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## **Somatoform disorders in general practice.**

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# Chapter 8



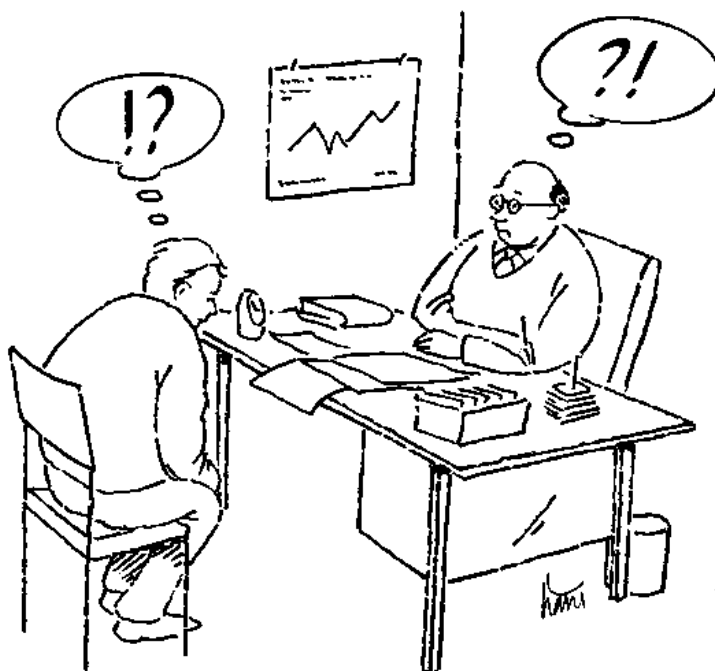
Cognitive-behavioural treatment of unexplained physical symptoms with a generic model: changing illness behaviour in general practice.

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Submitted as editorial

Illustrations: Hans Borkent (patient folder, 2001)

It is essential for doctors to aim at decreasing the medical consequences of unharmed bodily sensations. Almost one third of all patients presenting to general practitioners suffer from physical symptoms without adequate somatic explanations.<sup>1 2</sup> In secondary care the numbers of patients with unexplained physical symptoms are even higher, between 52 and 66%.<sup>3 4</sup> Patients expect doctors to explain and treat their symptoms, whereas doctors often cannot explain the symptoms and are not prepared to treat illness without a diagnosis.



Besides help-seeking behaviour, persisting unexplained physical symptoms often lead to significant impairments in daily functioning. Since these symptoms are so common and impose a major pressure on health care, a professional opinion on prevention and treatment is crucial. Concern about the magnitude of the problem has been expressed and specialist interventions with cognitive behaviour therapy have proven beneficial for referred patients. However, few adequate protocols to tackle this enormous problem in primary care have been developed. We propose to use the consequences model for an integrative approach.

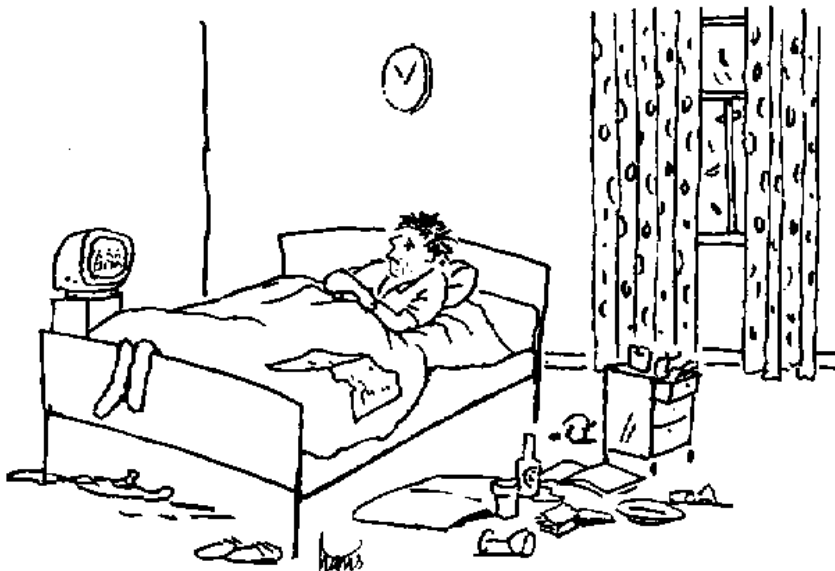
Since cognitions and illness behaviour are important factors in the translation of bodily sensations into functional limitations, it is not surprising that cognitive-behavioural interventions have shown to be effective.<sup>5 6 7 8</sup> Reattribution has some promise in primary care<sup>9 10</sup>, but is not feasible if the patient does not experience psychological problems. Many patients know that they have to change the way they

