

SOMATIZED MENTAL DISORDERS IN PRIMARY HEALTH CARE: DIAGNOSTIC PROBLEMS AND MENTAL HEALTH INTEGRATION MODELS

N. N. Rakhalskaya*, S. Z. Yeshimbetova

NEI «Kazakh-Russian medical university», Kazakhstan, Almaty

*Corresponding author

Abstract

Relevance. Somatized mental disorders and persistent physical symptoms are an important but often insufficiently recognized problem in primary health care. Such patients usually turn to primary health care doctors first; however, the variety of symptoms, accompanied by anxiety and depression, stigma, and diagnostic difficulties, hinders their timely detection. In this regard, it is important to integrate mental health into the primary health care system and develop interdisciplinary care models.

Objective. To systematize current evidence on the evolution of terminology, the causes of underrecognition, the tools for early identification, and the organizational models of mental health integration relevant to the diagnosis of somatized mental disorders at the primary health care level.

Materials and Methods. This study was conducted as a narrative review, with a systematic literature search across PubMed, Scopus, and Web of Science, and an analysis of documents issued by the World Health Organization, World Health Organization /Europe, and the World Organization of Family Doctors. The main focus was placed on publications from 2015 to 2025; however, earlier works of conceptual importance were also included. The initial search identified 107 publications, of which 43 sources were included in the final analysis after title and abstract screening and duplicate removal.

Conclusions. Current scientific data show that the transition from the concepts of somatoform disorders and medically unexplained symptoms to the concepts of Somatic Symptom Disorder, bodily distress disorder, and persistent physical symptoms is important for clinical practice in primary health care. The diagnosis of these conditions should be based on periodic clinical assessment, including screening tools (PHQ-15, SSS-8, SSD-12), dynamic monitoring, and functional status assessment. The integration of mental health into primary health care and the development of a multidisciplinary approach will contribute to early detection and improved access to health care.

Keywords: somatized mental disorders, persistent physical symptoms, somatic symptom disorder, primary health care, early diagnosis, mental health integration, collaborative care.

Introduction

In primary health care (hereinafter – PHC) practice, patients presenting with persistent physical symptoms, functional complaints, and somatized mental disorders represent a significant clinical and organizational challenge. In contemporary literature, this group of conditions is increasingly described under the umbrella term of persistent physical symptoms/persistent somatic symptoms, which encompasses distressing bodily complaints that persist for several months or more, regardless

of their origin [1]. At the same time, recent years have seen a continuing shift away from earlier terms such as somatoform disorders and medically unexplained symptoms toward more contemporary diagnostic and conceptual frameworks, including somatic symptom disorder and bodily distress disorder, which is of fundamental importance for clinical practice at the PHC level [1; 2].

The relevance of this issue is largely determined by the fact that patients with such symptomatology most often seek care from a general practi-

tioner, internist, or another PHC professional rather than a psychiatrist. Studies conducted in PHC settings show that bodily distress syndrome and related conditions are fairly common in PHC and are associated with reduced quality of life, marked psychoemotional disturbances, and a considerable subjective symptom burden. Thus, PHC represents a key level for the early recognition and appropriate referral of such patients [3; 4].

At the same time, the diagnosis of somatized mental disorders in PHC remains challenging. This is related to the clinical heterogeneity of symptoms, their frequent coexistence with anxiety and depressive manifestations, as well as the continued dominance of a somatically oriented approach in routine practice. K. Piontek et al. reported that in only 32.3 % of cases of somatoform disorders did the diagnoses made by PHC physicians match those established during standardized interviews. This indicates a significant underdiagnosis in the PHC system and the need for clinical vigilance and stepwise diagnostic assessment of such patients [5].

The topic is further reinforced by ongoing psychiatric service reform and the international movement toward integrating mental health into PHC. World Health Organization (hereinafter – WHO) and World Organization of Family Doctors (WONCA) documents emphasize that transferring part of the functions of early detection, management, and referral of patients with mental disorders to the PHC level can improve access to care, reduce stigma, and ensure greater continuity of follow-up [6]. These principles were further developed in the mhGAP Intervention Guide for non-specialized health settings [7] and in recent WHO/Europe documents, where scaling up mental health services within the PHC approach is regarded as a priority direction for health system development [8]. This direction is also highly relevant to Kazakhstan in the context of developing multidisciplinary PHC teams and a people-centered PHC model [9].

In view of the above, an analysis of current evidence on the diagnosis of somatized mental disorders at the PHC level in the context of psychiatric service reform appears highly relevant, with particular attention to the evolution of terminology, the causes of underrecognition, the opportunities for early identification, and the organizational models for integrating mental health into primary medical care.

Despite the growing number of publications on persistent physical symptoms, somatic symptom disorder, and bodily distress disorder, data on the diagnosis of these conditions in routine PHC practice, as well as their consideration within the broader context of mental health integration and psychiatric service reform, remain fragmented. The novelty of the present review lies in bringing together contemporary clinical and organizational evidence relevant to PHC.

This review aimed to systematize current data on the evolution of terminology, the causes of underrecognition, the tools for early identification, and the models of mental health integration relevant to the diagnosis of somatized mental disorders at the PHC level.

Materials and Methods

The present study included a narrative review with a systematized literature search focused on the diagnosis of persistent physical symptoms, somatic symptom disorder, bodily distress disorder, and related conditions at the PHC level in the context of psychiatric service reform and the integration of mental health into PHC.

The literature search was performed in the electronic databases PubMed, Scopus, and Web of Science. In addition, documents of the World Health Organization, WHO/Europe materials, WONCA guidance documents, and publications addressing organizational models for integrating mental health into PHC were reviewed. The main focus of the search was on publications from 2015 to 2025; however, earlier studies of conceptual importance were also included to better understand the evolution of terminology, the development of collaborative care, and the emergence of models for integrating mental health into PHC. The search was last updated in January 2026.

The search strategy was based on combinations of the following terms: somatic symptom disorder, somatoform disorders, medically unexplained symptoms, persistent physical symptoms, persistent somatic symptoms, bodily distress disorder, bodily distress syndrome, functional somatic symptoms, somatization, PHC, primary health care, family medicine, general practice, diagnosis, screening, recognition, identification, underdiagnosis, integrated mental health care, collaborative care, mental health reform, and mhGAP.

In the Russian-language segment, the fol-

lowing search combinations were additionally used: «somatized mental disorders», «somatoform disorders», «persistent somatic symptoms», «primary health care», «integration of mental health into PHC», and «psychiatric service reform».

The initial search identified 107 publications potentially relevant to the review topic. After screening titles and abstracts, removing duplicates, and excluding studies that did not meet the inclusion criteria, 43 sources were selected for the final analysis, including original studies, systematic reviews, meta-analyses, scoping reviews, clinical and organizational guidelines, and WHO documents.

The inclusion criteria comprised publications addressing the prevalence, recognition, diagnosis, screening, coding, referral pathways, management, and organizational models of care for patients with persistent physical symptoms and related conditions in PHC, general practice, family medicine, and outpatient settings. Priority was given to studies focused on the integration of mental health into PHC, collaborative care, task-sharing, and systemic aspects of psychiatric service reform.

The exclusion criteria comprised case reports, publications devoted exclusively to inpatient psychiatric care without relevance to the PHC level, studies focused predominantly on psychotic disorders, substance dependence, or highly specialized conditions unrelated to persistent somatic symptomatology, as well as articles that did not contain data relevant to diagnosis or service organization at the PHC level.

The literature was synthesized thematically. The analysis was structured into the following analytical domains:

- Contemporary terminology and the evolution of concepts;
- The prevalence and clinical-organizational significance of these conditions in PHC;
- The causes of their underrecognition at the PHC level;
- Screening tools and diagnostic assessment approaches;
- Patient management strategies in general practice;
- The integration of mental health into PHC and organizational models of care in the context of psychiatric service reform.

Results

Terminology and evolution of concepts. The

conceptual framework used to describe somatized mental disorders and functional bodily complaints has changed substantially over recent decades. Earlier literature and clinical practice widely used the terms «somatoform disorders» and «medically unexplained symptoms». For a long time, the concept of medically unexplained symptoms served as a convenient working label for patients with recurrent bodily complaints lacking sufficient somatic explanation, particularly in PHC settings [10; 11]. However, as evidence accumulated, it became clear that such a negative definition, based primarily on the absence of a clear biomedical explanation, had important limitations and did not always reflect the actual clinical complexity of these conditions [11; 12].

Criticism of these earlier approaches was largely related to the fact that the dichotomy of «explained» versus «unexplained» symptoms functions poorly in real-world PHC practice, where patients often present with a combination of somatic pathology, psychoemotional distress, and persistent complaints that do not fit neatly into narrow nosological categories. In this context, a more clinically oriented and prognostic approach has been proposed for PHC, focusing not only on etiological assumptions but also on the risk of symptom persistence, functional limitations, repeated consultations, and excessive use of medical resources [10]. This approach appears particularly important in PHC, as it is better aligned with the tasks of early recognition and patient stratification than attempts to make an immediate final nosological determination of such complaints [10].

