Somatoform Disorders Among First-Time Referrals to a Neurology Service

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Consecutive new neurology inpatients and outpatients (N = 198) were assessed for somatoform disorders by using the Schedules for Clinical Assessment in Neuropsychiatry. Sixty-one percent of the patients (59% of the female patients and 63% of the male patients) had at least one medically unexplained symptom, and 34.9% fulfilled the diagnostic criteria for an ICD-10 somatoform disorder (27.7% of the male patients, 41.3% of the female patients, 20.5% of the inpatients, and 43.2% of the outpatients). The prevalence figures were about the same when DSM-IV criteria for somatoform disorders were used. Of the patients with a somatoform disorder, 60.5% also had another mental disorder. Somatization disorder, somatoform autonomic dysfunction, pain disorder, and neurasthenia were equally prevalent (6%–7%); dissociative (conversion) disorders and undifferentiated somatoform disorders were found in 2–3% of the patients. Fifty percent of the patients with somatoform disorders were identified by the neurologists.

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Mental disorders are highly prevalent among patients attending neurological services.[1–6] Patients presenting with physical symptoms not attributable to any known medical condition (i.e., functional or medically unexplained symptoms) are particularly common.[3,4,6–8] In ICD-10 and DSM-IV these conditions are classified mainly in the somatoform disorders group. In a study that used the same data set used in this study, somatoform disorders were the most prevalent psychiatric diagnoses among neurological inpatients and outpatients.[4] Little is known about the symptoms and types of somatoform disorders experienced by patients in neurological settings. In studies that have been conducted in this area, ICD-10 or DSM-IV criteria have not been used, or only one or a few of the diagnostic subcategories in the somatoform disorders group and not the whole diagnostic spectrum have been investigated.

The aims of this study were to determine the prevalence of medically unexplained symptoms and of somatoform and related disorders (classified according to ICD-10 and DSM-IV diagnostic subcategories) among new inpatients and outpatients seen in a neurological setting, determine the comorbidity of these disorders with other mental disorders, and assess whether somatoform and related disorders are diagnosed by neurologists.

METHOD

Inclusion

The study population included consecutive patients age 18 years or older referred for the first time to the neu-

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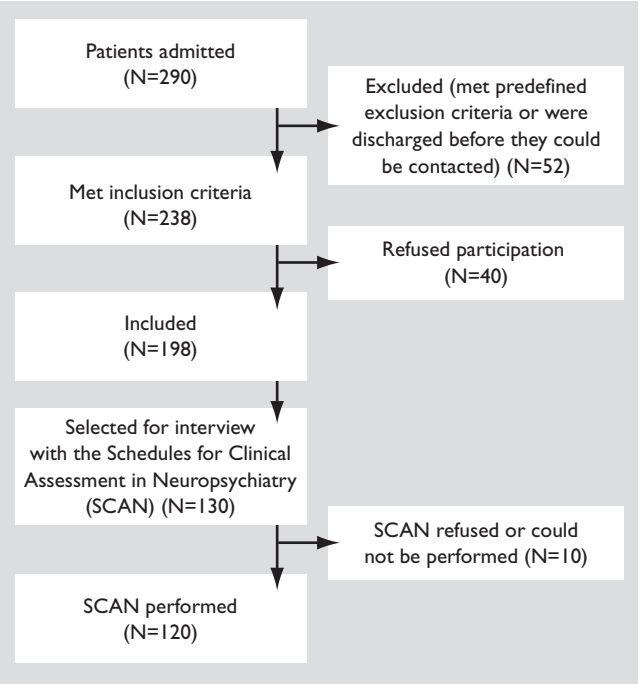
rological department of Vejle County Hospital, Vejle, Denmark, during a 3-month period in 1997. Only patients who had never previously been examined by a neurologist were eligible. The department provides all hospital-based neurological services for the general population of Vejle County, a total of approximately 356,000 inhabitants. The county is a mixed rural and urban area with four fairly large towns in which about one-half of the population is middle class. In total 290 patients were admitted either as inpatients or outpatients for the first time during the inclusion period (Figure 1). Excluded according to predefined criteria were patients who were not of Scandinavian origin (N = 5) and patients who could not be interviewed because they were too ill (N = 13) or because of deafness (N = 4), somnolence (N = 5), unconsciousness (N = 3), aphasia (N = 8), or disorientation (N = 3). In addition, 11 patients were discharged before a research worker could contact them. Forty patients refused to participate in the investigation. Thus, 198 patients were included.

The excluded patients were compared to the included patients on age, gender, and use of psychiatric and nonpsychiatric health care. These analyses, reported in a previous study,[4] showed only minor differences.

Table 1 summarizes the study subjects' sociodemographic and admission characteristics, and Table 2 lists their ICD-10 discharge diagnoses.

FIGURE 1. Sample Selection in a Study of Somatoform Disorders Among New Patients Seen in a Neurology Service



Procedure and Assessment

A two-phase design was used. At admission or first contact, all patients were interviewed by one of two research nurses. The interview included an eight-item version of the Symptom Check List (SCL-8d),[9] used to assess anxiety and depression, and the seven-item Whiteley index, which was slightly modified for use in the interview (available from the author on request). This scale measures illness worry and convictions about the presence of illness and has been shown to detect somatization.[10] The responses to each item were dichotomized.

Patients were selected in the following manner to undergo a diagnostic psychiatric interview. Patients with a score of 2 or more on the SCL-8d and/or 3 or more on the seven-item Whiteley index were considered high scorers. A random sample consisting of 50% of all patients was selected for psychiatric interview, and of the remaining 50% of patients, all high scorers were selected for the interview. Thus, a stratified subsample consisting of all patients with high scores and approximately one-half of the patients with low scores was selected. The psychiatric interview was conducted either during admission or at the first visit in the outpatient clinic. If the patient could not be interviewed in these settings, an appointment was made for the interview to take place as soon as possible after the first visit. Of the 130 patients selected for psychiatric interview, 10 refused to participate. Thus, 120 patients were interviewed.

The psychiatric interview was conducted with the Schedules for Clinical Assessment in Neuropsychiatry, version 2.1 (SCAN).[11] The SCAN interview is used to inquire about 76 physical symptoms in seven symptom groups. Each symptom is rated by the interviewer according to whether it can be attributed to a medical condition/dysfunction or not. Symptoms for which this distinction cannot be made reliably are rated with a separate code. In this study, we included in the analysis only those symptoms that were rated "definitely unexplained." The interviewers were free to explore aspects that were not fully clarified in the interview (e.g., by reviewing medical records or discharge letters). The interviewers met regularly during the course of the study to confer about specific cases and to discuss strategies for interpreting and rating ambiguous responses and symptoms that seemed to fall between the response categories. They were free to consult other physicians. The two SCAN interviewers, who had received psychiatric training during residency and who had been trained and certified at the World