

## REVIEW ARTICLE

Diagnosis and assessment of somatic symptom  
and related disorders among older adults: Issues  
and strategiesCharlotte Howell<sup>1</sup> , Daniel L. Segal<sup>1\*</sup> , and Shaynie Segal<sup>2</sup> <sup>1</sup>Department of Psychology, University of Colorado at Colorado Springs, Colorado Springs, Colorado, United States of America<sup>2</sup>Albert Einstein College of Medicine, Bronx, New York, United States of America**Abstract**

The limited understanding and literature concerning somatic symptom and related disorders (SSRDs), especially in older adults, further complicates accurate and sensitive diagnosis and assessment for this growing and specialized population. As the population of older adults is expected to grow exponentially, the purposes of this paper are to identify and elucidate key diagnostic and assessment challenges for SSRDs among older individuals to inform further research and guide practice. This paper also describes common self-report measures for SSRDs and describes the psychometric evidence for the use of these measures with older adults. Regarding diagnosis, older adults have higher rates of somatic multimorbidity and can incorrectly attribute somatic symptoms to normal aging. Furthermore, cognitive impairment rates are higher in older adults, impacting the accuracy of reporting SSRD symptoms. Regarding assessment, there are no elder-specific measures of SSRDs. Moreover, few of the current SSRD measures have been specifically validated for use with older adults. In addition, due to lack of education and awareness, mental health clinicians and medical providers may hold stigmatizing views of older adults with SSRD symptoms. The complex symptom presentation of SSRDs in older adults also complicates the efficacy of assessments. The paper concludes with suggestions for further research on SSRDs with diverse older adult populations.

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(dsegal@uccs.edu)**Citation:** Howell C, Segal DL, Segal S. Diagnosis and assessment of somatic symptom and related disorders among older adults: Issues and strategies. *J Clin Basic Psychosom.* 2025;3(4):21-29. doi: 10.36922/JCBP025080013**Received:** February 20, 2025**Revised:** April 7, 2025**Accepted:** May 7, 2025**Published online:** May 28, 2025**Copyright:** © 2025 Author(s). This is an Open-Access article distributed under the terms of the Creative Commons Attribution License, permitting distribution, and reproduction in any medium, provided the original work is properly cited.**Publisher's Note:** AccScience Publishing remains neutral with regard to jurisdictional claims in published maps and institutional affiliations.**1. Introduction**

Physical symptoms have been a part of diverse psychiatric disorders since the earliest conceptions of psychopathology.<sup>1</sup> In the distant past, philosophers espoused a strong dualism between mind and body, essentially arguing that the mind and body are fundamentally distinct. Modern-day medical providers, health service psychologists, and other behavioral health providers now know differently; it is clear that the mind and body are impactfully and inexorably linked.<sup>1</sup> This strong interaction is a key component of the biopsychosocial model of psychopathology.<sup>2</sup>

The mental disorder category most closely linked to this strong mind-body connection is called somatic symptom and related disorders (SSRDs) in the current

Diagnostic and Statistical Manual of Mental Disorders (DSM-5-TR).<sup>3</sup> This category has undergone significant change and clarification over prior editions of the DSM, which has hampered research efforts to understand these disorders more clearly in diverse populations. Before the publication of the DSM-5,<sup>4</sup> SSRDs were previously called somatoform disorders, which was a confusing name that was also not very intuitive for people to understand. Specific mental disorders under the umbrella of somatoform disorders included somatization disorder, undifferentiated somatoform disorder, conversion disorder, pain disorder, hypochondriasis, body dysmorphic disorder, and somatoform disorder not otherwise specified.<sup>5</sup>