A major stage in the evolution of classification was the introduction of the DSM-5 diagnosis of somatic symptom disorder, which shifted the focus away from the very fact of symptom «unexplainedness» toward the clinically significant combination of bodily complaints with excessive thoughts, anxiety, health-related preoccupation, and maladaptive behavior [2]. The advantages of the SSD concept include greater clinical applicability and improved reliability and validity. In PHC practice, this is fundamental, as it allows such conditions to be viewed not as a residual diagnostic category but as an independent clinical problem requiring active identification and follow-up [2; 13].

Alongside the DSM-oriented line, the concept of bodily distress syndrome / bodily distress

has developed in the European literature as a unifying diagnostic framework for functional and somatoform conditions. This approach is oriented toward grouping frequently overlapping syndromes and symptom complexes that often coexist in real clinical practice. An important advantage of this model is its applicability in general practice, where the physician must work not with formally separated nosologies, but with a patient presenting with multiple, persistent, and subjectively significant bodily complaints [12; 14].

At the present stage, the umbrella term of persistent physical symptoms/persistent somatic symptoms is also increasingly used to denote persistent bodily symptoms regardless of their original nature. Its main advantage lies in moving beyond an overly polarized opposition between the «somatic» and the «mental» and instead focusing on symptom duration, degree of distress, functional impairment, and the patient's need for care [1]. For this reason, in PHC settings, this term appears particularly useful for clinical communication, referral pathways, and the development of an interdisciplinary model of care [1; 10; 13].

The problem of underrecognition of somatized mental disorders in PHC. Despite the high prevalence of persistent bodily symptoms in PHC practice, their timely recognition remains difficult. This is related not only to the clinical heterogeneity of complaints but also to the fact that such patients often present with symptoms that initially appear predominantly somatic. As a result, the diagnostic process frequently focuses on ruling out organic pathology, while the mental component of the disorder remains overshadowed [5; 10; 15].

One reason for underdiagnosis is the very logic of general practice. At the PHC level, the physician first must exclude potentially dangerous somatic diseases; therefore, even when features of a somatized disorder are present, vigilance for possible organic pathology remains high. According to a survey of PHC physicians, the most significant barriers include fear of missing a physical illness, patients' expectations of rapid symptomatic relief, and insufficient knowledge of current recommendations for managing patients with persistent somatic symptoms [16]. This makes the diagnosis of somatized mental disorders not a one-time decision, but a gradual process requiring repeated contacts and clinical observation [16].

The issue of coding such conditions in real outpatient practice is also of considerable importance. As shown in the qualitative study by N.J. Pohontsch et al., general practitioners often avoid directly coding medically unexplained symptoms and somatoform disorders, preferring functional or more nonspecific formulations [17]. The reasons for this approach included the wish to protect patients from stigmatization, insufficient confidence in ICD-10 criteria, lack of time, and reliance on practical «rules of thumb» rather than strict diagnostic algorithms [17]. In a subsequent study by the same authors, coding practices were shown to be influenced particularly by the physician's subjective experience, familiarity with guidelines, and overall experience in general practice [18]. These findings suggest that part of the underrecognition problem is related not to denial of the patient's suffering, but to the professional culture of PHC and the limitations of existing diagnostic routines [17; 18].

An additional factor complicating the recognition of somatized mental disorders is the stigmatization of such patients within the health care system. The systematic review by B. McGhie-Fraser et al. showed that patients with persistent somatic symptoms encounter stigmatizing attitudes and behaviors on the part of health care professionals, while the issue of professional stigma itself remains insufficiently and inconsistently measured [19]. In clinical practice, this may manifest as reduced trust in the patient's complaints, a perception of the patient as «difficult» and a delay in a more focused psychosomatic assessment. Against this background, even in the presence of frequent repeat consultations and substantial functional impairment, the diagnosis may be established late or not established at all [19].

It should also be noted that the clinical significance of somatic symptom disorder may be underestimated in general practice. According to M. Lehmann et al., general practitioners estimated that approximately 7.7 % of their patients might meet the clinical criteria for full SSD, whereas individual symptoms and psychological features of the disorder occur even more frequently [20]. More recent mixed-methods studies involving general practitioners confirm that the care of such patients is accompanied by marked communicative and organizational difficulties, while the need for interdisciplinary support and more accessible low-threshold

forms of care remains high [21]. Thus, the diagnostic process at the PHC level should be regarded as inherently multistage [16-21].

Detection tools and the diagnostic stage in PHC. Early diagnosis of somatized mental disorders in PHC requires a combination of clinical assessment and standardized instruments that make it possible to quantify symptom severity and the related psychological features. At present, the most widely used tools include the PHQ-15 and SSS-8 scales, designed to assess somatic symptom burden, as well as the SSD-12 questionnaire, which reflects the cognitive, emotional, and behavioral components corresponding to the criteria of somatic symptom disorder [22-24]. According to the systematic review and meta-analysis by J. Hybelius et al., PHQ-15 and SSS-8 may be recommended primarily for assessing and monitoring somatic symptom severity. However, their use requires recognition of the complex, multidimensional nature of the phenomenon being measured [22]. This is especially important in PHC, where a high burden of bodily

complaints is not, in itself, equivalent to clinically significant somatic symptom disorder [22].

The validity of individual scales in PHC has been supported by several studies. In the study by H. van Ravesteijn et al., the PHQ-15 demonstrated moderate reliability and sufficient diagnostic value for identifying patients at risk of somatoform disorders in general practice; at a threshold of three or more severe somatic symptoms over the preceding four weeks, sensitivity was 78 % and specificity was 71 % [23]. In turn, the study by A. Toussaint et al. showed that the SSD-12 is a reliable, valid, and sufficiently brief instrument for assessing the psychological characteristics associated with somatic symptoms and is suitable for use in PHC settings [24]. These data suggest that PHQ-15 and SSD-12 should be viewed not as interchangeable, but rather as complementary instruments that reflect different aspects of the clinical picture [23, 24]. The main characteristics of the most commonly used screening instruments for somatic symptoms and somatic symptom disorder in PHC are presented in Table 1.

Table 1. Main instruments for identifying somatic symptom disorder and persistent physical symptoms in primary health care

Instrument	What it assesses	Key characteristics	Applicability in PHC	Source
PHQ-15	Somatic symptom burden	Assesses the frequency and severity of 15 common somatic symptoms	Used for initial screening and monitoring of symptom burden	[22; 23]
SSS-8	Somatic symptom burden	Short-form instrument for the assessment of somatic symptoms	Convenient for routine use in time-limited consultations	[22]
SSD-12	Cognitive, emotional, and behavioral components of SSD	Reflects the patient's psychological response to somatic symptoms	Suitable for assessing the criteria of somatic symptom disorder	[24]
PHQ-15 + SSD-12	Combined assessment of symptom burden and psychological factors	Allows identification of patients at increased risk of SSD	A practically applicable screening algorithm for PHC	[25]

Source: compiled by the authors

The most promising approach for PHC appears to be a combined one, in which measures of symptom burden are used together with instruments assessing the psychological criteria of SSD. In the study by A. Toussaint et al., the combination of the PHQ-15 or SSS-8 with the SSD-12 was shown to be a simple, time-efficient, and cost-efficient method for identifying individuals at increased risk of somatic symptom disorder [25]. In practice, this

means that at initial contact, the physician may apply a brief screening algorithm: first assess the severity of somatic symptoms, then consider possible excessive preoccupation, anxiety related to symptoms, or maladaptive behavior [25]. Such an approach is more consistent with the DSM-5 framework while remaining feasible under the time constraints of outpatient care [25].

At the same time, findings from more recent

studies indicate that previously proposed cut-off values should be applied with caution in PHC settings. In the study by V. von Schrottenberg et al., it was shown that the sensitivity and specificity of PHQ-15 and SSD-12 combinations, originally proposed based on studies in higher-prevalence clinical samples, are not fully reproduced in PHC settings [26]. This underscores that, at the PHC level, questionnaires should not be used as definitive diagnostic criteria, but rather as instruments for risk stratification and support of clinical decision-making [26]. Accordingly, the interpretation of results should take into account symptom duration, the recurrence of consultations, the degree of functional impairment, and the overall clinical context [22; 26].

Another important direction in the development of the diagnostic stage is the use of routine PHC data to early identify patients with persistent somatic symptoms. According to W.M. Kitselaar et al., electronic medical records in general practice can be used for data-driven and theory-driven predictive modelling aimed at earlier detection of patients at identifiable risk of persistent somatic symptoms [27]. This approach opens the possibility of moving from passive responses to repeated complaints toward a more proactive PHC model, in which at-risk patients can be identified before marked chronicity develops [27]. However, even when digital solutions are used, clinical diagnosis must retain a stepwise character. It should include careful history-taking and physical examination, sufficient diagnostic testing, and discussion of the impact of symptoms on the patient's daily functioning [27; 28].

