Somatoform disorders in general practice.

Arnold, Ingrid Antonette; Waal, Margaretha Wilhelmina Maria de

Chapter 6

Somatoform disorder in primary care: course and the need for cognitive-behavioural treatment.

Ingrid A. Arnold, Margot W.M. de Waal, Just A.H. Eekhof, Albert M. van Hemert

Psychosomatics, in press.

Abstract

Medically unexplained physical symptoms are prevalent in primary care. Of all patients attending the family physician, 16% has a somatoform disorder according to DSM-IV. Cognitive-behavioural treatment has demonstrated to be effective in secondary care. However, the course of somatoform disorders and the need for treatment were not yet established in primary care. In this study data from 1,046 attendees in family practice were analysed on prevalence, course and eligibility for treatment. During a 6 months follow-up the prevalence of somatoform disorder decreased from 16.1% to 12.3%. After assessment of eligibility, a need for treatment was present in 5% of all patients.

Introduction

Somatoform disorders are among the most prevalent psychiatric disorders in primary care. Recently, we reported a point prevalence of 16.1% of DSM-IV somatoform disorders in a Dutch primary care consulting population.[1] Most common was the undifferentiated somatoform disorder, with a prevalence of 13.1%. These patients suffer from one or more medically unexplained physical symptoms such as fatigue, headache or gastro-intestinal symptoms causing clinically significant impairment for at least 6 months. Earlier, Fink et al reported an even higher prevalence of somatoform disorders of 30% in a Danish primary care consulting population.[2]

Over the last ten years it has become increasingly clear that cognitive-behavioural therapy is an effective treatment for patients with somatoform disorders. A number of systematic reviews have concluded that cognitive-behavioural therapy is an effective treatment for selected medically unexplained physical symptoms such as fatigue, irritable bowel syndrome and fibromyalgia.[3-6] A randomized controlled trial conducted at a general medical outpatient clinic demonstrated that cognitive-behavioural treatment was also effective in patients with more heterogeneous medically unexplained physical symptoms.[7] Many of the patients included in these studies would qualify for a diagnosis of undifferentiated somatoform disorder. If all patients with somatoform disorders in primary care were offered cognitive-behavioural therapy this would result in a very substantial increase in the need for treatment.

It remains to be seen, however, whether treatment is indicated for and acceptable to each and every patient that is identified with a somatoform disorder in primary care. The natural course of somatoform disorders is often benign. Studies on the prognosis of medically unexplained physical symptoms mostly report improvement of symptoms or recovery in the majority of patients after one year.[8-10] In treatment studies recovery in the non-treatment arm is usually also considerable. It seems wise to start with a period of 'wait-and-see' before formal treatment is initiated. Furthermore, it may be doubted whether all patients with somatoform disorders are willing to accept psychological treatment. In one study in secondary care we found that most patients accepted psychological treatment, but it is unclear whether the same applies to patients in primary care.[4,11-12] Moreover, common clinical wisdom states that 'somatising patients do not like psychologising'.

In the SOmatization study of the University of Leiden (SOUL) we had the opportunity to estimate the proportion of patients in primary care with persistent symptoms of somatoform disorders that would accept treatment if a programme of brief cognitive-behavioural therapy was offered to them. After an initial diagnostic assessment of somatoform disorders, patients were followed for 6 months to monitor

spontaneous recovery. Patients reporting persistence of their symptoms were subsequently evaluated for a brief cognitive-behavioural treatment by their own general practitioner. Our findings may help to make a realistic estimate of the additional need for treatment for somatoform disorders.

Methods

SOUL-cohort

The SOmatization study of the University of Leiden (SOUL-study) was designed as a prospective cohort study in family practice. Screening questionnaires were used to identify high-risk patients. For a further diagnostic assessment by means of a psychiatric interview, all high-risk patients and a sample of 15% of the low risk patients were invited. More details on the procedure have been published elsewhere.[1]

For the present study, the prevalence of persistent somatoform disorders was established after six months. All the patients with persistent symptoms underwent an assessment as to their eligibility for cognitive-behavioural treatment provided by their own family physician. The Medical Ethical Committee of the Leiden University Medical Center approved the study protocol.

