

Consultation-Liaison Psychiatrists' Management of Somatoform Disorders

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The authors studied interventions recommended by consultation-liaison (C-L) psychiatrists when they diagnosed somatoform disorder prospectively in a cohort of 4,401 consecutive inpatients referred to the C-L psychiatry service of a general teaching hospital, using standardized MICRO-CARES methodology. A DSM-III-R somatoform disorder was diagnosed in 2.9%, somatoform pain disorder in 1.4%, conversion disorder in 0.7%, hypochondriasis or somatization disorder undifferentiated/not otherwise specified in 0.6%, and somatization disorder in 0.2%. In 3.4%, somatoform disorder was considered a differential diagnosis. Psychiatric comorbidity included mood disorder (39%), personality disorder (37%), and psychoactive substance use disorder (19%). Recommendations were made about antidepressants in 40% of the patients, anxiolytics in 18%, sedatives in 18%, and antipsychotics in 10%. Psychiatrists recommended the following: more laboratory tests for 14%; additional medical/surgical consultations for 11%; an increase in the vigor of medical treatment for 13%; and psychological treatment for 76%; also they stressed an earlier discharge of 16%. Psychiatrists were more likely to request a prolongation of inpatient stay for patients with comorbid somatoform, mood, anxiety, and personality disorder. Differences in characteristics and treatment of the subgroups tended to be consistent with their constructs and comorbid psychiatric diagnoses. (Psychosomatics 2000; 41:481–489)

Somatization is a phenomenon encountered in much of inpatient consultation-liaison (C-L) psychiatry work. Lipowski¹ originally postulated a continuum of somatization reactions from the “conversion and hypochondriacal disorders” to the “psychophysiological disorders.” The somatic components of anxiety disorders, depression, sleep disorders, eating disorders, and sexual function all came within Lipowski’s concept of somatization, as did factitious disorders. Data derived from studies in primary care confirm the validity of this broad conceptualization. Somatic symptoms are the most common presentation of psychiatric distress in primary care, and this appears to be independent of physical health status.² Somatic symptoms, irrespective of etiology, have a strong association with psy-

chiatric morbidity.³ The DSM-III-R classification,⁴ used in this study, does not adequately address the high prevalence, complexity, and functional importance of somatization,⁵ nor does the DSM-IV. The DSM classifications allow identification of pure somatizers but not those who somatize their presentations of anxiety and depression. These are distinct populations.⁶ The DSM classifications do not con-

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tain the category "neurasthenia" and provide only in the most general way for the construct of "medically unexplained symptoms." These are important constructs in the international conceptualization of somatization.³

Somatization as a phenomenon is extremely important for primary care doctors and C-L psychiatrists alike, far beyond the disorders so narrowly defined in the DSM classification. Up to 17% of primary care patients have impairing, subsyndromal somatoform disorder.^{5,6} Barsky et al.,⁷ based on their 5-year follow-up, concluded that hypochondriasis carries a very substantial long-term burden of morbidity, functional impairment, and personal distress. Perhaps as a result of the inadequacy of definition and conceptualization of patients with somatization, there is little to guide its management except consensus opinion. There are no formal practice guidelines for a somatoform disorder, except as implied in those for the management of cancer pain published by the Agency for U.S. Health Care Policy and Research⁸ and for chronic pain published by The American Society of Anesthesiologists.⁹

The Quality Assurance Project of the Royal Australian and New Zealand College of Psychiatrists¹⁰ established some preliminary treatment outlines for the management of somatoform disorders, using the following three sources of information: the treatment outcome literature, the opinions of a sample of practicing psychiatrists, and the views of a panel of nominated experts. The recommendations were as follows: for hypochondriasis—brief dynamic psychotherapy, family therapy, and excellent medical consultation; for somatization disorder—limited supportive psychotherapy and good medical consultation; and for psychogenic pain disorder—symptom relief, psychotherapeutic support, and meticulous collaboration with physicians. Those working on the project stated that physiotherapy to improve physical functioning and patient education to facilitate the distinction between normal symptoms and abnormal illness behaviors are important in all three conditions.

The few controlled trials of psychotherapy that have been reported subsequently begin to provide the basis for substantial guidelines. These have concerned cognitive therapy for medically unexplained symptoms,¹¹ for chronic fatigue syndrome,¹²⁻¹⁵ for hypochondriasis,^{16,17} and for noncardiac chest pain.¹⁸ They also include dynamic interpersonal psychotherapy for irritable bowel syndrome¹⁹ and group therapy for somatization disorder²⁰ and for irritable bowel syndrome.²¹ Trials of medication in fibromyalgia²² and of systemic intervention^{23,24} have been reported. Further views of experts have been published.²⁵⁻²⁷

Our study is an example of the third type of data gathering used by the Quality Assurance Project, a sampling of psychiatrists' practice, which is important in providing valuable information about what psychiatrists do when they make specific diagnoses.²⁸ Reliable documentation of the types of diagnoses made and interventions recommended when experienced C-L psychiatrists diagnose somatoform disorders will be an important part of the process of developing guidelines in this field. Here we report such data, as we have done previously for organic mental disorder,²⁹ depression,³⁰ and adjustment disorder.³¹

The purpose of our study is to describe the interventions recommended by C-L psychiatrists when they make a diagnosis of somatoform disorder in referred inpatients. We also seek to determine whether or not the constructs of the DSM classification of this disorder are validated by usage in the field. We hypothesized that diagnosis of somatoform disorder comorbidly with other psychiatric diagnoses would significantly affect the treatment recommendations and the hospital process variables (e.g., length of stay, lagtime in referral, and time spent).³²

METHODS

We studied prospectively 4,401 consecutive inpatient referrals to the adult C-L psychiatry services of two metropolitan general teaching hospitals affiliated with Monash University, Melbourne, Australia, over a 5-year period (the "referred cohort"). At each hospital, consultant psychiatrists and psychiatry trainees rotate through the C-L psychiatry service, work in a mixture of liaison and consultation mode, and see referrals from medical, surgical, and specialty units including obstetrics and gynecology. Each hospital used the MICRO-CARES clinical database system routinely.^{33,34} Training and quality assurance processes to help ensure intrahospital reliability were common to each hospital, and interhospital reliability was addressed by having one of the authors (GCS) supervise the process in each hospital.³⁴

We collected the following data: 1) demographics; 2) reasons for referral and relevant problems as stated by the consultee (referring doctor) and by the consultant (psychiatrist)—up to 5 reasons/problems per patient; 3) DSM-III-R Axis I & II terminal diagnoses for the admission episode—up to 6 diagnoses per patient, confirmed (meets DSM-III-R criteria) or rule out (considered likely but does not reach criteria because of insufficient data, confounded by physical factors, or subthreshold status); 4) ICD-9CM physical diagnoses for the admission episode—up to 3 di-

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