Thus, the diagnostic stage at the PHC level should be structured as a multistep process. Its foundation includes clinical vigilance, stepwise assessment of the somatic and psychological components of complaints, the use of validated questionnaires to assess symptom burden and SSD features, and repeated assessment over time. Such an approach helps avoid both excessive psychiatric labeling of somatic complaints and unjustified delays in diagnosis in patients with marked bodily distress and functional impairment [22; 25; 28].

Approaches to patient management at the PHC level. The management of patients with persistent physical symptoms in PHC should be built not around an endless search for a single bio-

medical explanation, but rather around sequential clinical assessment, the development of a symptom model understandable to the patient, and the maintenance of a therapeutic alliance. Contemporary reviews emphasize that, for PHC, particular importance lies in jointly constructing a plausible explanation of symptoms with the patient, understanding typical communication pitfalls in such consultations, and developing a multimodal care plan [29]. Analyses of guidelines and systematic reviews likewise show that, at the level of general practice, a structured history, careful discussion of complaints, cautious and justified use of additional testing, and attention not only to the symptom itself but also to the resulting impairment in daily functioning are preferred [30].

In practical terms, this means that episodic reactive consultations should be replaced by a more organized model of patient management. The most rational strategy is one in which the PHC physician arranges repeated planned contacts, monitors symptom dynamics, levels of anxiety, depression, and functional limitation, and avoids both premature «psychiatrization» of complaints and excessive expansion of the diagnostic work-up without sufficient clinical grounds [29; 30]. This strategy is particularly important in patients with repeated consultations, since it is precisely in this group that frustration, dissatisfaction with medical care, and the risk of symptom chronicity tend to accumulate [29; 31].

Communication remains a key component of management. The systematic review by A.K. Byrne et al. showed that various communication interventions for patients with medically unexplained symptoms have already been studied in PHC; however, the existing evidence base remains heterogeneous, and the quality of some studies limits the strength of the conclusions [32]. Nevertheless, even with these methodological limitations, the accumulated data suggest that patient-centered communication approaches that do not rely solely on formal reattribution techniques may improve pain and mental and physical functioning, as well as increase physician confidence in working with such patients [32]. Of additional importance is a qualitative review of behavioral intervention acceptability: patients are more likely to accept care when they receive a clear explanation of symptoms, feel supported by the clinician, and have the oppor-

tunity for continued follow-up rather than abrupt termination of contact [33].

Interventional studies also support the promise of structured management models at the PHC level. In the feasibility cluster randomized trial by M. Patel et al., an integrated GP care approach, which included patient educational materials and physician training in the use of cognitive-behavioral skills during consultations, demonstrated acceptability and feasibility in general practice; physician knowledge and confidence increased after training, although the expected clinical effects remained modest in the pilot format [31]. More pronounced results were obtained in the Norwegian cluster randomized study by C. Abrahamsen et al., where the use of the structured communication tool ICIT in PHC was associated with improvements in well-being, functioning, and quality of life, as well as a reduction in the proportion of sick leave compared with usual care [34]. These findings indicate that, at the PHC level, the greatest potential lies not in isolated symptomatic prescriptions, but in structured consultation models that combine symptom explanation, elements of a cognitive-behavioral approach, and an orientation toward restoration of daily functioning [31; 34].

Additional support for this approach comes from systematic reviews of psychological interventions for persistent physical symptoms. According to K. Swainston et al., psychological interventions in PHC may contribute to reductions in somatic symptom severity and depressive symptoms, whereas their effect on anxiety symptoms appears less consistent [35]. Taken together, these data support viewing the management of patients with somatized mental disorders in PHC as a stepped process that includes clinical observation, a valid explanation of symptoms, structured communication, behavioral and psychological components of care, and, when necessary, multidisciplinary support [29-35].

Integration of mental health into PHC and organizational care models. In contemporary health systems, psychiatric service reform is increasingly associated not only with the development of specialized psychiatric care but also with the transfer of some functions for early identification, follow-up, and patient referral to PHC. The joint WHO and WONCA report emphasizes that integrating mental health into PHC can improve access to care, bring

services closer to the patient's first point of contact, reduce stigma, and provide greater continuity of follow-up [6]. These principles were further developed in the mhGAP Intervention Guide for non-specialized health settings, intended for physicians, nurses, and other primary-level workers [7]. In the most recent WHO/Europe document, scaling up mental health services within the PHC approach is considered an independent strategic direction, grounded in the principles of integrated, people-centered, and team-based care [8].

For PHC practice, the collaborative care model is of particular interest because it provides an organizational framework for interaction between the PHC physician, the mental health specialist, and additional members of the care team. According to the Cochrane review by J. Archer et al., collaborative care is associated with statistically significant improvements in outcomes for depression and anxiety disorders compared with usual care [36]. In the systematic review and meta-analysis by E. Woltmann et al., collaborative chronic care models were shown to improve mental and physical outcomes across various mental health conditions in different care settings, including PHC [37]. Although these studies were not specifically focused on somatized mental disorders, they provide the evidence base for the organizational logic of mental health integration into PHC, which may also be applied to patients with persistent physical symptoms, somatic distress, and comorbid anxiety-depressive manifestations [36; 37].

More recent reviews indicate that effective integrated care models in PHC involve not only the formal «co-location» of specialists, but also the presence of specific organizational components, including shared case management, the involvement of a care manager, regular symptom monitoring, integrated documentation, a clear patient pathway, supervision, and workforce training [38]. In the scoping review by A.N. Isaacs and E.K.L. Mitchell, it is emphasized that the sustainable implementation of integrated mental health care in routine practice requires the co-location of specialists, case management, a standardized workflow, clear role allocation, and stable funding mechanisms [38]. In turn, the systematic review by L. Cubillos et al. showed that integrating mental health services into PHC in low- and middle-income countries is associated with greater effectiveness than usual care, though it

may require additional resources [39]. These data are important in the present context because they underscore that the diagnosis of somatized mental disorders in PHC cannot be sustainable without an organizational environment that supports interdisciplinary interaction and long-term patient follow-up [38; 39].

The systemic nature of integration is demonstrated particularly clearly in the work by I. Petersen et al. on scaling up integrated primary mental health care in six low- and middle-income countries. The authors concluded that embedding mental health in PHC is far more complex than simply training PHC physicians and requires strengthening the core building blocks of the health system: governance, financing, human resources, information systems, medication supply, and service delivery organization [40]. The review article by R.C. Keynejad et al. also shows that the literature on integrating mental health into primary and community care is much broader than projects based solely on mhGAP, encompassing diverse training programmes, intervention models, and forms of task-sharing [41]. In the context of somatized mental disorders, this is especially important because such patients often lie at the boundary between somatic, psychological, and psychiatric care and are therefore particularly vulnerable to fragmentation of the system [40; 41].

In the regional context, post-Soviet examples of integrating mental health into PHC are also of interest. The work by R. Jenkins et al. showed that, in Sverdlovsk, a multistage programme including situation analysis, policy dialogue, development of materials, training, and the creation of standards enabled the embedding of mental health training sustainably into the broader health care reform agenda [42]. In the study by G. Rezvy et al. on Arkhangelsk Oblast, a model of systematic cooperation between general practitioners and specialists was described, involving ICT-based support, division of responsibility according to problem severity, and targeted training of physicians in diagnostic and communication skills [43]. For Kazakhstan, the relevance of this direction is also supported by WHO materials on developing multidisciplinary PHC teams to better align services with the needs of the population [9]. Taken together, these data allow mental health integration into PHC to be regarded as an important organizational condition for

earlier diagnosis of somatized mental disorders [8; 9; 42; 43].

Discussion

The present analysis of the literature shows that the diagnosis of somatized mental disorders at the PHC level should be considered not as a narrowly specialized psychiatric task, but as an interdisciplinary clinical and organizational problem. Contemporary publications indicate that patients with persistent physical symptoms, somatic symptom disorder, and bodily distress disorder represent a significant proportion of PHC consultations; however, their timely recognition remains limited because of clinical heterogeneity of symptoms, diagnostic uncertainty, stigma, and insufficiently structured care pathways [1; 5; 16; 19]. In this regard, the key shift appears to be moving from a model of «excluding everything possible» to a stepwise clinical assessment that simultaneously considers somatic complaints, psychological features, functional impairment, and the risk of chronicity [1; 10; 22; 25].