Population

In a flowchart the recruitment and follow-up of patients is demonstrated (table 1). The study took place in eight university-affiliated family practices in The Netherlands. The distribution of age and gender is similar to the Dutch population. The study was limited to natives of The Netherlands. The electronic medical records of all patients were available through the central database of the family practice registration network Leiden RNUH-LEO. Between April 2000 and December 2001 patients were selected from a random sample of 1778 consecutive patients, aged 25 to 80. They received screening questionnaires by mail. A total number of 1046 patients (59%) returned the questionnaire and indicated that they were willing to participate. The main feature of the non-response analyses was a slight underrepresentation of young males in the examined sample.

Questionnaires

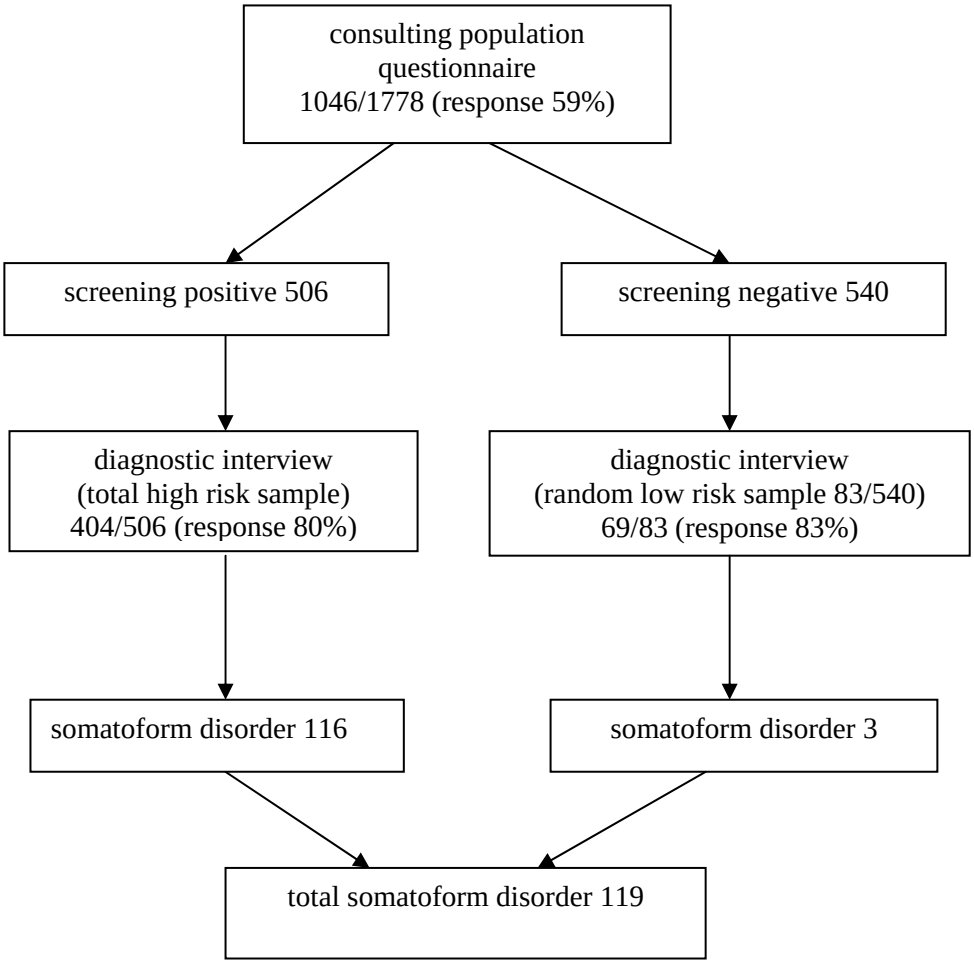
Participants completed the short form health survey (SF-36)[13] as a measure of functional impairment, the Hospital Anxiety and Depression Scale (HADS) [14] as a measure of anxiety and depression, the Illness Attitude Scales (IAS) as a measure of health anxiety and illness behaviour [15] and a Physical Symptom Checklist (PSC)[16] to quantify the number of reported physical symptoms. A total score of over 15 on the

