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Psychosocial characteristics and affective symptomatology associated with patient self-initiated consultations in Spanish general practice

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Abstract

We aimed to determine the sociodemographic and psychosocial profile, and the associated subclinical affective symptomatology of users above the 95th percentile in the distribution of patient self-initiated, face-to-face consultations. Additionally, we sought to determine the contribution of subclinical symptomatology in differentiating between the groups above or below this cut-off point. A total of 16,803 users who self-initiated at least one face-to-face consultation with a GP at any of 13 PHC practices over 1 year, were eligible. After discarding those fulfilling exclusion criteria, 129 cases and 109 controls, matched by gender and age, answered the Family APGAR, the Duke-UNC and the Goldberg Anxiety-Depression scale. Both groups did not differ significantly on any of the sociodemographic and psychosocial variables recorded showing a similar percentage distribution. However, users with high self-initiated consultation rates obtained lower scores on the affective social support subscale from the Duke-UNC. Regarding Goldberg scale, the two groups differed significantly on the likelihood of displaying depression and/or anxiety symptoms. Users with a high probability of suffering from depression and/or anxiety were more prevalent among users on the top 5% in the distribution. Altogether, results indicate that these users report a lack of affective social support and have a higher probability of suffering from subclinical depression and/or anxiety. Early detection and treatment of affective symptomatology would temperate this excess in consultation. General practitioners, social workers and psychologists could act as gatekeepers, preventing this overuse of medical services and in turn lowering economical costs, professional burnout and patients' suffering and discontent.

KEYWORDS

Affective symptomatology, Frequent attenders, Healthcare utilisation, Mental health, Overusers, Primary care, Psychosocial determinants of health

1 | INTRODUCTION

In a recent paper by Gomà-i-Freixanet, Calvo-Rojas, and Portell (2019), these authors described, by means of the MCMI (Millon & Davis, 1997), the personality and psychopathological profile of users with excessive self-initiated consultations in public primary healthcare (PHC) practices. The results indicated that those above the 95th percentile in the distribution, which corresponded to ≥18 face-to-face, patient self-initiated consultations with the PHC practices, showed a profile characterised by dependency, compulsivity, anxiety and major depression. This profile describes a pattern of passive confrontation, with difficulties in emotional

processing, and low self-confidence in one's own abilities. This excess in consultation requires family doctors to acknowledge their symptoms and provide reassurance, and consequently repeatedly seek medical advice. This overuse of medical resources results in a disproportionate workload, unjustified expenditure and saturation of healthcare services leading to discontent on users and health professionals.

As most studies on attendance rate have focused mainly on sociodemographic variables (Karlsson, Lehtinen, & Joukamaa, 1994; Scaife, Gill, Heywood, & Neal, 2000), in the current study we are going to provide additional sociodemographic and psychosocial data of the previously reported group of users with excessive self-initiated consultations (Gomà-i-Freixanet et al., 2019). Authors focusing on sociodemographic characteristics as being relevant to attendance rate found that these users were more likely to be women (Andersson, Linöe, Hallgren, & Nilsson, 2004), of advanced age (Vedsted, Fink, Olesen, & Munk-Jørgensen, 2001), being divorced or living alone (Vedsted & Olesen, 2005), socioeconomically disadvantaged (Scaife et al., 2000), unemployed or not active in the workforce (Gili et al., 2011) and having a low educational level (Bellón, Delgado, de Luna, & Lardelli, 1999).

Additionally, other variables, such as social and family difficulties, have also been shown to be relevant to this excess in consultation. Thus, some studies suggest that social support dysfunction and family dysfunction are both significantly related to attendance rate (Bellón, Delgado-Sánchez, Luna, & Lardelli-Claret, 2007; Blanchard, Gurka, & Blackman, 2006; Scaife et al., 2000). There is also evidence supporting an association between attendance rate and family life cycle, as well as with family size and family structure. In a comparative study of frequent and non-frequent attenders, it was found that 34.6% of the frequent attenders were middle-aged or retired parents (Muñoz et al., 1996), they usually came from small or single-parent families and, to a lesser extent, from nuclear families without close relatives (Muñoz, Mariscal, Rubio, & Rey, 2000).