An important conclusion of this review is that, at the PHC level, the greatest practical value lies not in rigid nosological distinctions but in the use of clinically convenient, less stigmatizing frameworks that allow physicians to work with patients before final formalization of the diagnosis. This is why the concepts of persistent physical symptoms and bodily distress are becoming increasingly important in the contemporary literature, as they enable the clinical situation to be described without prematurely opposing the «somatic» and the «mental» [1; 10; 12]. At the same time, data on the validity of the PHQ-15, SSS-8, and SSD-12 show that, even when standardized instruments are available, diagnosis cannot be reduced to the mechanical use of questionnaires; their results must be interpreted in conjunction with the history, clinical observation, and repeated assessment over time [22-26].

Particular attention should also be paid to the management of such patients in PHC. The analyzed data suggest that the most promising approaches are structured consultation models that combine a validating explanation of symptoms, elements of a cognitive-behavioral approach, longitudinal follow-up, and support for restoration of everyday functioning [29-35]. At the same time, accumulating evidence indicates that the quality of communication between physician and patient can

substantially influence acceptance of care, satisfaction with treatment, and subsequent adherence to follow-up [32-35]. Consequently, improving the clinical effectiveness of PHC in relation to somatized mental disorders requires not only the implementation of screening instruments, but also the development of communication competencies among PHC professionals [17; 21; 32].

Consideration of the problem in the context of psychiatric service reform leads to the conclusion that the isolated work of the general practitioner cannot ensure a sustainable solution to the task of early diagnosis and referral of such patients. International WHO and WONCA documents, the mhGAP guide, and contemporary reviews on integrated and collaborative care all point to the need to embed mental health into PHC, both organizationally and clinically [6-8; 36-41]. This implies not only a trained PHC physician but also accessible mechanisms for consultative support, clear role allocation within the team, a standardized patient pathway, opportunities for repeated assessment, and links with more specialized levels of care [38-41]. Such a model appears especially relevant for patients with somatized mental disorders, who often stand at the boundary between somatic, psychological, and psychiatric care and experience the consequences of system fragmentation most acutely [39-41].

Of particular interest for interpreting these findings are the data on post-Soviet and regional models of mental health integration into PHC. The experience of Sverdlovsk and Arkhangelsk shows that, even in systems historically characterized by strong differentiation between psychiatric and general medical care, it is possible to develop stepwise models based on training of PHC physicians, consultative support from specialists, and more clearly structured patient pathways [42; 43]. For Kazakhstan, this direction also appears important, as the development of multidisciplinary PHC teams creates organizational preconditions for earlier identification of patients with bodily distress, anxiety-depressive symptomatology, and somatized mental disorders [9]. In this context, diagnosis at the PHC level may be considered a practical indicator of the success of broader psychiatric service reform [8; 9; 42; 43].

It should also be noted that the existing evidence base has limitations. Some publications

use different terms to describe overlapping clinical states, which makes direct comparison of results difficult [1; 2; 10; 12]. In addition, a substantial proportion of available data comes from European countries and from studies focused either on MUS or SSD. In contrast, the number of studies specifically addressing the diagnosis of somatized mental disorders in routine PHC practice in post-Soviet countries remains limited [38-43]. This underscores the need for further research to adapt diagnostic algorithms to the conditions of specific national health systems, including Kazakhstan [8; 9].

Conclusions

Somatized mental disorders, persistent physical symptoms, and related conditions represent a significant and often underestimated problem in PHC. Contemporary literature shows that difficulties in diagnosing these conditions at the PHC level are associated with clinical heterogeneity of symptoms, limited recognition, stigma, imperfect coding practices, and insufficient organizational support for PHC physicians.

The most justified contemporary approach is stepwise diagnosis combining clinical assessment, the use of validated instruments to evaluate symptom burden and the psychological features of somatic symptom disorder, repeated follow-up over time, and assessment of functional impairment. Such an approach helps reduce both the risk of overdiagnosing mental disorders and the risk of prolonged underrecognition in patients with marked bodily distress.

Psychiatric service reform is particularly relevant for integrating mental health into PHC, developing collaborative care, implementing multidisciplinary models of care, and training PHC professionals. Embedding the diagnosis and management of somatized mental disorders into the routine work of PHC may therefore be regarded as one of the practical conditions for improving the accessibility, continuity, and people-centeredness of mental health care in the modern health system.

References

1. Löwe B., Toussaint A., Rosmalen J. G. M., Huang W. L., Fischer T. W., Henningsen P. et al. Persistent physical symptoms: definition, genesis, and management // *Lancet*. – 2024. – Vol. 403(10444). – P. 2649-2662. – DOI: [https://doi.org/10.1016/S0140-6736\(24\)00623-8](https://doi.org/10.1016/S0140-6736(24)00623-8)

2. Löwe B., Levenson J., Depping M. et al. Somatic symptom disorder: a scoping review on the empirical evidence of a new diagnosis // *Psychological Medicine*. – 2022. – Vol. 52(4). – P. 632-648. – DOI: <https://doi.org/10.1017/S0033291721004177>
3. Budtz-Lilly A., Vestergaard M., Fink P., Carlsen A. H., Rosendal M. Patient characteristics and frequency of bodily distress syndrome in PHC: a cross-sectional study // *British Journal of General Practice*. – 2015. – Vol. 65(638). – P. 617-623. – DOI: <https://doi.org/10.3399/bjgp15X686545>
4. Chaabouni A., Houwen J., Grewer G. et al. The burden of persistent symptom diagnoses in PHC patients: a cross-sectional study // *Scandinavian Journal of Primary Health Care*. – 2024. – Vol. 42(1). – P. 112-122. – DOI: <https://doi.org/10.1080/02813432.2023.2293930>
5. Piontek K., Shedden-Mora M. C., Gladigau M. et al. Diagnosis of somatoform disorders in PHC: diagnostic agreement, predictors, and comparisons with depression and anxiety // *BMC Psychiatry*. – 2018. – Vol. 18. – P. 361. – DOI: <https://doi.org/10.1186/s12888-018-1940-3>
6. World Health Organization; World Organization of Family Doctors (Wonca). Integrating mental health into PHC: a global perspective. – Geneva: World Health Organization, 2008. – 206 p. – URL: <https://www.who.int/publications/item/9789241563680> (accessed: 30.11.2025).
7. World Health Organization. mhGAP intervention guide for mental, neurological and substance use disorders in non-specialized health settings. Version 2.0. – Geneva: World Health Organization, 2016. – URL: <https://www.who.int/publications/item/9789241549790> (accessed: 30.11.2025).
8. WHO Regional Office for Europe. Scaling up mental health services within the PHC approach: lessons from the WHO European Region. – Copenhagen: WHO Regional Office for Europe, 2025. – URL: <https://www.who.int/europe/publications/item/WHO-EURO-2025-11303-51075-77740> (accessed: 30.11.2025).
9. WHO Regional Office for Europe. Kazakhstan: Multidisciplinary teams for better alignment of primary health care services to meet the needs and expectations of people (2021). Copenhagen: WHO Regional Office for Europe, 2022. – URL: [https://www.who.int/europe/publications/m/item/kazakhstan-multidisciplinary-teams-for-better-alignment-of-primary-health-care-services-to-meet-the-needs-and-expectations-of-people-\(2021\)](https://www.who.int/europe/publications/m/item/kazakhstan-multidisciplinary-teams-for-better-alignment-of-primary-health-care-services-to-meet-the-needs-and-expectations-of-people-(2021)) (accessed: 30.11.2025).
10. Rosendal M., Olde Hartman T. C., Aamland A., van der Horst H., Lucassen P., Budtz-Lilly A., Burton C. «Medically unexplained» symptoms and symptom disorders in PHC: prognosis-based recognition and classification // *BMC Family Practice*. – 2017. – Vol. 18(1). – P. 18. – DOI: <https://doi.org/10.1186/s12875-017-0592-6>
11. Katon W. J., Walker E. A. Medically unexplained symptoms in PHC // *Journal of Clinical Psychiatry*. – 1998. – Vol. 59(20). – P. 15-21. – URL: <https://www.psychiatrist.com/jcp/medically-unexplained-symptoms-primary-care/> (accessed: 30.11.2025).
12. Budtz-Lilly A., Schröder A., Rask M. T., Fink P., Vestergaard M., Rosendal M. Bodily distress syndrome: A new diagnosis for functional disorders in PHC? // *BMC Family Practice*. – 2015. – Vol. 16. – P. 180. – DOI: <https://doi.org/10.1186/s12875-015-0393-8>
13. Henningsen P. Management of somatic symptom disorder // *Dialogues in Clinical Neuroscience*. – 2018. – Vol. 20(1). – P. 23-31. – DOI: <https://doi.org/10.31887/DCNS.2018.20.1/phenningsen>
14. Henningsen P., Zipfel S., Sattel H., Creed F. Management of Functional Somatic Syndromes and Bodily Distress // *Psychotherapy and Psychosomatics*. – 2018. – Vol. 87(1). – P. 12-31. – DOI: <https://doi.org/10.1159/000484413>
15. Kirmayer L. J., Groleau D., Looper K. J., Dao M. D. Explaining medically unexplained symptoms // *Canadian Journal of Psychiatry*. – 2004. – Vol. 49(10). – P. 663-672. – DOI: <https://doi.org/10.1177/070674370404901003>
16. Lehmann M., Pohontsch N. J., Zimmermann T., Scherer M., Löwe B. Diagnostic and treatment barriers to persistent somatic symptoms in PHC – representative survey with physicians // *BMC Family Practice*. – 2021. – Vol. 22(1). – P. 60. – DOI: <https://doi.org/10.1186/s12875-021-01397-w>
17. Pohontsch N. J., Zimmermann T., Jonas C., Lehmann M., Löwe B., Scherer M. Coding of medically unexplained symptoms and somatoform disorders by general practitioners – an exploratory focus group study // *BMC Family Practice*. – 2018. – Vol. 19(1). – P. 129. – DOI: <https://doi.org/10.1186/s12875-018-0812-8>
18. Pohontsch N. J., Zimmermann T., Lehmann M., Rustige L., Kurz K., Löwe B., Scherer M. ICD-10-Coding of Medically Unexplained Physical