HADS or a score of over 5 on the PSC defined the high-risk sample. All patients with a high score and a sample of patients with a low score were invited for a diagnostic interview. Patients were excluded if they were unable to participate in an interview due to handicaps such as deafness, aphasia or cognitive impairment.

Diagnostic interview

WHO-certified clinical researchers used the Schedules for Clinical Assessment in Neuropsychiatry (SCAN version 2.1) [17] as the diagnostic interview. The assessment included psychiatric diagnoses and concurrent physical illnesses. In addition, patients with a somatoform disorder reported the frequency and the severity of the main unexplained symptoms. Frequency could be expressed in ‘never’, ‘sometimes’, ‘often’ or ‘always’. Patients indicated the severity on a visual analogue scale (VAS), on which 0 meant no symptoms and 10 meant unbearable symptoms. All chronic somatoform disorders with a duration of at least 6 months were recorded.

Table 1. Recruitment and follow-up of patients.



Follow-up

All 119 patients with a diagnosis of somatoform disorder received follow-up questionnaires 6 months after baseline with the PSC, HADS, SF-36 and IAS. In addition, they reported on the frequency and severity of their main physical symptoms. Somatoform symptoms were considered to be persistent if the patient reported on at least one unexplained symptom with a frequency of at least 'often' and a severity of at least 5 on a VAS.

Non-responding patients received a reminder, patients who had moved were traced with information from the family physician. A total of 100 patients returned the questionnaires, of which 99 were suitable for analysis, a response rate of 83%.

Eligibility and acceptability

All patients indicating persistent symptoms were evaluated by a family physician-researcher (IAA) on eligibility for cognitive-behavioural therapy by their family physician. Treatment was not offered to patients who were already receiving psychological treatment for their symptoms nor to patients with a serious somatic disease or a serious psychiatric disease such as psychosis, substance abuse, post-traumatic stress disorder or severe personality disorder. Patients with a concurrent anxiety or depressive disorder were not excluded since cognitive-behavioural therapy is an effective treatment for these disorders. All potentially eligible patients received a personal invitation letter for an interview with written information on cognitive-behavioural therapy. Subsequently, the family physician-researcher (IAA) contacted them by telephone and visited them at home. During the interview, it was checked if significant clinical impairment according to a DSM-IV diagnosis of somatoform disorder was still present or if new exclusion criteria had arisen. All eligible patients were offered cognitive-behavioural treatment for their symptoms.

Analyses

In order to obtain estimates for the consulting population all prevalence estimates and their 95% confidence limits were calculated by using weights that were inversely proportional to the sampling probabilities [18] Comparisons between groups of interested versus uninterested patients were performed by t-tests. Analyses were conducted using SPSS for Windows 11.0.

Results

Follow-up

Table 2 presents the follow-up and eligibility. Of all 99 patients with a somatoform disorder, 30 were regarded as recovered after six months. These patients reported a frequency of ‘never’ or ‘sometimes’ or a severity of less than 5 on a VAS for their main symptom. The remaining 69 patients reported persistent symptoms on the VAS. This corresponds with a weighted prevalence of persisting symptoms of 12.3% (CI 9.1-15.5%) in the consulting population.