At present, the DSM-5-TR section on SSRDs consists of somatic symptom disorder, illness anxiety disorder, functional neurological symptom disorder (conversion disorder), factitious disorder, psychological factors affecting other medical conditions, unspecified somatic symptom disorder, and other specified SSRDs.<sup>3</sup> For each of these disorders, there is a strong presumption that psychological factors play a meaningful role regarding the onset, severity, exacerbation, and/or maintenance of symptoms. While these disorders share similar symptoms, some notable differences are evident. For example, illness anxiety disorder differs from somatic symptom disorder in that somatic symptoms are typically not present or are minor in people with illness anxiety disorder, who are instead preoccupied with having or acquiring a serious illness. If somatic symptoms are present in people with illness anxiety disorder, the focus is more on the nefarious meaning of the symptoms, rather than on the somatic symptoms per se.<sup>6</sup> Functional neurological symptom disorder shares common symptoms with somatic symptom disorder. However, in functional neurological symptom disorder, the symptoms involve altered voluntary motor or sensory functions, mimicking a neurological disorder, despite evidence of the incompatibility of the symptoms with known neurological conditions. Further, individuals with functional neurological symptom disorder typically display a striking lack of worry or concern about their symptoms,<sup>6</sup> which is not typical in somatic symptom disorder, where distress about physical symptoms is a key component.

The previously formulated somatoform disorders required a hallmark symptom of unexplained medical symptoms, which was highly problematic. In the current conceptualization, this criterion was removed entirely. Indeed, the current SSRDs are characterized by one's reactions to physical symptoms (regardless of whether these is a clear organic etiology or not) which cause major emotional distress and/or problems functioning.

These so-called positive symptoms are in response to the individual's somatic symptoms and they can be identified with observable behaviors, emotions, and cognitions.<sup>6</sup> Positive symptoms can present in a multitude of ways, for example, spending an excessive amount of time focusing on health concerns, excessively seeking reassurance from medical professionals, or feeling intense and debilitating anxiety due to health concerns. Regardless of whether there is a known organic etiology to some (or all) of the person's somatic symptoms, it is important to recognize that the suffering and discomfort of the affected individuals are genuine, rather than being consciously fabricated, for example, in cases of malingering.

Cultural factors are also known to impact the SSRDs. According to the DSM-5-TR,<sup>3</sup> variations in SSRD symptoms can be due to sociocultural factors such as stigma. Language differences can also account for some variation, where somatic symptoms may have special meanings in particular cultural contexts. For example, sensations of heaviness, complaints of gas, too much heat in the body, or burning in the head are common in some cultures or ethnic groups but rare in others. In China, *shenjing shuairuo*, or "weakness of the nerves," manifests in fatigue and decreased energy, showing a distinct cultural manifestation. Regarding functional neurological symptom disorder, changes in functional neurological symptoms are common in certain culturally sanctioned rituals and thus should not be pathologized.

According to Kleinstäuber,<sup>7</sup> gender differences can be seen in SSRDs, where women tend to report somatic symptoms more commonly than men. Women, specifically, are diagnosed with functional neurological symptom disorder at higher rates than men. Still, gender differences are heavily influenced by cultural factors. For example, there are higher prevalence rates of SSRDs in women in Western societies. Moreover, race and ethnicity have been considered in epidemiological studies; SSRD symptoms are more common in South American primary care practices compared to other study centers in European countries, Africa, Asia, and the USA. Notably, studies have shown somatic symptoms and the distress commonly associated with these disorders represent a worldwide phenomenon. However, most somatic symptom self-report scales have been developed in Western contexts, and thus, these scales may not be fully sensitive to culture-specific symptoms. Overall, cultural beliefs, previous illnesses, insurance status, health literacy, and health care experiences influence one's perception of somatic symptoms and the health care use among individuals across the lifespan.

Due to a multitude of reformulations and revisions to the SSRD diagnostic category over time, these disorders

are particularly poorly understood, especially in older adults, a population that is rapidly expanding across the world.<sup>8</sup> Estimates indicate that between 2015 and 2050, the proportion of the world's population over 60 years of age will nearly double from 12% to 22%, making it more critical to explore a better understanding of these disorders. Older adults have specific biopsychosocial mental health needs that require specialized and age-sensitive approaches to diagnosis, assessment, and treatment.<sup>9,10</sup> This poor understanding of SSRDs among older adults increases the risks of misidentification, mistreatment, and stigma toward older adults who experience symptoms of SSRDs.

Due to the limited understanding and recognition of SSRDs among older adults, the purposes of this paper are to discuss and elucidate the key diagnostic and assessment challenges of SSRDs in older adults to inform further research and guide practice. While diagnosis and assessment go hand in hand, this paper has separated these two constructs to clarify the challenges associated with each. In the interests of transparency, our search strategy consisted of searching the APA PsycInfo and Google Scholar databases for articles pertaining to both SSRDs and aging. We used keywords including variations on “somatic symptom and related disorders” and “older adults/elderly/aging.”