- Symptoms and Somatoform Disorders – A Survey With German GPs // *Frontiers in Medicine*. – 2021. – Vol. 8. – Article No. 598810. – DOI: <https://doi.org/10.3389/fmed.2021.598810>
19. McGhie-Fraser B., Lucassen P., Ballering A., Abma I., Brouwers E., van Dulmen S., Olde Hartman T. Persistent somatic symptom related stigmatisation by healthcare professionals: A systematic review of questionnaire measurement instruments // *Journal of Psychosomatic Research*. – 2023. – Vol. 166. – Article No. 111161. – DOI: <https://doi.org/10.1016/j.jpsychores.2023.111161>
20. Lehmann M., Pohontsch N. J., Zimmermann T., Scherer M., Löwe B. Estimated frequency of somatic symptom disorder in general practice: cross-sectional survey with general practitioners // *BMC Psychiatry*. – 2022. – Vol. 22(1). – Article No. 632. – DOI: <https://doi.org/10.1186/s12888-022-04100-0>
21. Wangler J., Jansky M. Somatoform Disorders in PHC – An Exploratory Mixed-Methods Study on Experiences, Challenges and Coping Strategies of General Practitioners in the Federal Republic of Germany // *International Journal of Environmental Research and Public Health*. – 2024. – Vol. 21(7). – Article No. 901. – DOI: <https://doi.org/10.3390/ijerph21070901>
22. Hybelius J., Kopic A., Salomonsson S., Wachtler C., Wallert J., Nordin S., Axelsson E. Measurement Properties of the Patient Health Questionnaire-15 and Somatic Symptom Scale-8: A Systematic Review and Meta-Analysis // *JAMA Network Open*. – 2024. – Vol. 7(11). – Article No. 2446603. – DOI: <https://doi.org/10.1001/jamanetworkopen.2024.46603>
23. van Ravesteijn H., Wittkamp K., Lucassen P. et al. Detecting somatoform disorders in PHC with the PHQ-15 // *Annals of Family Medicine*. – 2009. – Vol. 7(3). – P. 232-238. – DOI: <https://doi.org/10.1370/afm.985>
24. Toussaint A., Riedl B., Kehrer S., Schneider A., Löwe B., Linde K. Validity of the Somatic Symptom Disorder-B Criteria Scale (SSD-12) in PHC // *Family Practice*. – 2018. – Vol. 35(3). – P. 342-347. – DOI: <https://doi.org/10.1093/fampra/cmz116>
25. Toussaint A., Hüsing P., Kohlmann S., Löwe B. Detecting DSM-5 somatic symptom disorder: criterion validity of the PHQ-15 and SSS-8 in combination with the SSD-12 // *Psychological Medicine*. – 2020. – Vol. 50(2). – P. 324-333. – DOI: <https://doi.org/10.1017/S003329171900014X>
26. von Schrottenberg V., Toussaint A., Hapfelmeier A., Teusen C., Riedl B., Henningsen P., Gensichen J., Schneider A., Linde K. Lessons learned from applying established cut-off values of questionnaires to detect somatic symptom disorders in PHC: a cross-sectional study // *Frontiers in Psychiatry*. – 2024. – Vol. 14. – Article No. 1289186. – DOI: <https://doi.org/10.3389/fpsy.2023.1289186>
27. Kitselaar W. M., van der Vaart R., Perschl J., Numans M. E., Evers A. W. M. Early identification of persistent somatic symptoms in PHC: data-driven and theory-driven predictive modelling based on electronic medical records of Dutch general practices // *BMJ Open*. – 2023. – Vol. 13(5). – Article No. 066183. – DOI: <https://doi.org/10.1136/bmjopen-2022-066183>
28. Husain M., Chalder T. Medically unexplained symptoms: assessment and management // *Clinical Medicine*. – 2021. – Vol. 21(1). – P. 13-18. – DOI: <https://doi.org/10.7861/clinmed.2020-0947>
29. Hubley S., Uebelacker L., Eaton C. Managing Medically Unexplained Symptoms in PHC: A Narrative Review and Treatment Recommendations // *American Journal of Lifestyle Medicine*. – 2016. – Vol. 10(2). – P. 109-119. – DOI: <https://doi.org/10.1177/1559827614536865>
30. Olde Hartman T. C., Rosendal M., Aamland A., van der Horst H. E., Rosmalen J. G. M., Burton C. D., Lucassen P. L. B. J. What do guidelines and systematic reviews tell us about the management of medically unexplained symptoms in PHC? // *BJGP Open*. – 2017. – Vol. 1(3). – Article No. bjgpopen17X101061. – DOI: <https://doi.org/10.3399/bjgpopen17X101061>
31. Patel M., James K., Moss-Morris R., Ashworth M., Husain M., Hotopf M., David A. S., McCrone P., Landau S., Chalder T. Integrated GP care for patients with persistent physical symptoms: feasibility cluster randomised trial // *BMC Family Practice*. – 2020. – Vol. 21(1). – Article No. 207. – DOI: <https://doi.org/10.1186/s12875-020-01269-9>
32. Byrne A. K., Scantlebury A., Jones K., Doherty L., Torgerson D. J. Communication interventions for medically unexplained symptom conditions in general practice: a systematic review and meta-analysis of randomised controlled trials // *PLOS ONE*. – 2022. – Vol. 17(11). – Article No. 0277538. – DOI: <https://doi.org/10.1371/journal.pone.0277538>

33. Scope A., Leaviss J., Booth A. et al. The acceptability of PHC or community-based behavioural interventions for persistent physical symptoms: qualitative systematic review // *British Journal of Health Psychology*. – 2021. – Vol. 26(4). – P. 1069-1094. – DOI: <https://doi.org/10.1111/bjhp.12521>
34. Abrahamsen C., Reme S. E., Wangen K. R. et al. The effects of a structured communication tool in patients with medically unexplained physical symptoms: a cluster randomized trial // *EClinicalMedicine*. – 2023. – Vol. 65. – Article No. 102262. – DOI: <https://doi.org/10.1016/j.eclinm.2023.102262>
35. Swainston K., Thursby S., Bell B. et al. What psychological interventions are effective for the management of persistent physical symptoms (PPS)? A systematic review and meta-analysis // *British Journal of Health Psychology*. – 2023. – Vol. 28(1). – P. 80-97. – DOI: <https://doi.org/10.1111/bjhp.12613>
36. Archer J., Bower P., Gilbody S., Lovell K., Richards D., Gask L., Dickens C., Coventry P. Collaborative care for depression and anxiety problems // *Cochrane Database of Systematic Reviews*. – 2012. – Vol. 10. – Article No. CD006525. – DOI: <https://doi.org/10.1002/14651858.CD006525.pub2>
37. Woltmann E., Grogan-Kaylor A., Perron B., Georges H., Kilbourne A. M., Bauer M. S. Comparative effectiveness of collaborative chronic care models for mental health conditions across primary, specialty, and behavioral health care settings: systematic review and meta-analysis // *American Journal of Psychiatry*. – 2012. – Vol. 169(8). – P. 790-804. – DOI: <https://doi.org/10.1176/appi.ajp.2012.11111616>
38. Isaacs A. N., Mitchell E. K. L. Mental health integrated care models in PHC and factors that contribute to their effective implementation: a scoping review // *International Journal of Mental Health Systems*. – 2024. – Vol. 18(1). – P. 5. – DOI: <https://doi.org/10.1186/s13033-024-00625-x>
39. Cubillos L., Bartels S. M., Torrey W. C., Naslund J., Uribe-Restrepo J. M., Gaviola C., Castro Díaz S., John D. T., Williams M. J., Cepeda M., Gómez-Restrepo C., Marsch L. A. The effectiveness and cost-effectiveness of integrating mental health services in PHC in low- and middle-income countries: systematic review // *BJPsych Bulletin*. – 2021. – Vol. 45(1). – P. 40-52. – DOI: <https://doi.org/10.1192/bjb.2020.35>
40. Petersen I., van Rensburg A., Kigozi F., Semrau M., Hanlon C., Abdulmalik J., Kola L., Fekadu A., Gureje O., Gurung D., Jordans M., Mntambo N., Mugisha J., Muke S., Petrus R., Shidhaye R., Ssebunnya J., Tekola B., Upadhaya N., Patel V., Lund C., Thornicroft G. Scaling up integrated primary mental health in six low- and middle-income countries: obstacles, synergies and implications for systems reform // *BJPsych Open*. – 2019. – Vol. 5(5). – Article No. 69. – DOI: <https://doi.org/10.1192/bjo.2019.7>
41. Keynejad R. C., Spagnolo J., Thornicroft G. Mental healthcare in primary and community-based settings: evidence beyond the WHO Mental Health Gap Action Programme (mhGAP) Intervention Guide // *Evidence-Based Mental Health*. – 2022. – Vol. 25(e1). – P. 1-7. – DOI: <https://doi.org/10.1136/ebmental-2021-300401>
42. Jenkins R., Bobyleva Z., Goldberg D., Gask L., Zacroeva A. G., Potasheva A., Krasnov V., McDavid D. Integrating mental health into PHC in Sverdlovsk // *Mental Health in Family Medicine*. – 2009. – Vol. 6(1). – P. 29-36. – URL: <https://pubmed.ncbi.nlm.nih.gov/22477885/> (accessed: 30.11.2025).
43. Rezvy G., Andreeva E., Ryzhkova N., Yashkovich V., Sørliie T. Integrating mental health into PHC in Arkhangelsk County, Russia: the Pomor model in psychiatry // *International Journal of Mental Health Systems*. – 2019. – Vol. 13. – Article No. 14. – DOI: <https://doi.org/10.1186/s13033-019-0271-1>

