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Somatoform disorders in general practice.

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Chapter 7



Medically unexplained physical symptoms: the feasibility of group cognitive-behavioural therapy in primary care.

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Abstract

Objective The aim of this study was to estimate the number of patients with medically unexplained physical symptoms (MUPS) that could be eligible for group cognitive-behavioural treatment (CBT) and to assess the acceptability of this treatment.

Methods For three months, all consultations of one general practitioner (GP) were screened for MUPS. Patients with MUPS who were considered eligible for group CBT were interviewed and offered treatment.

Results From January to March 1999, 1084 consultations of 796 patients were screened. The GP classified the symptoms of 104 patients aged 25-79 as unexplained. Of these, 71 patients were not considered to be eligible for treatment, mainly due to a psychological attribution of the symptoms. The research interview was offered to 33 patients, 16 of them declined and 12 were interviewed. Seven out of the 12 eligible patients accepted treatment.

Conclusion In primary care, 18% of patients aged 25-79 years was estimated to have MUPS. For only a minority of these patients group CBT was considered suitable and acceptable.

Introduction

Medically unexplained physical symptoms (MUPS) are considered to be an important problem in primary care. Fink et al.¹ reported the prevalence of MUPS in a general practice population of 18-65 years to be 30%. De Waal et al.² found a prevalence of 16% in a population aged 25-79, with a difference in prevalence for the age categories 25-45, 45-65 and 65-79 years (respectively, 22%, 15% and 5%).

In secondary care, cognitive-behavioural treatment (CBT) is a well-established treatment for different kinds of MUPS, such as fatigue, irritable bowel syndrome and fibromyalgia.^{3 4 5 6} In a randomised controlled trial, we conducted in newly referred general medical patients with heterogeneous MUPS, CBT was also demonstrated to be effective.⁷ Contrary to the widely held belief that patients presenting with MUPS do not readily accept psychological treatment, to the majority of the patients in secondary care CBT appeared to be acceptable.⁸ Because MUPS are not uncommon in primary care and some authors advocate treating MUPS in a primary rather than secondary setting, we were interested to know whether our treatment for MUPS, which had been demonstrated to be acceptable and effective in secondary care, would have similar applicability in primary care. The aim of this study was to estimate the number of patients that would be eligible for CBT for MUPS in primary care and to assess its acceptability in this setting, using the same methodology and procedure as we did in secondary care.⁷ We chose to offer group CBT because this seemed to be easier to deliver in primary care than individual treatment.

Method

Study population

The study population consisted of patients visiting one general practitioner (GP), who worked with two colleagues in a group practice in Leiderdorp, the Netherlands. The practice provides health care to a population of 5120 participants. Recruitment took place from January to March 1999 and was restricted to patients of Dutch nationality between 25 and 79 years old, and who consulted the GP at least once in the given period.

Procedure

Initially, the computerized medical files of the patients were examined by an independent research psychiatrist (AS) to exclude all patients whose symptoms were explained by a well-defined somatic illness. Subsequently, the GP classified the

presenting symptoms of the remaining patients as medically explained or unexplained using the International Classification of Primary Care (ICPC).⁹ The classification ‘medically unexplained’ was defined as “presenting with at least one symptom without any objective pathological finding that could account for it”.^{10 11} All patients whose symptoms were classified as medically unexplained were contacted by one of the GPs and asked if they still had symptoms. Patients who reported symptoms that they judged as distressing were asked if they were willing to participate in a treatment study. In accordance with the selection criteria of our previous study, we restricted inclusion in the study to those patients who considered a somatic attribution of their symptoms. Patients currently undergoing psychological treatment were excluded, as were those with hearing problems, cognitive impairments or major psychiatric disorders, such as psychosis or severe personality disorders as defined by DSM-IV.¹² Patients who were interested in participating were interviewed at home.