Finally, psychological distress is another topic of interest in the research on attendance rate, specifically anxiety and depression. Those with a high attendance rate are not only more likely to report psychological distress (Segovia, Pérez, Torío, & García, 1998; Vedsted et al., 2001), and depressive and somatoform disorders (Gili et al., 2011), but also elevated health anxiety and hypochondriac beliefs (Jyväsjärvi et al., 2001; Smits et al., 2014).

The literature reviewed so far refers to all kind of consultations with a general practitioner (GP), but yet few authors distinguish between consultations generated by GPs and consultations instigated by the user (Gomà-i-Freixanet et al., 2019; Vedsted & Christensen, 2005). The current study seeks to extend previous literature on attendance rate by reporting data of users classified by the number of patient self-initiated, face-to-face consultations with the GP and/or nursing staff in PHC practices, ignoring visits to emergency services and telephone consultations. Focusing on consultations due to the patient's own initiative (i.e. a consultation not generated by the GP but by the user's own initiative), we attempted to avoid visits scheduled by the GP to control for chronic illnesses requiring frequent controls (e.g. diabetes mellitus, glaucoma, heart diseases); for pregnancy, which requires frequent management; and/or for those on sick leave who have to contact their health centre for administrative purposes. These aforementioned selection criteria allowed a more clear-cut description of users whose exceptionally high consultation rates are not due to their medical, administrative or legal condition necessarily but to their own initiative. Considering only the patient self-initiated consultations to GPs and/or nursing staff, which had better reflect patient initiative, we tried to avoid considering the characteristics of the professionals as possible confounders of consultation rates (Smits et al., 2014). Additionally, we included a second selection criterion considering only those users in the top 5% in the distribution of patient self-initiated visits, which corresponded to ≥18 patient self-initiated visits during a 1-year period. By including this second selection criteria we aimed to exclude users with an acute medical condition as they would likely fall under the remaining 95% of the distribution. Finally, we excluded users with severe mental and/or cognitive disorders as these pathological conditions could interfere with the validity of the self-reported data. These three demanding selection criteria delimiting a specific population of users with a high rate of patient self-initiated, face-to-face consultations focused on gaining a better understanding of users who generate large workloads for the healthcare system.

Hence, the objective of this research was twofold: first, we aimed to determine the differential sociodemographic and psychosocial profile, and the associated subclinical symptomatology of a group of users above the 95th percentile in the distribution of patient self-initiated consultations; and second, to determine the contribution of subclinical affective symptomatology in differentiating between the aforementioned group and a cross-matched group comprising users below the 95th percentile.

What is known about this topic

- There has been limited research establishing the characteristics of patients with self-initiated consultations in general practice.
- Frequent attendance is related to sociodemographic and socio-family characteristics.
- Psychological distress is a predictor of frequent attendance in general practice.

What this paper adds

- Patient self-initiated attendance seems not to be related to sociodemographic characteristics.
- It seems related neither to family dysfunction nor functional social support.
- Affective symptomatology also predicts patient self-initiated overuse in general practice.

2 | METHOD

2.1 | Participants, design and procedure

A total of 16,803 users who made at least one face-to-face consultation with a GP and/or a nursing staff on their own initiative at PHC practices were eligible. Users from this initial sample were categorised into two groups based on the total number of self-initiated consultations per patient. To be categorised as a user with a high patient self-initiated consultation rate, we set the cut-off point as the 95th percentile in the distribution of consultations, which corresponded to ≥18 face-to-face, patient self-initiated consultations with PHC services within the period of 1 year. Applying this criterion, we identified 789 users. From the rest of the eligible sample (i.e. those with ≤17 patient self-initiated consultations), we selected a random subsample of 800 users, who matched the first group of users by gender and age range. We frequency matched both groups by gender and age range because these demographic variables are systematically associated with high attendance rates (Smits et al., 2014).

The social health workers in each PHC team, supervised by one of the authors (VC), reviewed the electronic medical records of the 1589 users (n = 789 with ≥18 face-to-face, patient self-initiated consultations plus n = 800 with ≤17 patient self-initiated consultations) to identify those who met the exclusion criteria. We used the following exclusion criteria: drug abuse or dependence, except for nicotine and tetrahydrocannabinol (n = 31); comorbidity with DSM-IV-TR (American Psychiatric Association, 2000) severe mental disorders (n = 73); comorbidity with ICD-10 (World Health Organization, 2008) severe cognitive disorders or sensory disabilities (n = 235); major locomotor mobility limitations (n = 105) or terminal illness (n = 48). Users who met the aforementioned exclusion criteria were either too physically impaired to go to their PHC practice to be assessed or too mentally impaired to guarantee a reliable psychological testing. We could not contact other users because they had moved, their mailing address was incorrect or they did not answer our telephone call (22%). Others declined to participate in the study (47%). Additionally, we excluded 11 users to cover adulthood only (25–85 years), as young adulthood and very senior old age are distinct periods of human development with specific health demands (National Research Council, 2014). The final total number of users assessed through face-to-face interviews was 238.