References

- Löwe, B., Toussaint, A., Rosmalen, J. G. M., Huang, W. L., Fischer, T. W., Henningsen, P., et al. (2024). Persistent physical symptoms: Definition, genesis, and management. *Lancet*, 403(10444), 2649-2662. DOI: [https://doi.org/10.1016/S0140-6736\(24\)00623-8](https://doi.org/10.1016/S0140-6736(24)00623-8)
- Löwe, B., Levenson, J., Depping, M., et al. (2022). Somatic symptom disorder: A scoping review on the empirical evidence of a new diagnosis. *Psychological Medicine*, 52(4), 632-648. DOI: <https://doi.org/10.1017/S0033291721004177>
- Budtz-Lilly, A., Vestergaard, M., Fink, P., Carlsen, A. H., & Rosendal, M. (2015). Patient characteristics and frequency of bodily distress syndrome in PHC: A cross-sectional study. *British Journal of General Practice*, 65(638), 617-623. DOI: <https://doi.org/10.3399/bjgp15X686545>
- Chaabouni, A., Houwen, J., Grewer, G., et al. (2024). The burden of persistent symptom diagno-

- ses in PHC patients: A cross-sectional study. *Scandinavian Journal of Primary Health Care*, 42(1), 112-122. DOI: <https://doi.org/10.1080/02813432.2023.2293930>
5. Piontek, K., Shedden-Mora, M. C., Gladigau, M., et al. (2018). Diagnosis of somatoform disorders in PHC: Diagnostic agreement, predictors, and comparisons with depression and anxiety. *BMC Psychiatry*, 18, 361. DOI: <https://doi.org/10.1186/s12888-018-1940-3>
6. World Health Organization, & World Organization of Family Doctors (Wonca). (2008). *Integrating mental health into PHC: A global perspective*. Geneva: World Health Organization. Retrieved November 30, 2025, from <https://www.who.int/publications/i/item/9789241563680>
7. World Health Organization. (2016). *mhGAP intervention guide for mental, neurological and substance use disorders in non-specialized health settings (Version 2.0)*. Geneva: World Health Organization. Retrieved November 30, 2025, from <https://www.who.int/publications/i/item/9789241549790>
8. WHO Regional Office for Europe. (2025). *Scaling up mental health services within the PHC approach: Lessons from the WHO European Region*. Copenhagen: WHO Regional Office for Europe. Retrieved November 30, 2025, from <https://www.who.int/europe/publications/i/item/WHO-EURO-2025-11303-51075-77740>
9. WHO Regional Office for Europe. (2022). *Kazakhstan: Multidisciplinary teams for better alignment of primary health care services to meet the needs and expectations of people (2021)*. Copenhagen: WHO Regional Office for Europe. Retrieved November 30, 2025, from [https://www.who.int/europe/publications/m/item/kazakhstan-multidisciplinary-teams-for-better-alignment-of-primary-health-care-services-to-meet-the-needs-and-expectations-of-people-\(2021\)](https://www.who.int/europe/publications/m/item/kazakhstan-multidisciplinary-teams-for-better-alignment-of-primary-health-care-services-to-meet-the-needs-and-expectations-of-people-(2021))
10. Rosendal, M., Olde Hartman, T. C., Aamland, A., van der Horst, H., Lucassen, P., Budtz-Lilly, A., & Burton, C. (2017). «Medically unexplained» symptoms and symptom disorders in PHC: Prognosis-based recognition and classification. *BMC Family Practice*, 18(1), 18. DOI: <https://doi.org/10.1186/s12875-017-0592-6>
11. Katon, W. J., & Walker, E. A. (1998). Medically unexplained symptoms in PHC. *Journal of Clinical Psychiatry*, 59(Suppl 20), 15-21. Retrieved November 30, 2025, from <https://www.psychiatrist.com/jcp/medically-unexplained-symptoms-primary-care/>
12. Budtz-Lilly, A., Schröder, A., Rask, M. T., Fink, P., Vestergaard, M., & Rosendal, M. (2015). Bodily distress syndrome: A new diagnosis for functional disorders in PHC? *BMC Family Practice*, 16, 180. DOI: <https://doi.org/10.1186/s12875-015-0393-8>
13. Henningsen, P. (2018). Management of somatic symptom disorder. *Dialogues in Clinical Neuroscience*, 20(1), 23-31. DOI: <https://doi.org/10.31887/DCNS.2018.20.1/phenningsen>
14. Henningsen, P., Zipfel, S., Sattel, H., & Creed, F. (2018). Management of functional somatic syndromes and bodily distress. *Psychotherapy and Psychosomatics*, 87(1), 12-31. DOI: <https://doi.org/10.1159/000484413>
15. Kirmayer, L. J., Groleau, D., Looper, K. J., & Dao, M. D. (2004). Explaining medically unexplained symptoms. *Canadian Journal of Psychiatry*, 49(10), 663-672. DOI: <https://doi.org/10.1177/070674370404901003>
16. Lehmann, M., Pohontsch, N. J., Zimmermann, T., Scherer, M., & Löwe, B. (2021). Diagnostic and treatment barriers to persistent somatic symptoms in PHC – representative survey with physicians. *BMC Family Practice*, 22(1), 60. DOI: <https://doi.org/10.1186/s12875-021-01397-w>
17. Pohontsch, N. J., Zimmermann, T., Jonas, C., Lehmann, M., Löwe, B., & Scherer, M. (2018). Coding of medically unexplained symptoms and somatoform disorders by general practitioners – An exploratory focus group study. *BMC Family Practice*, 19(1), 129. DOI: <https://doi.org/10.1186/s12875-018-0812-8>
18. Pohontsch, N. J., Zimmermann, T., Lehmann, M., Rustige, L., Kurz, K., Löwe, B., & Scherer, M. (2021). ICD-10-coding of medically unexplained physical symptoms and somatoform disorders – A survey with German GPs. *Frontiers in Medicine*, 8, 598810. DOI: <https://doi.org/10.3389/fmed.2021.598810>
19. McGhie-Fraser, B., Lucassen, P., Ballering, A., Abma, I., Brouwers, E., van Dulmen, S., & Olde Hartman, T. (2023). Persistent somatic symptom related stigmatisation by healthcare professionals: A systematic review of questionnaire measurement instruments. *Journal of Psychosomatic Research*, 166, 111161. DOI: <https://doi.org/10.1016/j.jpsychores.2023.111161>
20. Lehmann, M., Pohontsch, N. J., Zimmermann,