Table 2. Follow-up and eligibility for treatment

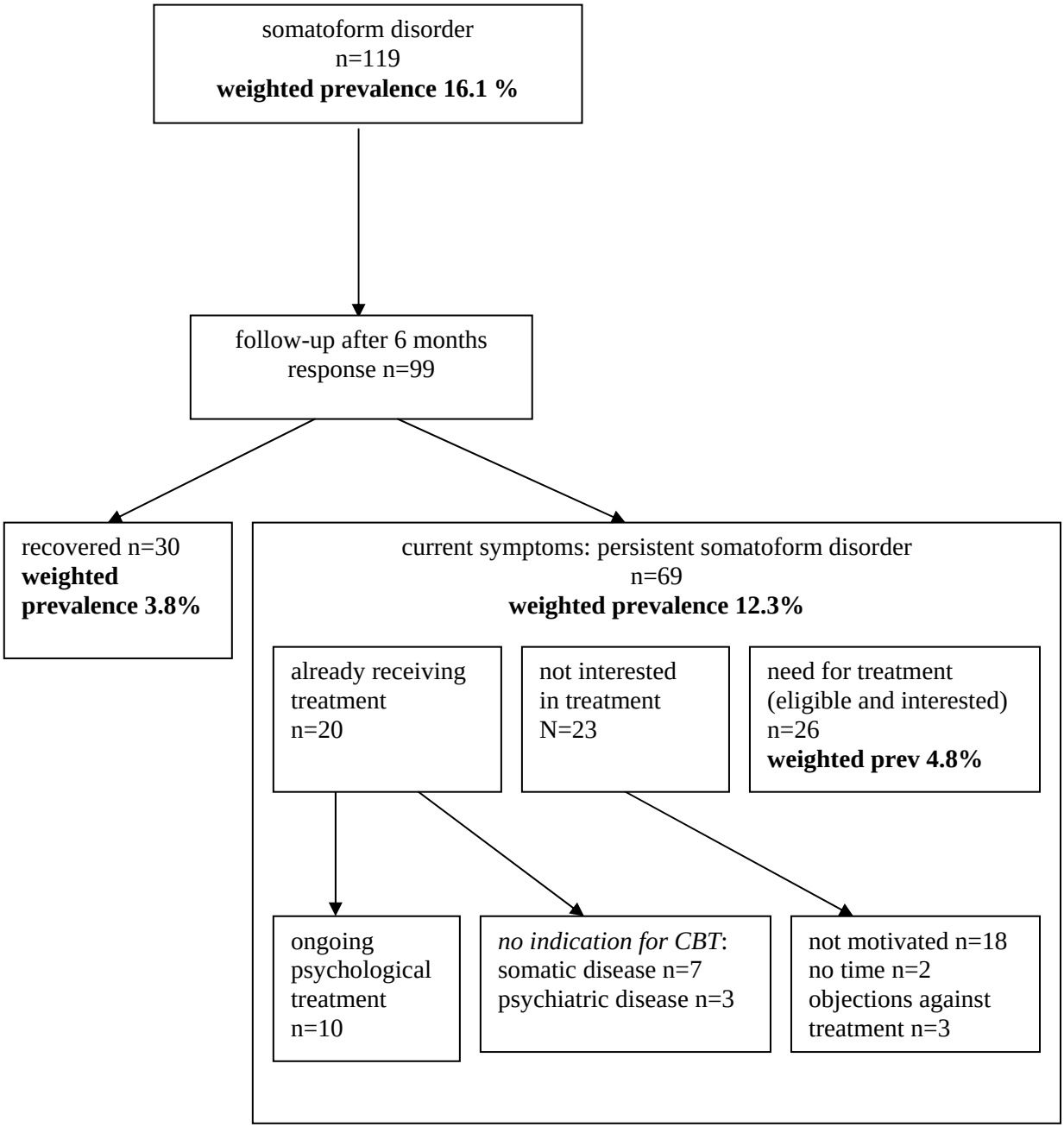


Table 3. Patient characteristics at follow-up; gender and weighted means (with 95% confidence limits) of age, symptoms and functional limitations.

