of Interest: The authors declare no conflicts of interest. The funders had no role in the design of the study; in the collection, analyses, or interpretation of data; in the writing of the manuscript; or in the decision to publish the results.

Abbreviations

The following abbreviations are used in this manuscript:

SSD	somatic symptom disorder
ED	emergency department
EP	emergency physician
FRCPC	Fellows of the Royal College of Physicians of Canada
CCFP	Certification in the College of Family Physicians
CCFP-EM	Certification in the College of Family Physicians with additional certificate in Emergency Medicine
PCP	primary care physician

Appendix A

Surveying Physician Attitudes Toward Somatic Symptom Disorder in the Emergency Department

Survey Introduction and Consent

Risks: The risks of this study are minimal, and the harms or discomforts are not greater than those that are related to common experiences of everyday life. Although rare, there is a small risk of a data breach where survey responses could be exposed to unauthorized individuals or entities. To mitigate this risk, we have implemented industry standard security measures to protect your data. In addition, we will not be collecting sensitive personal information.

Compensation / Reimbursement

Participants will not be compensated for their time. Participation is voluntary and will not be coerced in any way.

How your information will be protected:

Only Jesse Wells and Dr. Samuel Campbell will have access to the study data and there will be no way to link your individual data with any personally identifying information, including your email address. They survey will be conducted with Opinio software, which treats all data as confidential and complies with the highest industry standards for data privacy. All data will be stored on Dalhousie's secure servers and/or a password protected Dalhousie cloud storage software.

We will describe and share our findings in a scientific journal. We will only report group results and not individual results. This means that you will not be identified in any way in our reports.

Once the study is over your data will be stored for five years from the time of collection. It will be stored anonymized digitally and deleted after the five-year period is concluded.

If You Decide to Stop Participating

If you decide to stop participating during the survey, simply close the webpage and your data will not be included in the study. Once a survey response is submitted, it will be impossible to remove an individual participant's data due to the anonymous nature of data collection.

How to Obtain Results

The study results will be published in a scientific journal to be decided at a later time. If you would like to be provided with the results, please contact Jesse Wells directly via email. No individual results will be provided.

Questions

We are happy to talk with you about any questions or concerns you may have about your participation in this research study. Please contact Jesse Wells (at 902 293-0044, jessewells@dal.ca) at any time with questions, comments, or concerns about the research study.

If you have any ethical concerns about your participation in this research, you may also contact Research Ethics, Dalhousie University at (902) 494-3423, or email: ethics@dal.ca (and reference REB file #2023-6757).

Q1: Are you currently employed in an emergency department setting?

◯ Yes ◯ No

Section 1

Figure A1. *Cont.*

Q2: What is your gender?

◯ Male ◯ Female ◯ Prefer not to answer
◯ Other (please specify)

If you have chosen "other", please specify:

Q3: What was your training route to emergency medicine?

◯ FRCPC ◯ CCFP(EM) ◯ CCFP
◯ Other (please specify)

If you have chosen "other", please specify:

Q4: For how many years have you been practicing emergency medicine?

◯ Less than 10 years ◯ 10 - 20 years ◯ 21 - 30 years ◯ 31 years or more
◯ Prefer not to answer

Q5: With respect to your main patient care/practice setting, which of the following best describes the geographic population PRIMARILY served by you in your practice/residency?

◯ Urban/suburban ◯ Small town/rural
◯ Geographically isolated, remote ◯ Cannot identify a primary geographic population
◯ Prefer not to answer

Q6: Which of the following best describe(s) your primary work/ residency setting?

◯ Community hospital ◯ Academic health centre ◯ Private office or clinic ◯ Prefer not to answer
◯ Other (please specify)

If you have chosen "other", please specify:

Q7: What is your primary patient demographic?

◯ Adult only ◯ Pediatric only ◯ Mixed

Figure A1. Section 1 of the survey collecting demographic information.

