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THE COURSE AND OUTCOME OF SOMATOFORM DISORDER: A 3-YEAR FOLLOW-UP

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The aim of the study was to investigate the effectiveness of standard medical treatment in patients with a somatoform disorder. Physical and psychosocial data were gathered from 100 patients of the medical outpatient clinic at the University Hospital in Zurich. Participants fulfilled the ICD-10 diagnosis of somatoform disorder, undifferentiated somatoform disorder, somatoform autonomic dysfunction and unspecified somatoform disorder. At the end of the 3-year study period, 58 patients took part in the follow-up. They reported an improvement of their symptoms during the first year after the standard medical treatment, which remained stable over the following 2 years. Medication could be reduced and doctors' consultations decreased from once a month to once every 3 months. Most participants were working full-time. The 42 who dropped out had significantly higher scores on symptom scales at the beginning of the study and non-native German speakers were overrepresented. Also, 21 of them agree to a short telephone interview in the 3 years of follow-up and reported persisting symptoms, low satisfaction with life and low social support.

Conclusions: A standard medical intervention on a regular basis (once a month), establishing a structured physician–patient relationship, appears to be an effective, economic and long-lasting treatment in patients with a moderately severe somatoform disorder.

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SOMATOFORM DISORDERS IN GENERAL PRACTICE: COMORBIDITY WITH OTHER PSYCHIATRIC DISORDERS

De Waal MWM, Arnold IA, Eekhof JAH, Van Hemert AM.

Background: There is an important and complex relationship between somatoform disorders and presence of anxiety or depression. The Somatization Study of the University of Leiden (SOUL) study aims to quantify the prevalence and cooccurrence of these psychiatric disorders in a two-phase sample in general practice. The SCAN (2.1) was used as a standardized psychiatric interview to diagnose clinically relevant disorders. In DSM-IV and in the SCAN interview, functional limitations in daily life constitute an important diagnostic criterion.

Methods: A sample of 1400 consecutive attenders, aged 25–80 years, of eight general practitioners (GP) was sent a screening questionnaire. The questionnaire included a Physical Symptom Checklist (PSC), the Hospital Anxiety and Depression Scale (HADS), the RAND-36 functional limitation questionnaire and the Illness Attitude Scale. A stratified sample of patients was invited for the psychiatric diagnostic interview. Somatoform disorders were diagnosed, focusing on symptoms during the last 6 months. Current anxiety and depressive disorders were diagnosed for the last month. A total of 351 patients were interviewed.

Results: Somatoform disorders are on the most prevalent psychiatric disorder in general practice with a prevalence of 16%. An anxiety disorder, a depressive disorder or a combined disorder was found in 8%. Comorbidity was more prevalent than could be expected by chance. Of all patients with an anxiety and/or depressive disorder, 53% had also a somatoform disorder. Of all patients with a somatoform disorder, 24% had also an anxiety and/or depressive disorder. Specific diagnoses and related functional limitations will be discussed.

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DIMENSIONS OF VITAL EXHAUSTION AND DEPRESSION ON FIRST MYOCARDIAL INFARCTION PATIENTS

McGowan L, Dickens C, Percival C, Douglas J, Tomenson B, Creed F.

Background: Both depression and vital exhaustion (VE) have been implicated as precursors of myocardial infarction (MI) or predictors of negative outcome, but the symptoms of VE (fatigue, feelings of demoralisation) overlap with depression. This study aimed to clarify the relationship between vital exhaustion, depression and comorbidity in a sample of first MI patients.

Method: 285 consecutive first MI patients were examined a few days after their heart attack. The Maastricht VE questionnaire was administered together with the Hospital Anxiety and Depression scale (HADS), SF36 and a measure of comorbid physical illness. A Principal Component Analysis (PCA) was used to examine the underlying structure of the Maastricht VE questionnaire. These factors were then entered into a second PCA with the other measures.

Results: In the first factor analysis, four factors emerged: fatigue (18.2% of variance), depression (18.1%), lack of concentration (9.6%) and sleep difficulties (1.9%). In the second factor analysis, the fatigue score of the Maastricht questionnaire loaded highly with SF36 subscales, indicating poor physical functioning and number of comorbid physical conditions. The depression factor loaded highly with the HADS scores. The Energy and Vitality subscale of the SF36 loaded highly with both factors.