	Recovered (n= 30)	**Current symptoms**		
		Already receiving treatment (n=20)	**Not interested in treatment** (n=23)	**Interested in treatment** (n=26)
Gender M/F	8/22	5/15	1/22	5/21
Age	41.7 (38.4-45.0)	48.6 (43.4-54.8)	42.1 (38.7-45.5)	50.0 (45.9-54.1)
Severity of main symptom (VAS)	3.8 (3.1-4.4)	7.4 (6.7-8.1)	6.9 (6.5-7.3)	7.4 (6.9-7.8)
Symptoms				
No of physical symptoms †	4.5 (3.0- 6.0)	12.8 (8.6-17.0)	9.1 (6.3-11.9)	8.9 (6.6-11.1)
HADS total score ‡	8.3 (5.5-11.0)	16.0 (11.8-20.2)	12.0 (9.9-14.9)	14.2 (11.9-16.6)
- anxiety score	5.2 (3.4- 6.9)	9.0 (6.8-11.2)	7.2 (5.4- 8.9)	7.7 (6.5- 8.9)
- depression score	3.1 (1.9- 4.4)	7.0 (4.6- 9.4)	4.8 (3.2- 6.3)	6.5 (5.1- 8.0)
Functional limitations §				
Physical functioning	86 (80-91)	62 (49-76)	73 (62-83)	73 (64-82)
Social functioning	80 (66-95)	50 (35-65)	66 (54-77)	59 (37-72)
Role funct: physical problems	71 (59-86)	28 (12-43)	57 (37-76)	55 (37-72)
Role funct: emotional problems	77 (63-91)	28 (8-48)	70 (52-88)	62 (44-80)
Pain	74 (65-82)	48 (31-54)	52 (44-61)	52 (45-60)
Subjective health	62 (56-68)	40 (30-50)	50 (42-58)	58 (51-65)
Health change	71 (61-81)	45 (34-56)	51 (44-58)	61 (51-71)
Illness attitude scale ǁ				
Illness behaviour	8.3 (6.9- 9.9)	12.0 (9.6-14.4)	10.2 (9.0-11.4)	11.4 (10.1-12.7)
Health anxiety	8.0 (5.5-10.5)	11.4 (6.4-16.3)	12.5 (9.0-15.9)	6.3 (3.8- 8.9)

† Symptoms on Physical Symptom Checklist 'bothersome often or most of the time during last week'

‡ Subscales of the Hospital Anxiety and Depression Scale: anxiety (0-21) and depression (0-21)

§ Scales of SF-36: standardised to range 0-100

ǁ Subscales of IAS: illness behaviour (0-24) and health anxiety (0-44)

Eligibility and acceptability

Out of the 69 patients who reported persisting medically unexplained physical symptoms, 20 patients were not offered treatment. Ten of them already received ongoing psychological treatment for their symptoms. In 3 patients major psychiatric disorders were the cause of exclusion and the remaining 7 had a serious somatic disorder.

For 49 patients with persistent symptoms cognitive-behavioural treatment was considered as suitable. Regarding psychiatric comorbidity, 15 of the 49 patients had a concurrent anxiety and/or depressive disorder diagnosed at baseline. All 49 potentially eligible patients received written information about cognitive-behavioural therapy and were contacted by the family physician-researcher (IAA) to ask if they were interested in treatment. Twenty-three patients indicated they were not interested. Eighteen of these indicated that they were not motivated to undergo treatment because they had accepted their symptoms as a part of their life. Three patients had objections against treatment due to negative experiences in the past and two patients reported a lack of time.

A total of 26 patients was interested in treatment. This corresponds with a weighted prevalence of 4.8% (CI 2.6-7.0%) in the consulting population that was screened at baseline.