- T., Scherer, M., & Löwe, B. (2022). Estimated frequency of somatic symptom disorder in general practice: Cross-sectional survey with general practitioners. *BMC Psychiatry*, 22(1), 632. DOI: <https://doi.org/10.1186/s12888-022-04100-0>
21. Wangler, J., & Jansky, M. (2024). Somatoform disorders in PHC – An exploratory mixed-methods study on experiences, challenges and coping strategies of general practitioners in the Federal Republic of Germany. *International Journal of Environmental Research and Public Health*, 21(7), 901. DOI: <https://doi.org/10.3390/ijerph21070901>
22. Hybelius, J., Kopic, A., Salomonsson, S., Wachtler, C., Wallert, J., Nordin, S., & Axelsson, E. (2024). Measurement properties of the Patient Health Questionnaire-15 and Somatic Symptom Scale-8: A systematic review and meta-analysis. *JAMA Network Open*, 7(11), e2446603. DOI: <https://doi.org/10.1001/jamanetworkopen.2024.46603>
23. van Ravesteijn, H., Wittkamp, K., Lucassen, P., et al. (2009). Detecting somatoform disorders in PHC with the PHQ-15. *Annals of Family Medicine*, 7(3), 232-238. DOI: <https://doi.org/10.1370/afm.985>
24. Toussaint, A., Riedl, B., Kehrer, S., Schneider, A., Löwe, B., & Linde, K. (2018). Validity of the Somatic Symptom Disorder-B Criteria Scale (SSD-12) in PHC. *Family Practice*, 35(3), 342-347. DOI: <https://doi.org/10.1093/fampra/cmz116>
25. Toussaint, A., Hüsing, P., Kohlmann, S., & Löwe, B. (2020). Detecting DSM-5 somatic symptom disorder: Criterion validity of the PHQ-15 and SSS-8 in combination with the SSD-12. *Psychological Medicine*, 50(2), 324-333. DOI: <https://doi.org/10.1017/S003329171900014X>
26. von Schrottenberg, V., Toussaint, A., Hapfelmeier, A., Teusen, C., Riedl, B., Henningsen, P., Gensichen, J., Schneider, A., & Linde, K. (2024). Lessons learned from applying established cut-off values of questionnaires to detect somatic symptom disorders in PHC: A cross-sectional study. *Frontiers in Psychiatry*, 14, 1289186. DOI: <https://doi.org/10.3389/fpsy.2023.1289186>
27. Kitselaar, W. M., van der Vaart, R., Perschl, J., Numans, M. E., & Evers, A. W. M. (2023). Early identification of persistent somatic symptoms in PHC: Data-driven and theory-driven predictive modelling based on electronic medical records of Dutch general practices. *BMJ Open*, 13(5), e066183. DOI: <https://doi.org/10.1136/bmjopen-2022-066183>
28. Husain, M., & Chalder, T. (2021). Medically unexplained symptoms: Assessment and management. *Clinical Medicine*, 21(1), 13-18. DOI: <https://doi.org/10.7861/clinmed.2020-0947>
29. Hubley, S., Uebelacker, L., & Eaton, C. (2016). Managing medically unexplained symptoms in PHC: A narrative review and treatment recommendations. *American Journal of Lifestyle Medicine*, 10(2), 109-119. DOI: <https://doi.org/10.1177/1559827614536865>
30. Olde Hartman, T. C., Rosendal, M., Aamland, A., van der Horst, H. E., Rosmalen, J. G. M., Burton, C. D., & Lucassen, P. L. B. J. (2017). What do guidelines and systematic reviews tell us about the management of medically unexplained symptoms in PHC? *BJGP Open*, 1(3), bjgpopen17X101061. DOI: <https://doi.org/10.3399/bjgpopen17X101061>
31. Patel, M., James, K., Moss-Morris, R., Ashworth, M., Husain, M., Hotopf, M., David, A. S., McCrone, P., Landau, S., & Chalder, T. (2020). Integrated GP care for patients with persistent physical symptoms: Feasibility cluster randomised trial. *BMC Family Practice*, 21(1), 207. DOI: <https://doi.org/10.1186/s12875-020-01269-9>
32. Byrne, A. K., Scantlebury, A., Jones, K., Doherty, L., & Torgerson, D. J. (2022). Communication interventions for medically unexplained symptom conditions in general practice: A systematic review and meta-analysis of randomised controlled trials. *PLOS ONE*, 17(11), e0277538. DOI: <https://doi.org/10.1371/journal.pone.0277538>
33. Scope, A., Leaviss, J., Booth, A., et al. (2021). The acceptability of PHC or community-based behavioural interventions for persistent physical symptoms: Qualitative systematic review. *British Journal of Health Psychology*, 26(4), 1069-1094. DOI: <https://doi.org/10.1111/bjhp.12521>
34. Abrahamsen, C., Reme, S. E., Wangen, K. R., et al. (2023). The effects of a structured communication tool in patients with medically unexplained physical symptoms: A cluster randomized trial. *EClinicalMedicine*, 65, 102262. DOI: <https://doi.org/10.1016/j.eclinm.2023.102262>
35. Swainston, K., Thursby, S., Bell, B., et al. (2023). What psychological interventions are effective for the management of persistent physical symptoms (PPS)? A systematic review and meta-analysis. *British Journal of Health Psychology*, 28(1), 80-97. DOI: <https://doi.org/10.1111/bjhp.12613>

36. Archer, J., Bower, P., Gilbody, S., Lovell, K., Richards, D., Gask, L., Dickens, C., & Coventry, P. (2012). Collaborative care for depression and anxiety problems. *Cochrane Database of Systematic Reviews*, 10, CD006525. DOI: <https://doi.org/10.1002/14651858.CD006525.pub2>
37. Woltmann, E., Grogan-Kaylor, A., Perron, B., Georges, H., Kilbourne, A. M., & Bauer, M. S. (2012). Comparative effectiveness of collaborative chronic care models for mental health conditions across primary, specialty, and behavioral health care settings: Systematic review and meta-analysis. *American Journal of Psychiatry*, 169(8), 790-804. DOI: <https://doi.org/10.1176/appi.ajp.2012.11111616>
38. Isaacs, A. N., & Mitchell, E. K. L. (2024). Mental health integrated care models in PHC and factors that contribute to their effective implementation: A scoping review. *International Journal of Mental Health Systems*, 18(1), 5. DOI: <https://doi.org/10.1186/s13033-024-00625-x>
39. Cubillos, L., Bartels, S. M., Torrey, W. C., Naslund, J., Uribe-Restrepo, J. M., Gaviola, C., Castro Díaz, S., John, D. T., Williams, M. J., Cepeda, M., Gómez-Restrepo, C., & Marsch, L. A. (2021). The effectiveness and cost-effectiveness of integrating mental health services in PHC in low- and middle-income countries: Systematic review. *BJPsych Bulletin*, 45(1), 40-52. DOI: <https://doi.org/10.1192/bjb.2020.35>
40. Petersen, I., van Rensburg, A., Kigozi, F., Semrau, M., Hanlon, C., Abdulmalik, J., Kola, L., Fekadu, A., Gureje, O., Gurung, D., Jordans, M., Mntambo, N., Mugisha, J., Muke, S., Petrus, R., Shidhaye, R., Ssebunnya, J., Tekola, B., Upadhaya, N., Patel, V., Lund, C., & Thornicroft, G. (2019). Scaling up integrated primary mental health in six low- and middle-income countries: Obstacles, synergies and implications for systems reform. *BJPsych Open*, 5(5), e69. DOI: <https://doi.org/10.1192/bjo.2019.7>
41. Keynejad, R. C., Spagnolo, J., & Thornicroft, G. (2022). Mental healthcare in primary and community-based settings: Evidence beyond the WHO Mental Health Gap Action Programme (mh-GAP) Intervention Guide. *Evidence-Based Mental Health*, 25(e1), 1-7. DOI: <https://doi.org/10.1136/ebmental-2021-300401>
42. Jenkins, R., Bobyleva, Z., Goldberg, D., Gask, L., Zacroeva, A. G., Potasheva, A., Krasnov, V., & McDaid, D. (2009). Integrating mental health into PHC in Sverdlovsk. *Mental Health in Family Medicine*, 6(1), 29-36. Retrieved November 30, 2025, from <https://pubmed.ncbi.nlm.nih.gov/22477885/>
43. Rezvy, G., Andreeva, E., Ryzhkova, N., Yashkovich, V., & Sørli, T. (2019). Integrating mental health into PHC in Arkhangelsk County, Russia: The Pomor model in psychiatry. *International Journal of Mental Health Systems*, 13, 14. DOI: <https://doi.org/10.1186/s13033-019-0271-1>

АЛҒАШҚЫ МЕДИЦИНАЛЫҚ КӨМЕК КӨРСЕТУДЕГІ СОМАТИЗАЦИЯЛАНҒАН ПСИХИКАЛЫҚ БҰЗЫЛУЛАР: ДИАГНОСТИКАЛЫҚ МӘСЕЛЕЛЕР ЖӘНЕ ПСИХИКАЛЫҚ ДЕНСАУЛЫҚТЫ ИНТЕГРАЦИЯЛАУ МОДЕЛЬДЕРІ

Н. Н. Рахальская*, С. З. Ешимбетова

«Қазақстан-Ресей медициналық университеті» МЕББМ, Қазақстан, Алматы

*Корреспондент автор

Аңдатпа

Өзектілігі. Соматизацияланған психикалық бұзылыстар мен тұрақты физикалық симптомдар алғашқы медициналық-санитарлық көмекте маңызды, бірақ жиі жеткіліксіз танылатын мәселе болып табылады. Мұндай науқастар әдетте алдымен алғашқы медициналық көмек дәрігерлеріне жүгінеді, алайда симптомдардың әртүрлілігі, мазасыздық және депрессиямен қатар жүруі, стигма және диагностикалық қиындықтар олардың дер кезінде анықталуын қиындатады. Осыған байланысты психикалық денсаулықты алғашқы медициналық көмек жүйесіне интеграциялау және пәнаралық көмек модельдерін дамыту маңызды.