Researchers have estimated the prevalence of somatoform disorders in older adults as ranging from 5% to 13%,<sup>11</sup> although definitive studies are lacking due to the changing nature of this diagnostic category. The especially poor understanding of SSRD symptoms and presentation among older adults could be attributed to the previous diagnostic criteria that required the absence of a medically explained disorder, where many older adults do indeed have physical disorders and associated somatic symptoms.<sup>12</sup> Indeed, SSRDs in older adults present a distinct set of challenges to the individual and care team. An accurate diagnosis and assessment must be made in older adults to provide effective treatment and to reduce the perceived stigma that many may hold concerning SSRDs.

A recent study by Wu *et al.*<sup>13</sup> analyzed the prevalence rates of somatic symptom disorder in a cross-sectional study in China with younger and older adults. The median age of older adults was 70 years old ( $n = 6814$ ), and the median age of younger adults was 48 years old ( $n = 2206$ ). The prevalence of somatic symptom disorder was higher in the older adult group (42.8% mild and 20.4% moderate/severe) than in younger adults (33.3% mild and 12% moderate/severe). Furthermore, depressive and anxiety disorders were 3.7 times higher than the expected amount in normative populations. Relatedly, Sammartino-Arbour *et al.*<sup>14</sup> conducted a systematic review analyzing

the associations between somatic symptom disorder and neurocognitive disorders in Canada. They captured 13 articles and found potential associations between late-onset SSRDs and a subsequent development of neurodegenerative disorders, specifically Lewy body spectrum disorders. Out of the 13 articles, a total of 123 SSRD participants were described, including 59 participants (47.9%) with conversion disorder, 6 (4.9%) with illness anxiety disorder, and 6 (4.9%) with a somatic symptom disorder. Of the 123 SSRD participants identified, 42 (34.1%) developed a neurocognitive disorder or Parkinson's disease. The most common clinical diagnosis was Lewy body spectrum disorder with 34 cases (80.9%). It is important to consider that older adults with an SSRD could be at an elevated risk for developing a neurocognitive disorder, which should be monitored closely.

We now turn to diagnostic challenges associated with older adults and SSRDs, which include high rates of somatic multimorbidity, a misattribution to aging and perceived stigma, and cognitive impairment. These issues are discussed next.

## 2. Diagnostic challenges

### 2.1. Somatic multimorbidity

It is a challenging reality of aging that many older adults have multiple chronic physical conditions, called somatic multimorbidity.<sup>15</sup> Somatic multimorbidity can result in many distressing physical symptoms experienced by the older adult, which may be difficult to differentiate from an SSRD. In cases of severe physical illnesses, it can be challenging to discern whether one's concerns about being ill or impaired are reasonable or excessive (that is, part of an SSRD). Several medical conditions are known to cause vague, confusing, and multiple somatic symptoms, including multiple sclerosis, systemic lupus erythematosus, fibromyalgia, irritable bowel syndrome, and chronic fatigue syndrome. As such, these conditions may mimic symptoms of an SSRD and they must be ruled out before diagnosis of an SSRD in older adults.

There is also frequent comorbidity of SSRDs with other mental disorders, especially depressive and anxiety disorders. For example, Dehoust *et al.*<sup>16</sup> found that older adults with an SSRD were 5 times more likely to have an anxiety disorder in the past year than older adults without an SSRD. Moreover, older adults with mood and anxiety disorders often present with a wide range of somatic symptoms, such as fatigue, poor sleep, increased heart rate, or shortness of breath, which can mimic symptoms of an SSRD and must be considered in the diagnostic process.