Table 3 presents the patient characteristics at follow-up. When comparing recovered patients with patients reporting current symptoms, the mean severity of the main physical symptoms was significantly higher in patients with current symptoms. Particularly those who already received treatment reported significantly more symptoms on all measures. Generally, patients with current symptoms also had higher scores on the HADS and more functional limitations, although this did not always reach significance. Among patients who would be eligible for treatment by the family physician and who did not already undergo treatment, most differences were minor. Interested patients were significantly younger (42 versus 50 year of age) and experienced less health anxiety according to the IAS (6.3 versus 12.5) than the ones not interested in treatment.

Discussion

Main findings

In this follow-up study we demonstrated that the course of somatoform disorders is not favourable since three-quarter of all patients diagnosed with a somatoform disorder reported persisting somatoform symptoms after 6 months. The estimated prevalence of

a persisting somatoform disorder was 12.3% of consecutive consulting patients in primary care.

Of all the patients with an initial diagnosis of a somatoform disorder in primary care, for only 26% a brief cognitive-behavioural therapy was a suitable treatment option. During the follow-up period the symptoms had diminished in 30% of the patients. Long-term psychological treatment for a psychiatric condition was already going on in 10%. In another 10% of the patients cognitive-behavioural therapy for somatoform disorders was not the preferential treatment because of a psychiatric disorder or a serious comorbid somatic disease. Finally, 23% of the initial selection of patients did not consider cognitive-behavioural therapy an acceptable treatment for their problems. Taking the sampling scheme into account, these figures suggest an additional need of cognitive-behavioural therapy for somatoform disorders of nearly 5% of the consulting population in primary care.

Strength and limitations

In our study the natural course of recovery was less favourable than in previous studies [8-10]. Most previous studies had focused on medically unexplained symptoms rather than on the more strict diagnosis of somatoform disorders. In our study we took meticulous care to limit the diagnoses to patients with clinically significant symptoms. In comparison to previous studies our total prevalence was estimated at 16.1%, which was rather low. These were the patients, however, with the more serious symptoms and functional limitations. In these patients spontaneous recovery is less likely and treatment could bring about a substantial improvement.

For a considerable number of patients cognitive-behavioural treatment was not an acceptable option. Our approach of the patients was similar to the one in our previous studies.[7 12] Patients received personal letters from their own family physician. They were contacted by telephone and visited at home by the family physician-researcher (IAA) who offered information concerning the treatment in a sympathetic way, avoiding unnecessary psychologising. A systematic account of the reasons why cognitive-behavioural treatment was unacceptable suggests that most patients, often with longstanding symptoms, simply did not feel like investing their time and effort in therapy. We assume that younger patients declined more often because they gave priority to their work or family. In addition, the higher level of health anxiety in patients who did not accept treatment might have led to avoidance of explicit treatment of their symptoms. It cannot be excluded that an intervention offered in a regular consultation with their family physician, would have been more acceptable to some patients.

The non-response merits separate discussion. Our study may be biased because it may well be possible that non-responding patients withdrew because they were less

interested in treatment. This may have led to an overestimation of the need for treatment. In a scenario in which the non-responding patients were considered ineligible or not interested in treatment 2.5 % of the consulting population would have been suitable for treatment.

Implications

Our findings suggest that an extra 4.8% of the consulting population in primary care may need cognitive-behavioural therapy. These patients constitute a selection of the more severe, persistent and debilitating unexplained physical symptoms. The figure would be higher if more patients accepted therapy when offered. Consequently, somatoform disorders warrant a substantial extra effort from the health care system to provide appropriate treatment. In addition to the treatment options in secondary care, general practitioners require time-limited, focussed and effective approaches to address these problems in primary care.

Conclusions

The prevalence of persistent somatoform disorders is high in primary care. One in eight patients reports persisting somatoform symptoms after six months of follow-up. At least one in 22 patients would accept cognitive-behavioural therapy for somatoform disorders when offered. To meet the needs of this group of patients, the development of suitable interventions for primary care is implicated.