Conclusion: These findings raise the possibility that studies of depression and outcome in MI patients may be measuring an aspect of fatigue as well as depression. Both are closely associated with comorbid physical conditions, which may also have an adverse effect on outcome.

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THE TERM MODEL — A NEW ADVANCED EDUCATIONAL PROGRAM FOR GPS IN THE TREATMENT OF FUNCTIONAL SOMATIC SYMPTOMS

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Abstract: About half of consecutive patients consulting their GP present with medically unexplained physical symptoms (i.e. functional somatic symptoms). About V4 fulfils the diagnostic criteria for a somatoform disorder. These disorders often go undiagnosed and untreated.

Aim: The overall aim of the TERM treatment model (The Extended Reattribution Model) is to offer general practitioners (GPs) a course in diagnosing and treating patients who present with functional somatic symptoms. It is intended that the educational elements of the course are acceptable and usable for all GPs in everyday clinical practice, irrespective of their qualifications. The objectives of the program are to (1) mediate knowledge about functional disorders, (2) introduce GPs to general interview technique and specific treatment techniques for functional disorders and (3) mediate a change of attitude towards functional disorders.

The principles of the educational program are based on The Reattribution Model H developed in the UK in the early 1980s. However, it has been modified significantly and new elements have been added. The program and techniques are described in detail in a booklet. Training material used during the course as well as teacher's notes are available.

Overall structure: The program consists of a 2-day residential course followed by three to four evening meetings, each with 1-week interval, one booster meeting after 3 months and finally a facilitator visit in the GPIS clinic after 6 months.

The residential course consists of four modules of 3 h in a fixed structure with

1. an introduction to the exercises including a short video demonstration
2. practical training with GPs working two and two or with an actor, which is videotaped and supervised in groups of eight persons
3. a theoretical presentation.

The supervision groups continue with a weekly evening meeting, where the participants bring video recordings of treatment sessions with their own patients. Each supervision group of eight persons has two supervisors (a GP and a psychiatrist).

Testing the program: The effect of the educational program has been tested in two randomized controlled studies, including 78 GPs and about 4000 patients.

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DETERMINANTS OF HIGH-END HEALTH SERVICES UTILIZATION IN FIBROMYALGIA

Dobkin PL, De Civita M, Fitzcharles M-A, Kang H, Dayan N.

Background: Fibromyalgia (FM) is characterized by symptoms of widespread musculoskeletal pain, multiple tender points, sleep disturbance, fatigue and morning stiffness. Its etiology is unknown, no clear diagnostic markers have been identified and no single treatment is consistently successful. Multiple testing, referral to specialists and use of complementary services are common, increasing costs of care. Little is known about what drives high-end health services utilization.

Objective: The primary objective was to identify determinants of visits to medical doctors (MDs) and complementary health care providers (CHCPs) (e.g., physiotherapists and psychologists).

Methods: Women with FM ($n = 178$, mean age = 50.8, S.D. = 10.3, 88% Caucasian) were examined by a rheumatologist who confirmed the diagnosis. The sample was derived from an urban setting, about half were recruited from territory care and the other half from the general community. The participants completed a standardized psychosocial test battery, which measured pain (MPQ), perceived stress (PSS), social support (SSQ6), global psychological distress (GSI of SCL-90-R) and styles of coping (CISS), disability due to FM (FIQ), as well as a health services cost questionnaire, which documented visits to doctors and CHCPs and comorbid conditions, during the past 6 months.

Results: The average number of visits to MDs was 7.54 (S.D. = 5.07) and 6.57 to CHCPs (S.D. = 3.29). To identify the most significant determinants, the psychosocial variables were entered into a single multivariate regression model. Separate analyses were conducted for visits to MDs and CHCPs. Using a backward selection procedure, higher levels of disability ($P = .003$) and more comorbid conditions ($P = .003$) contributed to MD visits. When CHCPs was the criterion variable, the determinants were pain intensity ($P = .03$) and being classified as a "case" on the global psychological distress scale. Interestingly, when culture (English- or French-Canadian) was included in these analyses, the determinants of visits to CHCPs became only marginally significant, whereas the determinants of MD visits remained the same.

Conclusion: Actively addressing disability and comorbid conditions may help to decrease the number of MD visits.