Assessment

During the interview, information was gathered about the frequency (never, rarely, sometimes, often, always) and intensity (visual analogue scale (VAS) from 0, *no symptoms*, to 10, *unbearable symptoms*) of the physical symptoms. In addition, the following questionnaires were completed: The Hospital Anxiety and Depression Scale (HADS) to assess psychological distress (range 0-42)^{13 14} and the Physical Symptoms Checklist (PSC) to measure the number and frequency of somatic symptoms (range 0-55).¹⁰

Acceptability of group CBT

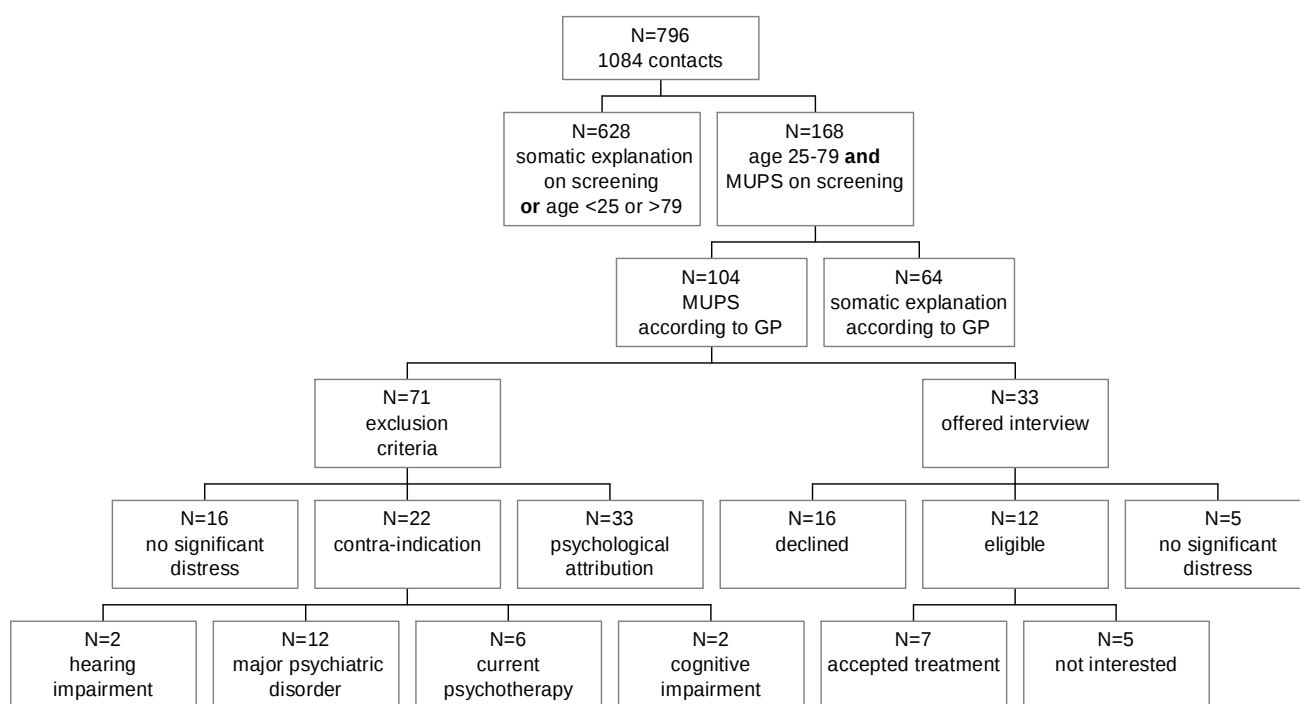
Patients whose symptoms had been present for at least 6 months and had an intensity of at least five were offered cognitive-behavioural group treatment for their symptoms. The rationale that was provided was similar to the one used in our previous study in secondary care and delivered by the same person (AS). Illness-related beliefs, behaviours and social interactions were labelled as consequences of the physical symptoms rather than possible aetiological factors. It was explained that treatment was aimed at breaking the vicious circles of physical symptoms and their consequences. Treatment would consist of 12 weekly sessions of 90 min in a nearby Primary Care Centre. Some of the therapeutic techniques used would be identifying and challenging negative automatic thoughts, activity scheduling and relaxation exercises.