Мақсаты. Алғашқы медициналық-санитарлық көмек деңгейінде соматизацияланған психикалық бұзылыстарды диагностикалауға қатысты терминология эволюциясы, жеткіліксіз та-

нылу себептері, ерте анықтау құралдары және психикалық денсаулықты интеграциялау жөніндегі ұйымдастырушылық модельдер туралы қазіргі ғылыми деректерді жүйелеу.

Материалдар мен әдістер. Зерттеу PubMed, Scopus және Web of Science дерекқорларында жүйелі әдебиет іздеумен, сондай-ақ, Дүниежүзілік денсаулық сақтау ұйымы /Еуропа және WONCA шығарған құжаттарды талдаумен жүргізілген баяндау сипатындағы шолу ретінде орындалды. Негізгі назар 2015-2025 жылдар аралығындағы жарияланымдарға аударылды, алайда тұжырымдамалық маңызы бар бұрынғы еңбектер де енгізілді. Бастапқы іздеу барысында 107 жарияланым анықталды, олардың ішінен атауы мен аннотациясын скринингтен өткізу және қайталанатын материалдарды алып тастау нәтижесінде 43 дереккөз соңғы талдауға енгізілді.

Қорытындылар. Қазіргі ғылыми деректер соматоформалық бұзылыстар және медициналық тұрғыдан түсіндірілмейтін симптомдар ұғымдарынан соматикалық симптом бұзылысы, денелік дистресс бұзылысы және тұрақты физикалық симптомдар ұғымдарына көшу алғашқы медициналық көмектегі клиникалық тәжірибе үшін маңызды екенін көрсетеді. Бұл жағдайларды диагностикалау скринингтік құралдарды (PHQ-15, SSS-8, SSD-12), динамикалық бақылауды және функционалдық жағдайды бағалауды қамтитын кезеңдік клиникалық бағалауға негізделуі тиіс. Психикалық денсаулықты алғашқы медициналық көмекке интеграциялау және мультидисциплинарлық тәсілді дамыту ерте анықтауға және медициналық көмекке қолжетімділікті жақсартуға ықпал етеді.

Түйін сөздер: соматизацияланған психикалық бұзылулар, тұрақты физикалық белгілер, соматикалық симптомдардың бұзылуы, алғашқы медициналық-санитарлық көмек, ерте диагностика, психикалық денсаулықты интеграциялау, бірлескен көмек.

СОМАТИЗИРОВАННЫЕ ПСИХИЧЕСКИЕ РАССТРОЙСТВА В ПЕРВИЧНОЙ МЕДИКО-САНИТАРНОЙ ПОМОЩИ: ПРОБЛЕМЫ ДИАГНОСТИКИ И МОДЕЛИ ИНТЕГРАЦИИ ПСИХИЧЕСКОГО ЗДОРОВЬЯ

Н. Н. Рахальская*, С. З. Ешимбетова

НУО «Казахстанско-Российский медицинский университет», Казахстан, Алматы

*Корреспондирующий автор

Аннотация

Актуальность. Соматизированные психические расстройства и персистирующие физические симптомы являются важной, но часто недостаточно распознаваемой проблемой в системе первичной медико-санитарной помощи. Такие пациенты обычно сначала обращаются к врачам первичного звена, однако разнообразие симптомов, их сочетание с тревогой и депрессией, стигматизация и диагностические трудности затрудняют своевременное выявление. В связи с этим важными задачами являются интеграция психического здоровья в систему первичной помощи и развитие междисциплинарных моделей оказания медицинской помощи.

Цель. Систематизировать современные данные об эволюции терминологии, причинах недостаточного распознавания, инструментах ранней идентификации и организационных моделях интеграции психического здоровья, значимых для диагностики соматизированных психических расстройств на уровне первичной медико-санитарной помощи.

Материалы и методы. Исследование выполнено в формате нарративного обзора с систематическим поиском литературы в базах данных PubMed, Scopus и Web of Science, а также анализом документов Всемирной организации здравоохранения, Всемирная организации здравоохранения/Европа и WONCA. Основное внимание уделялось публикациям за период 2015-2025 гг., однако также были включены более ранние работы, имеющие концептуальное значение. В результате первичного поиска было выявлено 107 публикаций, из которых после скрининга заголовков, аннотаций и удаления дубликатов в окончательный анализ включено 43 источника.

Выводы. Современные научные данные показывают, что переход от понятий соматоформ-

ных расстройств и медицински необъяснимых симптомов к концепциям расстройства соматических симптомов, телесного дистресс-расстройства и персистирующих физических симптомов имеет важное значение для клинической практики в первичной медико-санитарной помощи. Диагностика этих состояний должна основываться на поэтапной клинической оценке, включающей использование скрининговых инструментов (PHQ-15, SSS-8, SSD-12), динамическое наблюдение и оценку функционального статуса. Интеграция психического здоровья в систему первичной помощи и развитие мультидисциплинарного подхода будут способствовать более раннему выявлению и улучшению доступа к медицинской помощи.

Ключевые слова: соматизированные психические расстройства, стойкие физические симптомы, расстройство с соматическими симптомами, первичная медико-санитарная помощь, ранняя диагностика, интеграция в области психического здоровья, совместный уход.

АВТОРЛАР ТУРАЛЫ

Рахальская Наталья Николаевна – докторант, кәсіптік практика және клиникалық жұмыс бөлімінің бастығы, «Қазақстан-Ресей медициналық университеті» МEBБМ Қазақстан, Алматы; e-mail: n.rakhalskaya@medkrmu.kz; ORCID: <https://orcid.org/0000-0001-7857-3480>.

Ешимбетова Саида Закировна – медицина ғылымдарының докторы, профессор, психиатрия және наркология кафедрасының меңгерушісі, «Қазақстан-Ресей медициналық университеті» МEBБМ Қазақстан, Алматы; e-mail: s.eshimbetova@medkrmu.kz; ORCID: <https://orcid.org/0000-0002-3477-2565>.

ОБ АВТОРАХ

Рахальская Наталья Николаевна – докторант, начальник отдела профессиональной практики и клинической работы НУО «Казахстанско-Российский медицинский университет», Казахстан, Алматы; e-mail: n.rakhalskaya@medkrmu.kz; ORCID: <https://orcid.org/0000-0001-7857-3480>.

Ешимбетова Саида Закировна – доктор медицинских наук, профессор, заведующая кафедрой психиатрии и наркологии НУО «Казахстанско-Российский медицинский университет», Казахстан, Алматы; e-mail: s.eshimbetova@medkrmu.kz; ORCID: <https://orcid.org/0000-0002-3477-2565>.

ABOUT AUTHORS

Natalya Nikolaevna Rakhalskaya – doctoral student, Head of the Department of Professional Practice and Clinical Work at the NEI «Kazakh-Russian Medical University», Kazakhstan, Almaty; e-mail: n.rakhalskaya@medkrmu.kz; ORCID: <https://orcid.org/0000-0001-7857-3480>.

Yeshimbetova Saida Zakirovna – Doctor of Medical Sciences, Professor, Head of the Department of Psychiatry and Narcology, NEI «Kazakh-Russian Medical University», Kazakhstan, Almaty; e-mail: s.eshimbetova@medkrmu.kz; ORCID: <https://orcid.org/0000-0002-3477-2565>.

Authors' contribution. *Conceptualization: Rakhalskaya N.N., Yeshimbetova S.Z.; Methodology: Rakhalskaya N.N.; Data analysis: Rakhalskaya N.N.; Writing – original draft preparation: Rakhalskaya N.N.; Writing – review and editing: Yeshimbetova S.Z.; Supervision: Rakhalskaya N.N.*

Conflict of interest. *The authors declare no conflict of interest.*

Funding. *This research received no external funding.*

All authors have approved the final version of the article and are responsible for its content.

Article received: 31.12.2025year.

Accepted for publication: 20.02.2026 year.