cope with their symptoms but do not know how. To achieve more permanent changes in illness behaviour, techniques aimed at modifying inappropriate behaviour could add to the effect of a cognitive intervention. A biopsychosocial model as described by Sharpe e.a.<sup>11</sup> to treat unexplained physical symptoms may serve as the conceptual base for such an intervention. The central idea of the approach is to focus on consequences rather than on causes of symptoms, providing an opportunity to treat physical symptoms without fruitless discussions of causes. The approach can be used if reattribution is not applicable for the patient, and is also effective in the treatment of somatic symptoms with a known cause such as rheumatoid arthritis<sup>12</sup> or ischaemic heart disease<sup>13</sup>. In fact, the consequences model we propose may be useful in all situations in which the symptoms experienced by the patient are not in keeping with medical findings.

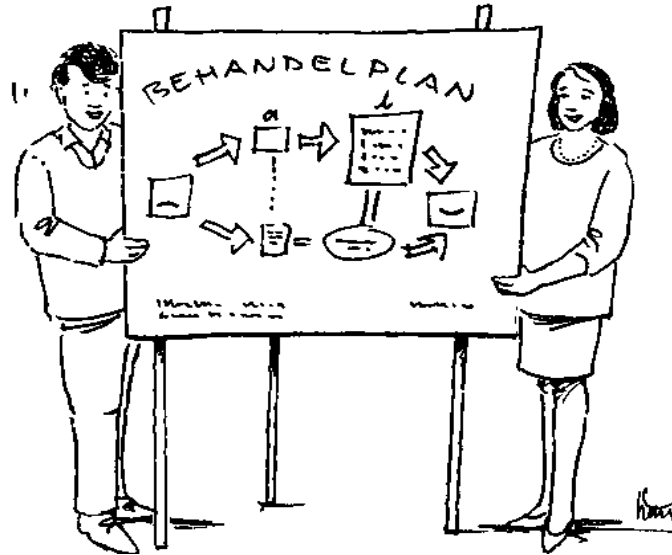


Persistent unexplained physical symptoms start with the patient's perceiving physiological bodily sensations. Interpretation and appraisal of these unharmed symptoms is complex and depends on personal factors such as cognitions about health and contextual cues. Several consequences can be recognized: 1) Cognitive consequences of symptoms such as preoccupation and selective attention lead to an increase in worrying and the awareness of physical symptoms. Catastrophic thinking about the potentially harmful origin of bodily sensations induces fear and results in new symptoms or a lower threshold for symptom perception. 2) Fear of a major illness may have emotional consequences such as anxiety. Emotional distress in itself

frequently produces body sensations, which in turn lead to more concern with disease. 3) Physical consequences are due to increased muscle tension, loss of physical condition because of inactivity and physiological stress reactions. The resulting pain, shaking, sweating, dizziness, palpitations, dyspnoea or fatigue may frequently aggravate the original symptoms. 4) Behavioural consequences often include various avoidance strategies for fear of provoking symptoms. A decrease in activities may lead to physiological changes, with pain or fatigue as a result. If symptoms are interpreted as potentially harmful, patients may consult their general practitioner. 5) Medical consequences may include an inappropriate focus of the general practitioner on identifying serious disease and carrying out diagnostic tests. In this stage reassurance is usually given sparsely, because doctors are always on guard for unexpected serious disease. The next step may be a referral to secondary care where the focus is almost exclusively on 'real' diagnoses. At the end of the medical path a patient who has a lot of symptoms and is impaired in his daily functioning often finds himself without any diagnosis or treatment. Severe impairments as a consequence of unexplained physical symptoms are also recognised in medical classifications such as the somatoform disorders in DSM-IV. 6) Finally, there will be social consequences when certain tasks, such as taking care of children or working, cannot be accomplished. Patients may avoid social contacts and become isolated, further contributing to their emotional distress.



Cognitive and behavioural techniques in the consequences model aim at changing the consequences of the symptoms. A good working relationship with the patient should be established first. It is vital that the patient collaborates in order to achieve changes in illness behaviour.