## 2.2. Misattribution to aging and perceived stigma

Another diagnostic issue is that some older adults may misattribute symptoms of SSRDs to normal aging or simply due to growing older. Under the “Development and Course” section of the DSM-5-TR for somatic symptom disorder, it is noted that underdiagnosis is common among older adults because somatic symptoms are either seen as a part of normal aging (and thus dismissed) or because high level of worry about illness is considered “normal” in older adults who are more likely to have medical illnesses and take medications for them compared to younger individuals.<sup>3</sup> To the extent that physical symptoms such as pain, headaches, abdominal symptoms, and fatigue (all key physical symptoms associated with SSRDs) are attributed to normal aging by older adults themselves, they will not report such issues to healthcare or mental health providers, which then prevents a full assessment of the person’s responses to those physical symptoms. In short, this process can lead to an underdiagnosis of SSRDs.

Chronic or persistent pain is an especially common problem, seen in 60 – 75% of older adults. However, pain symptoms are often incorrectly attributed to normal aging rather than as part of a possible mental disorder.<sup>10</sup> One method of discerning whether pain or other somatic symptoms are part of an SSRD is to assess whether the somatic symptoms cause significant and excessive disruptions to functioning and whether they are clearly associated with maladaptive and excessive emotional reactions, cognitions, and behaviors.<sup>10</sup>

In addition to older adults misattributing their symptoms of SSRDs to aging itself, there is a strong stigma associated with SSRDs,<sup>17</sup> perhaps more so than for most other categories of mental disorders. In a large survey study in Germany,<sup>17,18</sup> SSRD stigma was actually more pronounced among older people than younger people. In general, stigma in this category is due to the previous understanding that the physical symptoms associated with SSRDs must be medically unexplained, which led many people with SSRDs to be (incorrectly) told that “it is all in your head” or to be accused of being a fake.<sup>10,12</sup> Despite stigma, older adults with SSRDs are commonly encountered in primary care and other medical settings.<sup>3</sup> Unfortunately, older adults with SSRDs are less commonly encountered in mental health settings, including psychiatric settings.<sup>3</sup> Indeed, in medical settings, and especially in primary care settings, patients with SSRDs are so common that they have been called “heartsink patients” – patients who irritate and annoy their physicians and frequently come into their office.<sup>12,19</sup> The stigma about SSRDs likely contributes to the reluctance for some older adults to seek help in specialty mental health settings, for fear of being

judged or misunderstood. In medical settings, despite high service utilization rates, some older adults may fear being dismissed by medical providers, which puts them in a difficult position and may prevent them from effectively getting the care they seek and need.

## 2.3. Cognitive impairment

Cognitive impairment and neurocognitive disorders are common among older adults, as rates increase with advanced age.<sup>20,21</sup> Indeed, estimates suggest that 22% of individuals 70 years and older have some form of mild cognitive impairment and nearly 14% of individuals 70 years and older have a formal diagnosis of a neurocognitive disorder (oftentimes referred to as dementia).<sup>21</sup> Alzheimer’s disease, the most common form of major neurocognitive disorder, affects about 6.9 million people in the United States.<sup>22</sup>

Any degree of cognitive impairment on the part of older adult clients can adversely affect the detection and diagnosis of SSRDs. For proper diagnosis and assessment to be made, the client must have sufficient awareness and insight to adequately report their symptoms. Older adults with cognitive impairment may commonly experience difficulty accurately reporting their somatic symptoms and especially their reactions to these symptoms. Making temporal connections between physical symptoms and the subsequent distressing or impairing psychological and behavioral reactions is a challenge even among many with no cognitive deficits. Relatedly, older adults with cognitive impairment commonly experience difficulty accurately completing self-report screening and assessment tools for SSRDs (these tools are described below). Cognitive impairment has also been associated with the inability to rate the intensity of symptoms on numerical scales.<sup>7</sup> In sum, collecting reliable and valid information about SSRD symptoms from older adults with cognitive impairment can be convoluted and unreliable, further complicating the diagnosis of SSRDs.