Results

Prevalence of MUPS

From January to March 1999, the GP was consulted 1084 times by 786 patients, 74% of whom were estimated to be in the age range 25 to 79 years.¹⁵ The researcher (AS) selected 224 contacts of 168 patients between 25 and 79 years of age whose physical symptoms were possibly unexplained. The GP classified the symptoms as explained in 64 and as unexplained in 104 patients. In the age range of 25 to 79 years, the estimated prevalence of MUPS in consulting patients was 18% (104/589). The average age of the patients diagnosed with MUPS was 47 years (S.D. = 13.6). An overview of the selection procedure is presented in figure 1.

Figure 1. Selection procedure.



Eligibility and acceptability of group CBT

Of the 104 patients with MUPS, 71 met exclusion criteria for the research interview (figure 1). For 16 patients, their symptoms were not particularly distressing. Two patients had cognitive impairments and two had a hearing impairment. Thirty-three attributed their symptoms to a psychological cause and 6 received psychological treatment. Twelve patients were diagnosed with a major psychiatric disorder such as psychosis or severe personality disorder. Of the 33 patients who were contacted by their GP to ask if they were interested in treatment, 16 indicated that they were not

interested. The patients who declined gave various reasons, such as lack of time or because they had accepted their symptoms as a part of their life. Out of the 17 interviewed patients, 5 did not fulfil the criteria regarding the intensity or duration of the symptoms and 12 were eligible for treatment. Three of these were not interested in treatment after all, 2 objected to group therapy but indicated that they were willing to receive individual treatment by their GP and 7 patients were willing to participate in the group CBT.

Participants in the intervention

The average age of the 7 patients who participated in group therapy was 60 years, and all were female. They had suffered from MUPS for many years, causing significant impairments in their daily lives. In addition, virtually all participants had comorbid somatic diagnoses, such as osteoarthritis. On the VAS, the patients rated a mean intensity of 6.6 (S.D. = 1.4). On the HADS, they scored a mean of 14.9 (S.D. = 8.9), and on the PSC, 16.2 (S.D. = 7.3) symptoms. In the study that we carried out in secondary care⁷, the mean scores on the VAS, HADS and PSC for intervention patients were lower: respectively, 5.1, 12.2 and 12.9. The five nonparticipants and seven participants seemed to be quite similar in terms of physical and psychological symptoms, although the nonparticipants appeared to be substantially younger (40 years, S.D. = 19.5) than the participants were (60 years, S.D. = 8.4). Table 1 presents the age and gender of the four groups of patients with MUPS.

Table 1. Age and gender of four groups of patients with MUPS in the selection process for group therapy.

	Number of patients	Mean age in years (sd)	Gender	
			M	F
MUPS according to the general practitioner	104	47 (13.6)	17 (32%)	36 (68%)
Eligible	12	52 (16.9)	1 (8%)	11 (92%)
Eligible, accept treatment	7	60 (8.4)	0 (0%)	7 (100%)
Eligible, nonacceptance	5	40 (19.5)	1 (20%)	4 (25%)

Discussion

Through systematic selection, we estimated the prevalence of MUPS in a consulting primary care population to be 18% in patients aged 25-79 years. After applying the same in- and exclusion criteria we used for our previous trial of CBT for MUPS in a

secondary care setting⁷, only 12 patients out of the 104 were eligible for treatment, of which only 7 were willing to accept CBT for their symptoms.