Section 2

Q8: Estimate the proportion of your patients who YOU feel that the principal cause of their symptoms is emotional stress:

◯ 0 - 10% ◯ 11 - 20% ◯ 21 - 30% ◯ Greater than 31%

Q9: I think somatic symptom disorder is:

◯ Very frequently missed
◯ Occasionally missed
◯ Occasionally over diagnosed
◯ Very frequently over diagnosed
◯ Often missed
◯ Appropriately diagnosed
◯ Often over diagnosed

Q10: True somatic symptom disorders are rare.

◯ 1 (Definitely do not agree) ◯ 2 ◯ 3
◯ 4 ◯ 5 ◯ 6 (Definitely agree)

Q11: Identifying somatic symptom disorder in patients is NOT part of my job as an emergency physician.

◯ 1 (Definitely do not agree) ◯ 2 ◯ 3
◯ 4 ◯ 5 ◯ 6 (Definitely agree)

Q12: Diagnosing someone in the emergency department (ED) with somatization disorder is medico-legally NOT worth it.

◯ 1 (Definitely do not agree) ◯ 2 ◯ 3
◯ 4 ◯ 5 ◯ 6 (Definitely agree)

Q13: There is rarely time in the ED to broach this topic with patients.

◯ 1 (Definitely do not agree) ◯ 2 ◯ 3
◯ 4 ◯ 5 ◯ 6 (Definitely agree)

Figure A2. *Cont.*

Q14: I hate dealing with patients with medically unexplained symptoms.

◯ 1 (Definitely do not agree) ◯ 2 ◯ 3
◯ 4 ◯ 5 ◯ 6 (Definitely agree)

Q15: I get frustrated dealing with patients with medical unexplained symptoms.

◯ 1 (Definitely do not agree) ◯ 2 ◯ 3
◯ 4 ◯ 5 ◯ 6 (Definitely agree)

Q16: Patients will be insulted if I suggest that their symptoms are not organic.

◯ 1 (Definitely do not agree) ◯ 2 ◯ 3
◯ 4 ◯ 5 ◯ 6 (Definitely agree)

Q17: I'm NOT confident in broaching the subject of somatic symptom disorder with patients.

◯ 1 (Definitely do not agree) ◯ 2 ◯ 3
◯ 4 ◯ 5 ◯ 6 (Definitely agree)

Q18: Most of the time patients WILL NOT believe me if I tell them that organic/physical symptoms are stress related.

◯ 1 (Definitely do not agree) ◯ 2 ◯ 3
◯ 4 ◯ 5 ◯ 6 (Definitely agree)

Q19: I find it difficult to deal with the emotions of patients with somatic symptoms.

◯ 1 (Definitely do not agree) ◯ 2 ◯ 3
◯ 4 ◯ 5 ◯ 6 (Definitely agree)

Q20: Even when I suspect that a patients' symptoms are related to emotional stress, I am UNLIKELY to mention this to a patient.

◯ 1 (Definitely do not agree) ◯ 2 ◯ 3
◯ 4 ◯ 5 ◯ 6 (Definitely agree)

Figure A2. *Cont.*

Q21: I need to do a lot of tests before I am prepared to make a diagnosis of somatization disorder.

◯ 1 (Definitely do not agree) ◯ 2 ◯ 3
◯ 4 ◯ 5 ◯ 6 (Definitely agree)

Q22: I think there are clear enough signs and symptoms of somatic symptom disorder to make a presumptive ED diagnosis.

◯ 1 (Definitely do not agree) ◯ 2 ◯ 3
◯ 4 ◯ 5 ◯ 6 (Definitely agree)

Q23: I often have no idea what is wrong with my patients.

◯ 1 (Definitely do not agree) ◯ 2 ◯ 3
◯ 4 ◯ 5 ◯ 6 (Definitely agree)

Q24: I have NEVER made a definitive diagnosis of somatic symptom disorder.

◯ 1 (Definitely do not agree) ◯ 2 ◯ 3
◯ 4 ◯ 5 ◯ 6 (Definitely agree)

Q25: I believe there are effective therapies for patients with persistent somatic symptoms.

◯ 1 (Definitely do not agree) ◯ 2 ◯ 3
◯ 4 ◯ 5 ◯ 6 (Definitely agree)

Figure A2. Section 2 of the survey collecting the survey response data.

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