## 3. Assessment challenges

### 3.1. Lack of age-specific screening and assessment measures

To date, there are no assessment tools for SSRDs that have been specifically designed for older adults, which represent a significant barrier to accurate screening and assessment. It is well established in professional geropsychology that elder-specific assessment tools are preferable in most research and clinical contexts because such tools are specifically validated for use with older adults and designed with the unique contexts of later life in mind.<sup>10</sup> However, several assessment measures for SSRDs are now available for clinical and research use (Table 1 for a listing

**Table 1. Popular scales for the assessment of SSRDs**

Name	Number of items	Key details	Source
Pain catastrophizing scale (PCS)	13	Measures the degree of catastrophizing pain on a 5-point Likert scale from 0 (not at all) to 4 (all the time). The PCS provides a total score and three subscales (rumination, magnification, and helplessness).	Sullivan <sup>23</sup>
Patient health questionnaire-15 (PHQ-15)	15	Measures the severity of somatic symptoms on a 3-point Likert scale from 0 (not at all) to 2 (bothered a lot). The PHQ-15 provides a total score.	Kroenke <i>et al.</i> <sup>26</sup>
Scale for the assessment of illness behavior (SAIB)	26	Measures illness behavior on a 4-point Likert scale from 0 (I agree completely) to 3 (I disagree completely). The SAIB provides a total score and five subscales (verification of diagnosis, expression of symptoms, medication, consequences of illness, and scanning).	Rief <i>et al.</i> <sup>29</sup>
Short health illness anxiety inventory (SHAI)	18	Measures health anxiety symptoms on a 4-point Likert scale ranging from 0 (never) to 3 (most of the time). The SHAI provides two subscales (main scale and negative consequences).	Salkovskis <i>et al.</i> <sup>31</sup>
Somatic symptom disorder-B criteria scale (SSD-12)	12	Measures somatic symptom disorder scales on a 5-point Likert scale ranging from 0 (never) to 4 (very often). The SSD-12 provides a total score and three subscales (cognitive, affective, and behavioral).	Toussaint <i>et al.</i> <sup>35</sup>
Somatic symptoms experiences questionnaire (SSEQ)	15	Measures characteristics and symptoms similar to the DSM-5-TR SSRD criteria on a Likert scale ranging from 0 (never) to 5 (always). The SSEQ provides a total score and four subscales (health worries, experience of illness, difficulties with physicians, and consequence of illness).	Herzog <i>et al.</i> <sup>34</sup>
Whitely index (WI)	14	Measures health anxiety disorder symptoms on a dichotomous scale (yes or no). The WI provides a total score and three subscales (bodily preoccupation, disease phobia, and disease conviction).	Pilowsky <sup>28</sup>

Abbreviations: DSM-5-TR: Diagnostic and statistical manual of mental disorders; SSRD: Somatic symptom and related disorders.

of popular self-report tools and their key features). Some of the measures have been used in studies with older adults and we will describe the psychometric features of these instruments below. That being said, the use of assessment tools not specifically designed for older adults or validated for use with older adults can lead to potential inaccuracies. As such, clinicians and researchers should carefully review the psychometric properties of assessment tools that they wish to use to ensure that the tools are appropriate for the population of interest (in this case, older adults) or to conduct their own validity studies of those measures. In our opinion, development of elder-specific assessment tools for SSRDs is a clear priority.

In the following section, we describe several scales for SSRDs that have either been psychometrically evaluated in older adults or have been used in older adult populations, with positive or negative results.

### 3.1.1. Pain catastrophizing scale (PCS)<sup>23</sup>

Petrini and Arendt-Nielsen<sup>24</sup> investigated pain catastrophizing through the PCS in 32 healthy older adults (mean age = 74 years) and 34 healthy younger adults (mean age = 24 years). Participants were measured by pressure stimuli and experimental pain testing on a numerical rating scale. After testing, participants answered the PCS which contains a total score and scores on

3 subscales (rumination, magnification, and helplessness). Older participants reported significantly lower levels of pain catastrophizing in general, which was largely driven by their lower scores on the components of rumination and helplessness, whereas there were no age differences on the component of magnification. These results suggest some utility for the use of the PCS with older adults. However, this study did not include any participants with a formal diagnosis of an SSRD. In a related study, Ruscheweyh *et al.*<sup>25</sup> discovered that pain catastrophizing in older adults (mean age = 57.9 years) was more highly associated with pain intensity compared to younger adults (mean age = 26.5 years), suggesting that older adults experience pain catastrophizing more with intense pain. While this older sample was relatively young, with primarily participants in their sixties, the results indicate some preliminary evidence of utility of the PCS with older adults, and highlight the potentially important role of pain catastrophizing among older adults.