Two thirds of the 104 patients with MUPS in primary care did not meet the criteria for treatment. The main reason for not being invited for the research interview was a psychological attribution of their symptoms. This criterion was taken from the DSM-IV definition of somatoform disorders, where symptoms suggesting a medical condition but where no medical condition can be found are given as a key feature of somatoform disorders. Obviously, CBT might have been suitable for some of the patients with a psychological attribution of their symptoms, and those receiving psychological treatment may actually have undergone CBT. A similar argument could apply to those excluded because of a major psychiatric disorder.

Another reason for not being invited for the research interview was lack of severity of their symptoms. However, the majority of the patients whose symptoms were considered to be reasonably distressing still refused to participate in the research interview, and the most frequent reason given for this was lack of time and acceptance of their symptoms as part of life. It is possible that patients with MUPS presenting in primary care are different from those presenting in secondary care.

Finally, it cannot be excluded that some patients did not accept the rationale that we offered for CBT or possibly did not like the group approach. The treatment rationale provided during the research interview, however, was similar to the one successfully used in our previous study in secondary care and was delivered by the same person.^{7 8} Only two eligible patients explicitly preferred individual treatment to group therapy.

In summary, using the similar methodology and procedures as in previous studies^{7 10}, the prevalence of MUPS in primary care seems to be lower than in secondary care. CBT does not seem as suitable and acceptable to patients in this setting. Our findings emphasise the importance of developing suitable treatments to deliver in primary care. Given the fact that quite a few patients indicated that they did not have time to participate in the treatment, one of the possibilities that might be worth pursuing is more flexible forms of treatment, such as self-help or computerised CBT.

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References

1. 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;40:330-8.
2. De Waal MWM, Arnold IA, Eekhof JAH, Van Hemert AM. Somatoform disorders in general practice: prevalence, functional limitations and co-morbidity with anxiety and depressive disorders according to DSM-IV. *Br J Psychiatry* 2004;184:470-6.
3. Kroenke K, Swindle R. Cognitive-behavioral therapy for somatization and symptom syndromes: a critical review of controlled clinical trials. *Psychother Psychosom* 2000;69:205-15.
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;325:1082-93.
5. Nezu AM, Nezu CM, Lombardo ER. Cognitive-behaviour therapy for medically unexplained symptoms: a critical review of the treatment literature. *Behav Ther* 2001;32:537-83.
6. Looper KJ, Kirmayer LJ. Behavioral medicine approaches to somatoform disorders. *J Consult Clin Psychol* 2002;70:810-27.
7. Speckens AEM, van Hemert AM, Spinhoven P, Hawton KE, Bolk JH, Rooijmans HGM. Cognitive behavioural therapy for medically unexplained physical symptoms: a randomized controlled trial. *BMJ* 1995;311:328-32.
8. Speckens AEM, 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;39:855-63.
9. Lamberts H, Wood M. International classification of primary care (ICPC). Oxford Univ. Press: Oxford, 1990.
10. 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;23:167-73.
11. Reid S, Crayford T, Richards S, Nimnuan C, Hotopf M. Recognition of medically unexplained symptoms-do doctors agree? *J Psychosom Res* 1999;47:483-5.
12. American Psychiatric Association. Diagnostic and statistical manual of mental disorders, 4th ed. Washington D.C.: APA, 1994.
13. Zigmond AS, Snaith RP. The Hospital Anxiety and Depression Scale. *Acta Psychiatr Scand* 1983;67:361-70.
14. Spinhoven P, Ormel J, Sloekers PP, Kempen GI, Speckens AEM, Van Hemert AM. A validation study of the Hospital Anxiety and Depression Scale (HADS) in different groups of Dutch subjects. *Psychol Med* 1997;27:363-700.
15. Verheij RA, Jabaaij L, Abrahamse H, Van den Hoogen H, Braspenning J, Van Althuis T, Rutten R. Annual report 2002. In: National Information Network of GPs. Facts and Figures of General Practice: LINH. Available at: <http://www.linh.nl/jaarcijfers> 2002