This was a multicentre study comprising 13 public PHC practices from Barcelona (Spain) with a cross-sectional design using two control techniques of confounding: restrictions on the abovementioned participants' characteristics, and frequency matching by gender and age in accordance with the distribution of these two variables in the group with ≥18 patient self-initiated consultations. A flow chart summarising the process of selecting the sample as well as a more detailed description of the method can be checked at Gomà-i-Freixanet et al. (2019) study. The final total sample in the current study comprised 238 users (n = 129 with ≥18 patient self-initiated consultations and n = 109 with ≤17 patient self-initiated consultations): 125 (52.5%) women and 113 men, as we included all the participants who answered the MCMI (Gomà-i-Freixanet et al., 2019).

Participation was voluntary, with no remuneration given, and data were treated as strictly confidential. The Ethics Committee of the Jordi Gol i Gurina Foundation approved the protocol, and our study complied with the Declaration of Helsinki guidelines (World Medical Association, 2013).

2.2 | Measures

2.2.1 | Sociodemographic data

We collected the following variables: Age, gender, civil status, educational level, monthly income, employment status, family life cycle and family structure. Employment status was categorised as being active in the workforce with paid work (employee or employer) or inactive/unemployed.

Family life cycle was categorised as Stage I (couples with no children); Stage II (couples with children); Stage III (middle-aged parents: stage begins with empty nest) and Stage IV (aging family members: stage begins with spouses' retirement and ends at their deaths).

Family structure was categorised as living alone (without close relatives but may share housing with other relations), nuclear family (including single-parent families) and extended family (enlarged nuclear family, including relatives).

2.2.2 | Family APGAR Questionnaire

Family APGAR Questionnaire (Smilkstein, 1979). This is used to detect family dysfunction and consists of five questions with a three-response format (*almost never*, *sometimes* and *almost always*) to which answers are assigned 0, 1 or 2 points respectively. As a function of the final score, the questionnaire categorises as family dysfunction (Yes = 0 to 6 points) or normal functioning (No = 7 to 10 points). This questionnaire is very useful to address family problems in PHC because it is fast and simple. The Spanish version by Bellón, Delgado, Luna, and Lardelli (1996) shows a test–retest reliability of r = 0.86 and an internal consistency of α = 0.84.

2.2.3 | Duke-UNC Functional Social Support Questionnaire

Duke-UNC Functional Social Support Questionnaire (Broadhead, Gehlbach, De Gruy, & Kaplan, 1988). This self-report questionnaire is made up of 11 items that assess perceived social support on a 5-point Likert scale (1–5). The questionnaire categorises into two categories: lack of social support (Yes = values <33) and adequate social support (No = values ≥33). This scale also provides three indicators: Affective social support (ranges from 5 to 25 points), with a cut-off point of 15; Confidant social support (ranges from 6

to 30 points), with a cut-off point of 18; and Total social support (ranges from 11 to 55 points), with a cut-off point of 33. A final total score below 33 is considered indicative of a lack of social support. According to the authors, the quality of social support is a better health predictor than structural support, thereby justifying its use in PHC contexts. The Spanish version (De la Revilla et al., 1991) has demonstrated adequate psychometric properties and has shown to be valid and accurate in determining the degree of social support in non-institutionalised adult populations (Ayala et al., 2012).

2.2.4 | Goldberg Anxiety–Depression Scale

Goldberg Anxiety–Depression Scale (Goldberg, Bridges, Duncan-Jones, & Grayson, 1988). This is an 18-item self-report symptom inventory with a yes/no response format (Yes = 1, No = 0). The scores are based on responses to nine anxiety and nine depression items, asking how respondents have felt in the past month. The cut-off points of the Spanish version (Montón, Pérez, Campos, García, & Lobo, 1993) are ≥4 for anxiety and ≥2 for depression; higher scores are indicative of a high probability of having an anxiety or depressive disorder. This scale orients the diagnosis towards anxiety or depression, or both in mixed cases, and discriminates between the two entities while measuring their respective intensities, with a sensitivity of 83.1% and a specificity of 81.8%.