### 3.1.2. Patient health questionnaire-15 (PHQ-15)<sup>26</sup>

Van Driel *et al.*<sup>27</sup> investigated the psychometric properties of the PHQ-15<sup>26</sup> in a population of older adults with somatic symptoms. The PHQ-15 is part of a larger sample of questions that specifically measure the severity of somatic symptoms, rather than the similarly named PHQ-9 scale that measures depressive symptoms. The study aimed to

understand which scales best measure somatic symptoms in older populations by conducting a systematic review and examining previously collected data. They found that the PHQ-15, a measure commonly used in younger populations, was not correlated with other SSRD scales such as the Whiteley Index<sup>28</sup> and other somatic scales, suggesting that the PHQ-15 was not effective in detecting SSRD psychopathology in older adults.

### **3.1.3. Scale for the assessment of illness behavior (SAIB)<sup>29</sup>**

The SAIB is a popular self-report measure that was primarily validated for younger adults. Engelberg *et al.*<sup>30</sup> found that the factor structure of the SAIB did not replicate well among older adults, and they created a revised version better fit for aging populations. They concluded that the revised SAIB could be used for older adults with caution. However, this version's psychometric properties are only preliminarily established.

### **3.1.4. Short health illness anxiety inventory<sup>31</sup>**

Boston and Merrick<sup>32</sup> conducted a study with community-dwelling older adults to better understand the prevalence rates and etiology of health anxiety, as measured by the Short Health Illness Anxiety Inventory (SHAI). All participants were over the age of 65 and half were between 75 and 85 years of age. In this study, the mean score for the SHAI was 7.04 (SD = 4.31). The typical cutoff point for SHAI scores is 15, where any score higher indicates the presence of acute health anxiety. About 7.6% of participants scored higher than 15 in the present study, which was comparable to 10% reported in general population studies. This finding indicates that older adults and younger adults have similar levels of severe health anxiety. More recently, an exploratory study of the SHAI was conducted with older adults to determine the factors of health anxiety in community-dwelling older adults in China.<sup>33</sup> Results showed similar prevalence rates of health anxiety using the SHAI in older adults (9.53%) compared to prior findings by Boston and Merrick.<sup>32</sup> Both of these studies indicate that the SHAI was appropriately able to detect health anxiety in older adults at a similar rate to younger adults, suggesting some utility and effectiveness of the scale to adequately assess health anxiety in older adult samples.

### **3.1.5. Somatic symptoms experiences questionnaire (SSEQ)<sup>34</sup>**

In a review of SSRD scales, Van Driel *et al.*<sup>27</sup> found that none of the 15 items in the SSEQ overlap with common physical symptoms associated with old age or are inappropriate for older adult populations, providing at least some evidence for the content validity of the SSEQ. However, studies

examining other forms of validity of the SSEQ among older adults are lacking.

Regarding one other common assessment tool, the somatic symptom disorder criteria B<sup>35</sup> is an increasingly popular scale specifically designed to measure somatic symptoms commonly associated with somatic symptom disorder. To the best of our knowledge, however, this scale has not yet been validated or used in older adult samples.

### **3.2. Bias among mental health clinicians and medical providers**

Another potential barrier to assessment is that some medical providers may have preconceived notions about the normalcy of somatic symptoms in older adults, leading to biased assessments. Due to the prominence of physical symptoms associated with SSRDs, older adults with SSRDs commonly seek help from primary care doctors or general practitioners,<sup>36</sup> rather than mental health professionals. Indeed, while older individuals with SSRDs are commonly frequent users of diverse healthcare services, they often do not get the proper psychotherapeutic assessment and treatment from specialty mental health clinicians. As noted above, the stigma associated with SSRDs may prevent some older adults from accepting a referral to a mental health professional, due to concerns about being told that their physical symptoms "aren't real" or that their problems are fully psychogenic or psychological in nature. In medical settings, patients with SSRDs are at a higher risk of unnecessary testing or treatment and are sometimes seen as less favorable and challenging to physicians.<sup>37</sup> Relatedly, Segal *et al.*<sup>10</sup> noted that if medical providers and mental health professionals incorrectly attribute pain or other somatic symptoms to the aging process only, they risk underestimating and undertreating possible SSRD symptoms among older adults.

