

Effect of Comorbid Anxiety, Depressive, and Personality Disorders on Treatment Outcome of Somatoform Disorders

Rolf Leibbrand, Wolfgang Hiller, and Manfred M. Fichter

Comorbid mental disorders of DSM-IV axis I and axis II have repeatedly been found to be a negative predictor for the treatment of axis I disorders, although recent contrary findings exist. Little is known about the effect of comorbidity on the therapy outcome of somatoform disorders. We compared three types of comorbidity, (1) personality disorders (PDs), (2) major depression (MDD) and anxiety (ANX) disorders, and (3) PDS and MDD and ANX, with regard to their relevance for the treatment outcome of somatoform disorders. One hundred twenty-six inpatients were assessed at least

4 weeks before admission to treatment, upon admission, and again at discharge. Somatoform, hypochondriacal, and depressive symptomatology, dysfunctional cognitions about body and health, dysfunctional social relationships, and other clinical characteristics were measured. Diagnostic assessments were based on the DSM-IV. Our findings suggest that none of the three types of comorbidity influence the therapy outcome of somatoform disorders or have a modifying effect on the level of psychopathology.

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TREATMENT OF SOMATOFORM disorders, particularly somatization disorder, is regarded as difficult and ineffective, since many investigators believe that these are chronic and resistant to change.¹ Moreover, some have discussed somatization disorder as a type of personality disorder (PD) because of these characteristics.² Recent findings, though, suggest that a clear and stable improvement of somatization symptoms may be attained by cognitive-behavioral therapy programs in primary care patients, as well as inpatients with severe and chronic somatoform disorders.³⁻⁵

Little is known about the influence of comorbidity in somatoform patients, although high rates of comorbid depressive and anxiety (ANX) disorders⁶⁻⁸ and PDs⁹ were found in most studies. Comorbidity of multiple mental disorders in the same patient indicates a wide and complex spectrum of psychopathology that is often chronic. Since symptoms of co-occurring disorders may interact (e.g., a major depression that is maintained by a lack of positive activities caused by a somatization disorder), higher symptom levels and a worse treatment outcome for the target disorder might be the consequence.

In DSM-IV,¹⁰ PDs are diagnosed independently on a separate axis II, since their relationship to other mental disorders coded on axis I is not clear. They are characterized as deep-rooted, chronic, and generalized, and their treatment is regarded as difficult and problematic.¹¹ As a consequence, they might have particularly negative effects on the treatment of other disorders. Results of early studies on depression, ANX, and obsessive-compulsive disorder suggest that patients with additional PDs have a poorer treatment outcome than those without comorbid axis II disorders.¹² However, these

findings may be the result of the assessment methods (e.g., no structured diagnostic interviews) and small patient samples. Recent studies found little or no negative effects of PDs on treatment results, especially when a cognitive-behavioral psychological treatment was applied.¹³⁻¹⁵ However, in most studies, patients with comorbid PDs showed higher levels of general psychopathology at the beginning of treatment.¹⁴ In comparison, few studies exist for the effect of comorbid axis I disorders on the treatment of other specific axis I disorders. Only the comorbidity of major depression (MDD) and ANX has been assessed repeatedly and is reported to result in a poorer therapy outcome.¹⁶⁻¹⁸ However, a combination of both comorbid MDD and ANX in other disorders is an indicator of severe and generalized psychopathology and might have negative effects on the treatment outcome of somatoform disorders, as well as comorbid PDs. Since both types of comorbidity in combination with a primary somatoform disorder represent a very complex and interdependent symptomatology, it could be difficult or even impossible to focus on specific parts of the pathology. A poorer therapy outcome for somatoform disorders with any type of severe comorbidity might be the consequence.

To obtain more information about the effects of comorbidity of axis I (ANX and MDD) and axis II

From the Klinik Roseneck Center for Behavioral Medicine, Prien; Department of Psychiatry, University of Munich, Munich; and Department of Clinical Psychology, University of Mainz, Mainz, Germany.

Address reprint requests to Rolf Leibbrand, Ph.D., Psychologisches Institut der Universität Mainz, Abteilung Klinische Psychologie, Staudinger Weg 9, D-55099, Mainz, Germany.

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0010-440X/99/4003-0012\$10.00/0*

disorders on the treatment outcome of somatoform disorders and to compare these two comorbidity types, we investigated two questions. First, we analyzed whether there are any differences in general symptomatology between groups with different types of comorbidity of axis I and axis II disorders at the beginning of treatment, and which combination of comorbid disorders is related to the highest levels of psychopathology. Second, we investigated whether there are any differences with respect to treatment effects between groups with different types of comorbidity, and which combination of comorbid disorders best predicts the therapy outcome.