The general practitioner should give a physiological explanation for symptoms whenever possible and acknowledge that the symptoms are real for the patient. Since the cause of the symptoms is unknown the patient can only expect to benefit if the negative consequences of the symptoms decrease. One of the central tasks is to agree on a new important and realistic goal. To prevent disappointment it is necessary to make clear that the efforts are primarily focused on reducing disability and that a total relief of symptoms is not always attainable. Many patients will have reduced their activities and need explicit advice about a planned and graded increase in activities. On the other hand, most patients are not aware of an increased muscle tension and have to be instructed on how to relax. Another important step in changing illness behaviour is modification of cognitions. Many patients believe that bodily sensations always signify danger; this cognition induces emotional, behavioural and new physical responses. Thus, negative thoughts interfere with daily activities and may impede progress. Changing these dysfunctional cognitions may relieve anxiety and improve adequate coping.

There is one obstacle that may prove the most difficult to overcome: doctors worry about missing a diagnosis and could be prosecuted for it. This may be the reason why so many patients with unexplained physical symptoms have a 'diagnosis' of a

functional syndrome. Each specialty seems to have at least one<sup>14</sup>: for example, rheumatology has fibromyalgia and gastroenterology has the irritable bowel syndrome. On the other hand overdiagnosis, overtreatment and a lack of adequate communication usually make symptoms worse. Protocols for unexplained physical symptoms would provide safeguards for missing diagnoses, as would guidelines that take into account the pros and cons of diagnostic tools. They might prevent irrational searches for explanations and support doctors if they are restrictive in diagnostic procedures. Better communication skills to deal with the patients' and the doctors' own worries about serious diseases would improve mutual understanding.

We assume that a short cognitive-behavioural treatment may be carried out successfully by the general practitioner in patients experiencing physical problems that have existed for a relatively short period and have led to substantial impairments. These patients are mostly highly motivated to change their behaviour and to carry out homework exercises.



Chronic patients with several long-lasting physical and psychosocial problems may be more difficult to treat. It is essential to check their ability and motivation to actually change their behaviour.

As the average patient visits the general practitioner five times a year a switch in approach - from searching for causes to treating the consequences - need not take extra time. Activity planning, changing cognitions and relaxation training are techniques easily acquired by general practitioners and feasible in daily practice. The ultimate purpose of the treatment is that patients learn to cope more adequately with their symptoms and become less dependent on their general practitioner.

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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. Katon WJ, Walker EA. Medically unexplained symptoms in primary care. *J Clin Psychiatry* 1998;59 Suppl 20:15-21.
3. 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.
4. Nimnuan C, Hotopf, Wessely S. Medically unexplained symptoms: An epidemiological study in seven specialities. *J Psychosom Res* 2001;51:361-7.
5. 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;311:1328-32.
6. Kroenke K, Swindle R. Cognitive-behavioural therapy for somatization and symptom syndromes: a critical review of controlled clinical trials. *Psychother Psychosom* 2000;69:205-15.
7. Nezu AM, Nezu CM, Lombardo ER. Cognitive-behaviour therapy for medically unexplained symptoms: a critical review of the treatment literature. *Behaviour Therapy* 2001;32:537-83.
8. Looper KJ, Kirmayer LJ. Behavioral medicine approaches to somatoform disorders. *J Consult Clin Psychol* 2002;70:810-27.
9. Morriss RK, Gask L. Treatment of patients with somatized mental disorder: effects of reattribution training on outcomes under the direct control of the family doctor. *Psychosomatics* 2002;43:394-9.
10. Fink P, Rosendal M, Toft T. Assessment and treatment of functional disorders in general practice: the extended reattribution and management model--an advanced educational program for nonpsychiatric doctors. *Psychosomatics* 2002;43:93-131.
11. Sharpe M, Peveler R, Mayou R. The psychological treatment of patients with functional somatic symptoms: a practical guide. *J Psychosom Res* 1992;36:515-29.
12. Sharpe L, Sensky T, Timberlake N, Ryan B, Brewin CR, Allard S. A blind, randomized, controlled trial of cognitive-behavioural intervention for patients with recent onset rheumatoid arthritis: preventing psychological and physical morbidity. *Pain* 2001;89:275-83.
13. Lewin RJ, Furze G, Robinson J, Griffith K, Wiseman S, Pye M et al. A randomised controlled trial of a self-management plan for patients with newly diagnosed angina. *Br J Gen Pract* 2002;52:194-201.
14. Wessely S, Nimnuan C, Sharpe M. Functional somatic syndromes: one or many? *Lancet* 1999;354:936-9.