### **3.3. Limited training among professionals**

Healthcare providers commonly lack specialized training in the diagnosis and assessment of SSRDs in adults and older adults.<sup>17,37</sup> Medical team members should be well-versed in concepts from basic gerontology, for example, understanding the differences between normal aging and abnormal aging to better diagnose and treat a wide array of individuals with symptoms of SSRDs. Unfortunately, as noted earlier, the misattribution of symptoms of SSRDs to normal aging is common among older adults themselves and among diverse health professionals.

Kleinstäuber<sup>7</sup> provided several thoughtful recommendations for clinicians and other members of the medical team to consider when working with individuals presenting with symptoms of SSRDs or with individuals

with a diagnosed SSRD. It is recommended that clinicians build a relationship with other members of the client's healthcare team to gain as much information about the client as possible. Doing so can help the client feel understood and can assist in the development of rapport. Rapport can also be improved by providing the client the space to feel understood. Often times, clients with SSRDs want to find a physical cause for their symptoms to experience a successful treatment. Introducing psychotherapy as a second form of treatment to clients can help them not feel that their physical symptoms are not real, invalid, or only in their head. These recommendations are feasible ways to better communicate with individuals with SSRDs, which are transferrable skills that can also be used with older adults. There is also a limited knowledge of SSRDs in the general population. As such, public education campaigns are needed. Indeed, such campaigns can be similar to those devised for depression in later life, which have resulted in increased awareness of depression and increased referrals for appropriate treatment.<sup>38</sup>

### 3.4. Complex symptom presentation

A final barrier to adequate assessment of SSRDs among older adults is that older adults with SSRDs often present with a complex array of intertwined and reciprocal physical and psychological symptoms, requiring comprehensive assessment strategies. Chronic health conditions are common in older adults, and while some individuals with a health condition may have an SSRD, many do not, as their distress and reaction to being ill are reasonable and appropriate to the context and situation. Unfortunately, the rate of chronic conditions increases with age, and psychogenic stress can also exacerbate those physical health conditions, further complicating the assessment process of older adult.<sup>3,10</sup> Medical providers and mental health clinicians must carefully investigate symptoms and health history to determine whether the individual is experiencing an SSRD, an anxiety disorder, a mood disorder, or is simply suffering from chronic and unpleasant medical conditions. This process takes a certain amount of time and coordination between mental health clinicians and medical providers, which is necessary for improved patient care, but unfortunately is frequently not allowable for reimbursement from most insurance companies. As such, full coordination is often an aspiration and not a clinical reality.

## 4. Conclusions and future directions

In this paper, we have attempted to elucidate some of the nuances and challenges regarding the accurate diagnosis and assessment of SSRDs among older adults, who represent a growing and unique population. We

have also highlighted some of the historical challenges and changes to the diagnostic category of the SSRDs and noted how this category has been especially poorly understood and confusing to medical and mental health providers alike. The lack of elder-specific measures of SSRD psychopathology is a major gap that hopefully will be addressed by further research. Likewise, large-scale validity studies are critically needed to formally assess the psychometric properties of common assessment tools for SSRDs among diverse older adult populations. For example, basic studies yielding evidence in support of the internal consistency reliability, test-retest reliability, convergent validity, and discriminant validity for these measures are needed, including head-to-head comparisons between the key measures and evaluations of the proposed factor structures of measures with subscales. Studies are also needed to determine how these measures might be adapted for use with diverse older respondents, including development of empirically-based cutoff scores for the measures. Finally, treatment trials for older adults with SSRDs are necessary to establish sensitivity to change for the key assessment tools.

We hope the information in this article provides a good starting point for those interested in furthering their clinical and research work with older adults with SSRDs. Indeed, we think that clinicians and researchers would benefit from a more nuanced understanding of these complex disorders in diverse clinical and research contexts. From a clinical perspective, practitioners would benefit from learning more about SSRDs and assessing these types of symptoms more routinely in their older patients. Likewise, the time is ripe for empirical research to accelerate and for our overall understanding of SSRDs in later life to improve.

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The authors declare no conflicts of interest.

## Author contributions

*Conceptualization:* Daniel L. Segal, Charlotte Howell  
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