METHOD

Subjects

We investigated a sample of 126 inpatients consecutively admitted to the Klinik Roseneck Center for Behavioral Medicine in Prien, Germany. Hospitals of such type in Germany are part of the general healthcare system, specializing in the predominantly psychotherapeutic (but also medical and physiotherapeutic) treatment of patients with multiple and chronic mental disorders that are too severe for outpatient treatment. Patients with schizophrenia and patients with primary alcohol or substance use disorders were excluded from the study, because they are generally not admitted for treatment at Klinik Roseneck. All patients received the cognitive-behavioral-oriented standard treatment of our clinic to produce homogeneous therapies. It consists of individual therapy (partly based on standardized guidelines for the treatment of somatoform disorders) and problem-focused group therapy sessions, as well as standardized therapy programs focusing on specific parts of the psychopathology (e.g., pain, depression, or anxiety) and further psychotherapeutic and physiotherapeutic treatments. Therapy for each patient was planned by an experienced psychotherapist on the basis of diagnostic assessment and behavior analysis and was regularly supervised. Results of the standardized diagnostic assessments conducted in the course of this study were used as additional information by the therapists, and treatment was modified accordingly if necessary. However, heterogeneity of the treatments was limited by the standardized components described and the supervision of all therapies.

All subjects participated voluntarily in the study after provision of informed consent.

Assessments

The patients completed a battery of self-rating scales to measure different aspects of the general symptomatology at least 4 weeks before treatment and at the beginning and end of treatment, and a diagnostic interview for DSM-IV axis I and axis II was conducted immediately after hospital admission. Somatoform symptoms were measured by a modified version of the Screening for Somatoform Symptoms (SOMS-7),¹⁹ a 53-item self-rating scale that includes all somatoform complaints listed in the DSM-IV and ICD-10. The patients also completed the Whiteley Index,²⁰ a 14-item scale to measure hypochondriasis, the Beck Depression Inventory (BDI),²¹ the Symptom Checklist

(SCL-90R),²² and the Dysfunctional Analysis Questionnaire (DAQ),²³ a 45-item five-point scale to measure the perceived state of functioning on five subscales, social, vocational, personal, familial, and cognitive disabilities. It was standardized in studies with somatoform and other mental disorders in India. Furthermore, a newly developed 48-item self-rating scale, the Cognitions About Body and Health Questionnaire (CABAH),²⁴ was used to measure dysfunctional cognitions about body and health. It consists of five subscales, measuring catastrophizing cognitions, intolerance of bodily complaints, bodily weakness, autonomic sensations, and health habits with 48 items. It was evaluated in a sample of 484 inpatients; the results show positive correlations with other measures of somatoform disorders and specifically increased mean scores for somatoform patients compared with clinical and healthy controls in four of five subscales. For the diagnostic assessments, two clinically experienced interviewers were trained using the Structured Clinical Interview for DSM-IV Axis I Disorders²⁵ and Personality Disorders,²⁶ as well as the International Diagnostic Checklists (IDCL)²⁷ and IDCL for Personality Disorders (IDCL-P).²⁸ The IDCL are interview checklists available for DSM-IV and ICD-10 that are recommended by the World Health Organization to obtain reliable and valid diagnoses. They were used in all interviews to simplify the diagnostic procedure and to guarantee a high level of diagnostic quality. To control for severe depression and the effects of acute symptomatology on diagnosing PDs,²⁹ the diagnostic interviews of axis II were not conducted until 4 weeks after admission to treatment, and depressive symptomatology was measured by the Depression Status Inventory ([DSI] expert version).³⁰ One subject with somatization disorder who scored higher than 60 on the DSI by this time (which is the proposed cutoff for medium to severe depression) was excluded from the study.

Definitions

In addition to somatoform disorder categories provided by the DSM-IV, the Somatic Symptom Index (SSI 4/6),³¹ with at least four somatoform symptoms for men and six for women, was applied to include clinically relevant somatoform syndromes below the threshold of somatization disorder; it also served as a cutoff for the diagnosis of somatization syndrome.

Group Definition

Since the focus of this study was to compare different types of comorbidity, we decided not to subclassify somatoform disorders. Although the somatoform disorders are a heterogeneous group, one common characteristic is that all disorders are related to bodily symptoms and a preoccupation with or misinterpretation of these symptoms. Moreover, 86 of 95 patients with somatoform disorders in our sample had a diagnosis of somatization disorder or SSI 4/6 somatoform syndromes, both defined by multiple unexplained bodily complaints. Hence, a classification of all patients with somatoform disorders together in one somatoform group seems justified. According to the combination of axis I and axis II diagnoses for each patient, the sample was divided into five subgroups: (1) somatoform patients with minor axis I comorbidity, i.e., no combination of MDD and ANX, (2) somatoform patients with comorbid MDD and any specific ANX, (3) somatoform patients with comorbid axis II disorders but minor axis I comorbidity, (4) somatoform patients with comorbid MDD and any specific ANX and any PD, and (5) nonsomatoform controls with minor morbidity of axis I (i.e., no

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