Acknowledgements

The Netherlands Organization for Health Research and Development (ZON-MW) funded the study.

References

1. De Waal MW, Arnold IA, Eekhof JA, van Hemert AM. Somatoform disorders in family practice: Prevalence, functional impairment and comorbidity with anxiety and depressive disorders. Br J Psychiatry 2004;184:470-476.

2. Fink P, Sorensen L, Engberg M, Holm M, Munk-Jorgensen P. Somatization in primary care: prevalence, health care utilization, and general practitioner recognition. Psychosomatics 1999;40:330-338.

3. Kroenke K, Swindle R. Cognitive-behavioral therapy for somatization and symptom syndromes: a critical review of controlled clinical trials. Psychother Psychosom 2000;69:205-215.

4. Raine R, Haines A, Sensky T, Hutchings A, Larkin K, Black N. Systematic review of mental health interventions for common somatic symptoms: can research evidence from secondary care be extrapolated to primary care? BMJ 2002;325:1082-1093.

5. Nezu AM, Nezu CM, Lombardo ER. Cognitive-behaviour therapy for medically unexplained symptoms: a critical review of the treatment literature. Behaviour Therapy 2001;32:537-583.

6. Looper KJ, Kirmayer LJ. Behavioral medicine approaches to somatoform disorders. Journal of Consulting and Clinical Psychology 2002;70:810-827.

7. Speckens AE, Van Hemert AM, Spinhoven P, Hawton KE, Bolk JH, Rooijmans HG. Cognitive-behavioural therapy for medically unexplained physical symptoms: a randomised controlled trial. BMJ 1995;311:1328-1332.

8. Speckens AE, van Hemert AM, Bolk JH, Rooijmans HG, Hengeveld MW. Unexplained physical symptoms: outcome, utilization of medical care and associated factors. Psychol Med 1996;26:745-752.

9. Gureje O, Simon GE, Von Korff M. A cross-national study of the course of persistent pain in primary care. Pain 2001;92:195-200.

10. Khan AA, Khan A, Harezlak J, Tu W, Kroenke K. Somatic symptoms in primary care: etiology and outcome. Psychosomatics 2003;44:471-478.

11. Speckens AE, van Hemert AM, Bolk JH, Hawton KE, Rooijmans HG. The acceptability of psychological treatment in patients with medically unexplained physical symptoms. J Psychosom Res 1995;39:855-863.

12. Arnold IA, Speckens AEM, Van Hemert AM. Medically unexplained physical symptoms: The feasibility of group cognitive-behavioural therapy in primary care. J Psychosom.Res 2004;57:517-20.

13. Aaronson NK, Muller M, Cohen PD, Essink-Bot ML, Fekkes M, Sanderman R et al. Translation, validation, and norming of the Dutch language version of the SF-36 Health Survey in community and chronic disease populations. J Clin Epidemiol 1998;51:1055-1068.

14. Zigmond AS, Snaith RP. The hospital anxiety and depression scale. Acta Psychiatr Scand 1983;67:361-370.

15. Speckens AE, Spinhoven P, Sloekers PP, Bolk JH, van Hemert AM. A validation study of the Whitely Index, the Illness Attitude Scales, and the Somatosensory Amplification Scale in general medical and family practice patients. J Psychosom Res 1996;40:95-104.

16. Van Hemert AM, Hengeveld MW, Bolk JH, Rooijmans HG, Vandenbroucke JP. Psychiatric disorders in relation to medical illness among patients of a general medical out-patient clinic. Psychol Med 1993;23:167-173.

17. Wing JK, Babor T, Brugha T, Burke J, Cooper JE, Giel R et al. SCAN. Schedules for clinical assessment in neuropsychiatry. Arch Gen Psychiatry 1990;47:589-593.

18. Cochran WG. Sampling techniques. Third edition. New York - London: John Wiley & Sons, Inc, 1997.