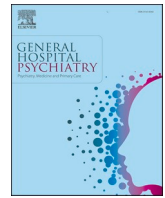




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## Letter to the editor

**Somatic symptom disorders and long COVID: A critical but overlooked topic**

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*To the editor,*

Long COVID is defined as the continuation of symptoms much longer than usually expected or the persistence of symptoms despite the recovery of the infection [1]. While research on long COVID is in full swing, only little attention has been paid to the associated psychiatric symptoms. In particular, the association between long COVID and somatic symptom disorders (SSD) has been overlooked.

In a recent letter, Sanack et al. emphasize the need to involve psychiatrists in the management of patients with long COVID, because of its frequent association with anxiety and depression [2]. Beyond anxiety and depression symptoms, patients with COVID-19 present a high risk to develop SSD. SSD, previously known as somatoform disorders, have been defined in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) as persistent and clinically significant somatic symptoms accompanied by excessive and disproportionate health-related thoughts, feelings and behaviors regarding the symptoms. The DSM-5's revision of diagnosis criteria fundamentally changed the way somatoform disorders were defined as SSD no longer require the persistent symptoms to be medically unexplained. This conceptual shift offers a new and positive definition of SSD based on the presence of symptoms, rather than the absence of them [3]. Moreover, the diagnosis of SSD may also apply to patients with symptoms of distress related to medical conditions, such as diabetes, cardiovascular disease, or infection. Patients with a history of COVID-19 or long COVID symptoms present an increased risk of comorbid SSD [4].

The current COVID-19 pandemic mirrors past pandemics and infectious diseases that have been related to SSD symptoms [4]. Indeed, social isolation, concerns for relatives, adverse media exposure, and limited access to health services have been shown to strongly impact mental health in the general population. Patients hospitalized for COVID-19 are additionally exposed to the effects of COVID-19 infection on the central nervous system, the secondary effects of organ failure, the impact of hospitalization and the effects of treatments such as corticosteroids or agents for sedation. Moreover, the fear of a poorly understood disease and the lack of knowledge about its long-term consequences make it difficult to reassure patients regarding their symptoms, contributing to the risk of developing SSD. Lastly, COVID-19 is associated with an increased risk of post-traumatic stress disorder [5],

which has been described as a risk factor for SSD [4].

As psychiatric symptoms often accompany long COVID, several authors point out the need to discriminate psychiatric from physical symptoms, suggesting that wrongly considering symptoms such as fatigue, insomnia, shortness of breath, as psychiatric symptoms may overlook the underlying disease and delay the appropriate treatment [2]. We agree that people with mental health problems have poorer physical health than the general population and that they face additional obstacles to access appropriate care. Nevertheless, we also think that the reverse is true. The diagnoses of SSD or related disorders are often delayed, after patients have received inappropriate and excessive “diagnosis” testing, dangerous or ineffective therapies, and multiple, often unnecessary, referrals. Considering the risk of SSD following hospitalization related to COVID-19 infection, its potentially detrimental effects on the patient's quality of life, and consequent cost for the health care systems, early detection and optimal management of SSD is essential. For this purpose, Toussaint et al. have recently developed the *SSD scale* (SSD-12), a self-rating questionnaire composed of 12 items, designed to assess patients' perceptions of their symptom-related thoughts, feelings, and behaviors using questions directly based on the DSM-5 criteria. SSD-12 appears as an easy tool that should assist clinicians in the diagnosis and assessment of SSD [3]. Patients with a diagnosis of SSD should then benefit from multidisciplinary care based on the biopsychosocial model [4]. The main objective of this approach is to help the patients to realize that persistent symptoms arise from the interaction of physiological, cognitive, behavioral, emotional and social factors, which need to be addressed concurrently.

Finally, recent literature has highlighted the importance of consultation-liaison psychiatrists (CLPs) in the evaluation of hospitalized patients with COVID-19 [2,5,6]. Indeed, as CLPs use to work with other specialist clinicians, they are particularly well-positioned to manage COVID-19 patients with, or at risk for, SSD who are hospitalized [6]. We believe that a multidisciplinary health care approach of SSD in the context of COVID-19 is an important measure to reduce the psychological impact of the COVID-19 pandemic.

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## Disclosure statement

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## References

- [1] Nabavi N. Long covid: how to define it and how to manage it. *BMJ*. 2020;370:m3489.
- [2] Sancak B, Agirbas UO, Kilic C. Long COVID and its psychiatric aspects. *J Acad Consult Liaison Psychiatry* 2021 Mar 29. <https://doi.org/10.1016/j.jaclp.2021.03.003>.
- [3] Toussaint A, Murray AM, Voigt K, Herzog A, Gierk B, Kroenke K, et al. Development and validation of the somatic symptom disorder-B criteria scale (SSD-12). *Psychosom Med* 2016 Jan;78(1):5–12. <https://doi.org/10.1097/PSY.0000000000000240>.
- [4] Willis C, Chalder T. Concern for Covid-19 cough, fever and impact on mental health. What about risk of Somatic Symptom Disorder? *J Ment Health* 2021;2020. <https://doi.org/10.1080/09638237.2021.1875418>.
- [5] Horn M, Wathélet M, Fovet T, Amad A, Vuotto F, Faure K, et al. Is COVID-19 Associated With Posttraumatic Stress Disorder? *J Clin Psychiatry* 2020 Dec 8;82(1):20m13641. <https://doi.org/10.4088/JCP.20m13641>.
- [6] Shalev D, Shapiro PA. Epidemic psychiatry: the opportunities and challenges of COVID-19. *Gen Hosp Psychiatry* 2020;64:68–71. <https://doi.org/10.1016/j.genhosppsy.2020.03.0092020>.

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