2.3 | Statistical analysis

We performed a descriptive analysis of sociodemographic, psychosocial and subclinical symptomatology variables. To assess group differences, we used the *Chi*-square test for categorical variables, and calculated the strength of the relationship using Phi or Cramer's V coefficient (for tables larger than 2-by-2). For non-categorical variables, we used student's *t* test for independent samples, and calculated the effect size using Cohen's *d*.

To determine if subclinical affective symptomatology predicted extremely high patient self-initiated consultation rates, we carried out a logistic regression analysis. Using the cut-off points of the Spanish version of the Goldberg scale for depression and anxiety, we obtained two variables and entered them into the model in a single step. As a goodness-of-fit measure, we used the Hosmer–Lemeshow test. We used the SPSS statistics package (IBM Corp., 2011) to conduct the statistical analysis.

3 | RESULTS

The group of users with ≥18 patient self-initiated consultations comprised 129 (54.2%) participants: 69 women (M = 62.8 years, SD = 14.5) and 60 men (M = 61.4 years, SD = 15.2). The group of users with ≤17 patient self-initiated consultations comprised 109 participants: 56 women (M = 61.7 years, SD = 15) and 53 men (M = 66.9 years, SD = 12.3). As both groups were frequency matched by gender and age, there was no statistically significant differences in either gender ($\chi^2_{(1)} = 0.11$, $p = .75$) or age ($t = 1.09$, $p = .28$).

Table 1 shows the values obtained for the sociodemographic variables. Both groups did not differ significantly on any of these variables showing a similar percentage distribution.

Table 2 shows the values obtained for family life cycle, family structure, APGAR family dysfunction, Duke-UNC social support dysfunction and Goldberg scale. The two groups did not differ significantly on any of the psychosocial variables assessed. However, when analysing separately the affective and confidant subscales from the Duke-UNC, users with high self-initiated consultation rates obtained lower scores, but only the affective social support subscale achieved statistical significance although with a small effect size. Finally, regarding Goldberg scale, the two groups differed significantly on the likelihood of displaying depression ($\chi^2_{(1)} = 16.65$, $p = .001$) and/or anxiety symptoms ($\chi^2_{(1)} = 20.87$, $p = .001$). Users with a high probability of suffering from depression were more prevalent among users with high self-initiated consultation rates (44.2% vs. 19.3%). Regarding the probability of suffering from anxiety, users with a high probability were more prevalent among those with high self-initiated consultation rates (69% vs. 39.4%).

To identify the independent contribution of each of the two scales from the Goldberg scale in predicting group belonging, the groups were coded into the model as 1 for the cases group and 0 for the control group. The tested model including the Goldberg scales was statistically significant ($\chi^2_{(2)} = 26.92$, $p < .001$) and acceptable according to the Hosmer–Lemeshow p value ($\chi^2_{(2)} = 0.14$, $p = .93$). Table 3 shows the estimated parameters of the model suggesting that both scales are prognostic factors that increase the odds of belonging to a group of users with high patient self-initiated consultation rates.

4 | DISCUSSION

Regarding sociodemographic and psychosocial characteristics, our results indicated that both groups did not differ on any of the variables assessed. Nevertheless, users with high self-initiated consultation rates obtained low scores on affective social support. Although both groups reported scores 10 points above the cut-off point on total functional social support, users with high self-initiated consultation rates obtained slightly lower levels only on the social support subscale. Thus, although our data do not confirm previous results about the reported low social support among frequent attenders (Sheehan, Bass, Briggs, & Jacoby, 2003), these differences only appeared when analysing the subscales separately. It might seem that the relationship between high self-initiated consultation rates and social support might be expressed by the affective component of social support. Lastly, users with high self-initiated consultation rates showed a higher probability of suffering from subclinical affective symptomatology. Our study supported previous results that showed a higher degree of psychological distress (Norton

TABLE 1 Sociodemographic characteristics as a function of the number of patient self-initiated consultations

