Somatoform Disorder in Primary Care: Course and the Need for Cognitive-Behavioral Treatment

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Medically unexplained physical symptoms are prevalent in primary care. Of all patients attending the family physician, 16% have a somatoform disorder as described by DSM–IV. Cognitive-behavioral treatment has been demonstrated to be effective in secondary care. However, the course of somatoform disorders and their need for treatment have not yet been established in primary care. In this study, data from 1,046 attendees in family practice were analyzed for prevalence, course, and eligibility for treatment. Over a 6-month follow-up, the prevalence of somatoform disorder decreased from 16.1% to 12.3%. After assessment of eligibility, about 5% of patients demonstrated a need for treatment. (Psychosomatics 2006; 47:498–503)

Somatoform disorders are among the most prevalent psychiatric disorders in primary care. Recently, we reported a prevalence of 16.1% for DSM–IV somatoform disorders in a Dutch primary-care consulting population.[1] Most common was the undifferentiated somatoform disorder, with a prevalence of 13.1%. These patients suffer from one or more medically unexplained physical symptoms, such as fatigue, headache, or gastrointestinal symptoms, causing clinically significant impairment for at least 6 months. Earlier, Fink et al.[2] reported an even higher prevalence of somatoform disorders: 30%, in a Danish primary-care consulting population.

Over the last 10 years, it has become increasingly clear that cognitive-behavioral therapy is an effective treatment for patients with somatoform disorders. A number of systematic reviews have concluded that cognitive-behavioral therapy is an effective treatment for selected medically unexplained physical symptoms, such as fatigue, irritable bowel syndrome, and fibromyalgia.[3–6] A randomized, controlled trial conducted at a general-medical outpatient clinic demonstrated that cognitive-behavioral treatment was also effective in patients with more heterogeneous medically unexplained physical symptoms.[7] Many of the patients included in these studies would qualify for a diagnosis of undifferentiated somatoform disorder. If all patients with somatoform disorders in primary care were offered cognitive-behavioral therapy, this approach would result in a very substantial increase in treatment.

It remains to be seen, however, whether treatment is indicated for and acceptable to each and every patient who is diagnosed with a somatoform disorder in primary care. The natural course of somatoform disorders is often benign. Studies on the prognosis of medically unexplained physical symptoms mostly report improvement of symptoms or recovery in the majority of patients after 1 year.[8–10] In treatment studies, recovery in the non-treatment arm is usually also considerable. It seems wise to start with a period of "wait and see" before formal treatment is initiated. Furthermore, we may doubt whether all patients with somatoform disorders are willing to accept psychological treatment. In one study in secondary care, we found that most patients accepted psychological treatment, but it is

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unclear whether the same applies to patients in primary care.[4,11,12] Moreover, common clinical wisdom states that "somatizing patients do not like psychologizing."

In the *SO*matization study of the *U*niversity of *L*eiden (SOUL), we had the opportunity to estimate the proportion of patients in primary care who had persistent symptoms of somatoform disorder who would accept treatment if a program of brief cognitive-behavioral therapy were offered to them. After an initial diagnostic assessment of their somatoform disorder, patients were followed for 6 months to monitor spontaneous recovery. Patients reporting persistence of their symptoms were subsequently evaluated for a brief cognitive-behavioral treatment by their own general practitioner. Our findings may help to make a realistic estimate of the additional need for treatment of somatoform disorders.

METHOD

The SOUL Cohort

The SOmatization study of the University of Leiden (SOUL study) was designed as a prospective, cohort study in family practice. Screening questionnaires were used to identify high-risk patients. For a further diagnostic assessment by means of a psychiatric interview, we invited all high-risk patients and a sample of 15% of the low-risk patients. More details on the procedure have been published elsewhere.[1]

For the present study, the prevalence of persistent somatoform disorder was established after 6 months. All the patients with persistent symptoms underwent an assessment as to their eligibility for cognitive-behavioral treatment provided by their own family physician. The Medical Ethical Committee of the Leiden University Medical Center approved the study protocol.

Population

In a flow-chart (Figure 1), we illustrate patient recruitment and follow-up. The study took place in eight university-affiliated family practices in The Netherlands. The distribution of age and gender is similar to that of the Dutch population. The study was limited to natives of The Netherlands. The electronic medical records of all patients were available through the central database of the family-practice registration network, Leiden RNUH-LEO. Between April 2000 and December 2001, patients were selected from a random sample of 1,778 consecutive patients, age 25 to 80. They received screening questionnaires by mail. A total number of 1,046 patients (59%) returned the questionnaire and indicated that they were willing to participate. The main feature of the non-response analyses was a slight underrepresentation of young men in the examined sample.

Questionnaires

Participants completed the Short Form Health Survey (SF–36)[13] as a measure of functional impairment, the Hospital Anxiety and Depression Scale (HADS)[14] as a measure of anxiety and depression, the Illness Attitude Scales (IAS) as a measure of health anxiety and illness behavior,[15] and a Physical Symptom Checklist (PSC)[16] to quantify the number of reported physical symptoms. A total score of >15 on the HADS or a score of >5 on the PSC defined the high-risk sample. All patients with a high score and a sample of patients with a low score were invited for a diagnostic interview. Patients were excluded if they were unable to participate in an interview because of handicaps such as deafness, aphasia, or cognitive impairment.

Diagnostic Interview

WHO-certified clinical researchers used the Schedules for Clinical Assessment in Neuropsychiatry (SCAN, Version 2.1)[17] as the diagnostic interview. The assessment included psychiatric diagnoses and concurrent physical illnesses. Also, patients with a somatoform disorder reported the frequency and the severity of the main unexplained symptoms. Frequency could be expressed as Never, Sometimes, Often, or Always. Patients indicated the severity on a visual-analog scale (VAS), on which 0 meant no symp-

FIGURE 1. Recruitment and Follow-Up of Patients