Variables	Users with ≥18 patient self-initiated consultations *n* = 129 *n* (%)	Users with ≤17 patient self-initiated consultations *n* = 109 *n* (%)	χ^2	*p*	ϕ/V
Civil status[a]			1.29	.73	0.07
Single	24 (18.6)	24 (22.2)			
Married	78 (60.5)	62 (57.4)			
Separated/divorced	12 (9.3)	7 (6.5)			
Widowed	15 (11.6)	15 (13.9)			
Educational level[a]			2.11	.55	0.10
No studies	26 (21.7)	22 (21.2)			
Primary	38 (31.7)	25 (24.0)			
Secondary	28 (23.3)	26 (25.0)			
University	28 (23.3)	31 (29.8)			
Monthly income			1.83	.40	0.09
<500 €	24 (18.6)	16 (14.7)			
500–1000 €	71 (55.0)	56 (51.4)			
>1,000 €	34 (26.4)	37 (33.9)			
Employment status[a]			1.18	.28	0.07
Active with paid work	23 (18.1)	26 (23.9)			
Inactive or unemployed	104 (81.9)	83 (76.1)			

Note: ϕ/ *V* = Phi/ Cramer's *V*.

[a]These variables have missing values (1–14 participants).

et al., 2012; Vedsted et al., 2001) or anxiety/depression (Kersnik, Svab, & Vegnuti, 2001; Rifel et al., 2013; Sheehan et al., 2003; Smits et al., 2014) among frequent attenders.

The current study also indicated that the probability of suffering from anxiety and/or depression is associated with high self-initiated consultation rates. Hence, users who were likely to experience anxiety and/or depression were at higher risk of having a high self-initiated consultation rates than users who did not meet this criterion. In a study conducted in the United Kingdom, Sheehan et al. (2003) found that somatisation, depression and low social support were related to an increase in primary care consultation. Likewise, in a prospective study conducted in Spain, Bellón et al. (2007) observed that family dysfunction and poor mental health were the most relevant psychosocial factors in predicting overusing in primary care consultation. Finally, our results also supported previous studies in the Netherlands (Smits et al., 2014) and Australia (Pymont & Butterworth, 2015) that found subclinical anxiety and depression could partly explain the excessive use of primary care by frequent attenders.

This study has some limitations worth mentioning. Although the eligible sample was large, a great deal of prospective participants did meet exclusion criteria and some others declined to participate in the study. This later circumstance could lead to a sampling bias in which participants with health/affective problems could be more willing to take part in the study or vice versa. However, the obtained results did not differ from those of the existing literature on frequent attendance and our participation rate was higher than others reported in the relevant literature (Hodgson, Smith, Brown, & Dowrick, 2005; Smits et al., 2014). Regarding the study design, the number of patient self-initiated consultations was recorded retrospectively, and this fact could have affected the scores obtained. Nevertheless, prospective studies in this area have reported that psychosocial factors precede frequent attendance, pointing at the unidirectionality of the factors (Bellón et al., 2007). Furthermore, the criterion we used for excessive patient self-initiated consultation was very restrictive, as we considered only the top 5% of users, which could be considered an exceptionally high self-initiated consultation rate. In addition, there is a gap between the period of consultation and the assessment of anxiety/depression. It could be possible that whatever triggered an excess in consultation also triggered an increase in anxiety/depression or the other way round could also be possible. However, our study did not aim at the aetiology of affective symptomatology, but rather at the contribution of emotional distress on an increase in consultation rates. Finally, we must take into account that this study took place in Spain, and this may difficult the generalisability of findings to countries in which most healthcare costs are covered by insurances rather than by the national healthcare system.

However, the strengths of this study also must be pointed out. To our knowledge, this is one of the few studies focusing solely on patient self-initiated consultations, providing novel insights into the field of excessive frequentation and attendance. Thus, considering

TABLE 2 Psychosocial characteristics and Goldberg scale as a function of the number of patient self-initiated consultations

Variables	Users with ≥18 patient self-initiated consultations *n* = 129 *n* (%)	Users with ≤17 patient self-initiated consultations *n* = 109 *n* (%)	χ^2	*p*	ϕ/V
Family life cycle[a]			0.25	.97	0.03
Stage I	23 (18.1)	17 (15.7)			
Stage II	33 (26.0)	29 (26.9)			
Stage III	44 (34.6)	39 (36.1)			
Stage IV	27 (21.3)	23 (21.3)			
Family structure[a]			0.27	.87	0.03
Living alone	10 (7.8)	7 (6.5)			
Nuclear family	34 (26.6)	27 (25.0)			
Extended family	84 (65.6)	74 (68.5)			
Family APGAR[a]			2.08	.15	0.09
Yes	36 (27.9)	21 (19.8)			
No	93 (72.1)	85 (80.2)			
Duke-UNC[a]			1.52	.22	0.08
Yes	17 (14.2)	9 (8.8)			
No	103 (85.8)	93 (91.2)			
Goldberg					
Depression			16.65	<.001	0.27
High probability	57 (44.2)	21 (19.3)			
No probability	72 (55.8)	88 (80.7)			
Anxiety			20.87	<.001	0.30
High probability	89 (69.0)	43 (39.4)			
No probability	40 (31.0)	66 (60.6)			
Duke-UNC	***M* (*SD*)**	***M* (*SD*)**	***t***	***p***	***d***
Affective support	18.09 (4.95)	19.31 (4.36)	1.97	.05	0.26
Confidant support	23.54 (5.57)	23.72 (5.22)	0.26	.79	0.03
Total	41.67 (9.77)	43.01 (8.64)	1.08	.28	0.15

Note: Stage I = Couples with no children, Stage II = Couples with children, Stage III = Middle-aged parents: stage begins with nest empty, Stage IV = Aging family members: stage begins with spouses' retirement and ends at their deaths; ϕ/V = Phi/Cramer's *V*; *d* = Cohen's *d*.

[a]These variables have missing values (1–9 participants).

TABLE 3 Logistic regression analysis output of subclinical affective symptomatology

Variables	*B*	Wald	*p*	*OR*	CI 95%
Anxiety	0.93	9.62	.002	2.53	1.41–4.54
Depression	0.79	5.68	.02	2.20	1.15–4.20

Note: 1 = Users with ≥18 patient self-initiated consultations; 0 = Users with ≤17 patient self-initiated consultations.

Abbreviation: CI, confidence interval.

only the patient self-initiated consultations, we avoided considering users whose exceptionally high consultation rates are not due to their medical, administrative, or legal condition necessarily but to their own initiative. Furthermore, it also allowed to avoid considering the characteristics of the GPs and nursery staff as possible confounders of consultation rates as these caregivers may influence attendance rates by prescribing subsequent follow-up consultations (Smits et al., 2014). Thus, considering only the patient's own initiative in defining consultation rates, the obtained results suggest that the patient's characteristics are probably more important than GP features. Moreover, unlike other studies that rely on self-reports of morbidity, our data come from the official national healthcare electronic medical records, thus avoiding self-report biases and assuring good data quality.

Overall, the current study together with the previously published by Gomà-i-Freixanet et al. (2019) delineate the sociodemographic and psychosocial characteristics, and the personality and psychopathology profile of users with high self-initiated

consultation rates, and indicate they mostly suffer from affective distress that they channel through health networks, reaching health professionals and public health managers. Taking into account the current composition of primary healthcare teams in Spain, we advocate for social health workers, acting as gatekeepers and channelling this affective demand through their training profile based on transversal skills. This approach would minimise the risk of burnout currently suffered by some GPs, and it would may lead to better management of human resources and a consequent reduction in expenditures (Armstrong & Swinglehurst, 2018; Malins et al., 2016; Organisation for Economic Co-operation & Development, 2017).

Furthermore, this study provides a unique opportunity to identify the characteristics of users with high self-initiated consultation rates and offers data to better inform planning and policy development in this significant healthcare area. In view of the obtained results and taking the above into account, incorporating a socio-health examination, including psychosocial factors such as social support and affective symptomatology, would provide valuable information for the management of such patients. Providing quaternary prevention focused on managing emotional distress would prevent the exacerbation of affective symptomatology, which, maintained over time, could lead to chronification and very likely the development of psychopathology. The findings of this study suggest that subclinical symptomatology, specifically anxiety and depression are both related to a disproportionate patient self-initiated consultation rates in primary healthcare. Having access to information that is easy to obtain (e.g. the Goldberg scale) and with an early intervention focused on educational interventions and reassurance techniques, social health workers could avoid the risk of iatrogenesis, providing an effective way for managing compelling emotional distress. Finally, but not less important, preventing strengthening and chronification of symptoms may contribute to alleviation of patient suffering.

CONFLICT OF INTEREST

The authors have no competing interests to report.

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