

## Somatoform disorders: severe psychiatric illnesses neglected by psychiatrists

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**Background** Somatoform disorders have few peers in terms of personal morbidity and cost to the health service, yet many psychiatrists train without any experience of them.

**Aims** To review the prevalence, disability and economic burden of somatoform disorders, and to explore the reasons why they are neglected by psychiatrists.

**Method** A selective review of the key literature.

**Results** Psychiatrists' current preoccupation with so-called 'serious mental illness' gives somatoform disorders low priority. Some health planners have erroneously equated severity with diagnosis rather than level of need and disability. As a consequence the development of psychiatric services has been neglected.

**Conclusions** Greater recognition of the importance of somatoform disorders will only occur if high quality research and teaching receive priority, and if the Royal Colleges continue to press for increasing public awareness of their importance. Services should be driven by clinical need rather than diagnosis.

**Declaration of interest** None.

Many patients who are referred to physicians and surgeons have chronic physical complaints which cannot be understood or explained in terms of underlying organic pathology. For example, as many as one-half of patients attending a district general gastroenterology service have no relevant organic disease to account for their complaints (Hamilton *et al*, 1996). Often, patients are discharged back to their general practitioners in the hope that the symptoms will diminish, but the evidence from follow-up studies suggests that, more often than not, they will continue to report physical symptoms and associated disability (Mayou *et al*, 1994). Once such patients develop complaints that last longer than 6 months they become difficult to help, and if their ability to work is impaired they may become dependent on state benefits (Sharpe *et al*, 1994). Most will satisfy diagnostic criteria for somatoform disorders. Because somatoform disorders are common and severe, they ought more often to be treated by psychiatrists or clinical psychologists. We discuss reasons why they are not, and consider ways in which this neglect can be corrected.

### PREVALENCE OF SOMATOFORM DISORDERS

Epidemiological studies of chronic widespread pain and chronic fatigue carried out in primary care settings have revealed the extraordinary scale of the problem. For example, in a World Health Organization study Gureje *et al* (1998) found that 22% of primary care patients reported persistent pain and that pain sufferers were more likely than those without pain to have an anxiety or depressive disorder and to experience significant activity limitations. Similar high prevalence rates have been reported for chronic fatigue syndrome, with a recent British study finding the point prevalence in the general population to be 2.6%

(Wessely *et al*, 1997). These findings suggest that chronic fatigue syndrome is almost as common as diabetes and significantly more common than anorexia nervosa.

Another important disorder, seen almost exclusively in general hospital and primary care settings, is somatisation disorder. Although the prevalence rate has been estimated to be 0.5% the true rate is probably higher, closer to 1%, which is about as common as schizophrenia (Bhui & Hotopf, 1997). Even an attenuated form of somatisation characterised by three or more medically unexplained but currently bothersome symptoms plus a 2-year history of somatisation has a prevalence of 8.2% in primary care (Kroenke *et al*, 1997).

Conversion hysteria is considered by many psychiatrists almost to have disappeared as a clinical entity since the days of Freud (Anonymous, 1976). This belief, encouraged by the publication nearly 40 years ago of an influential but misleading paper by Slater (1965), has led to a dearth of research into this subject until recently (Crimlisk *et al*, 1998). Prevalence studies carried out in the general population are rare, and the lowest figures suggest a rate of about 50 per 100 000, with perhaps twice that number affected over a 1–2 year period (Akagi & House, 2001).

### DISABILITY AND THE ECONOMIC BURDEN OF SOMATOFORM DISORDERS

Patients with multiple somatic complaints not only present formidable management problems but also often have severe functional impairments that may outweigh those of patients with other so-called severe mental illnesses such as schizophrenia (Hiller *et al*, 1997).

Some somatoform disorders, especially those associated with chronic widespread pain (fibromyalgia) and persistent fatigue, have been shown to be associated with marked functional impairment (Buchwald *et al*, 1996). The impact of somatoform disorders on occupational function deserves closer attention, especially at a time when disability payments are spiralling (*The Economist*, 22 May 1999). It has been established that the majority of patients with chronic pain attending a regional clinic are chronically disabled and dependent (Benjamin *et al*, 1988), yet few of these patients are likely to be assessed by clinical psychologists or psychiatrists, as recommended in a recent

editorial advocating joint working between liaison psychiatrists and pain doctors (Dolin & Stevens, 1998).

One of the most severe of the somatoform disorders (somatisation disorder) is associated with gross functional impairment. In a UK sample 10% were confined to wheelchairs (Bass & Murphy, 1991) and the self-rated physical functioning of these patients in a US survey was even poorer than in those suffering from a chronic organic disease (Smith *et al*, 1986): patients spent an average of 7 days in bed each month.

Patients with conversion disorder are also often grossly disabled, especially when the symptoms have become chronic. Recent studies suggest a burden of disability associated with chronic hysteria which is far higher than a typical practising psychiatrist might suspect, or than is reflected in standard textbooks of psychiatry or clinical psychology (Akagi & House, 2001). It is not uncommon to find patients who have become confined to wheelchairs (Davison *et al*, 1999).

## WHY ARE SOMATOFORM DISORDERS NEGLECTED BY PSYCHIATRISTS?

Given that they are common and disabling, why do somatoform disorders continue to be ignored by psychiatrists and health service planners? There are four main reasons.

First, is the nature of psychiatric diagnostic practice. Psychiatric classifications 'compartmentalise' somatoform disorders into relatively homogeneous groupings with low prevalence such as hypochondriasis and conversion disorder. The much more common presentations of somatic distress – syndromes characterised by prolonged fatigue, musculoskeletal aches and pains and gastrointestinal symptoms – are then relegated to the poorly validated category of 'undifferentiated somatoform disorders'. As a consequence they are not only marginalised from further clinical or research consideration but the true prevalence is underestimated.

Epidemiologists have contributed to this problem by failing to identify patients with psychologically based somatic presentations in large scale surveys. For example, the National Psychiatric Morbidity Survey of Great Britain did not provide meaningful prevalence data for these disorders, mainly because only those patients who were

screened positive for psychosis were interviewed by psychiatrists (Jenkins *et al*, 1997). Similarly, the National Institute for Mental Health Epidemiological Catchment Area study, conducted in the USA, largely ignored all but the most severe and least common of the somatoform disorders (Swartz *et al*, 1991).

Second, there is psychiatry's current preoccupation with 'serious mental illness', which is usually equated with schizophrenia or bipolar illness. Non-psychotic disorders are then given low priority by clinicians and service planners. This approach was endorsed in a recent publication by the Audit Commission (1996), which recommended that not more than 10% of the psychiatric case-load should concern itself with people who do not have identifiable mental illnesses. Furthermore, the National Service Framework for Mental Health (Department of Health, 1999) contained no information about patients with somatoform disorders.

A recent welcome exception to this narrow approach was adopted by the Australian Health Ministers in their National Mental Health Plan (1998). This acknowledged that the overly restrictive interpretation of the term "severe mental health problems and mental disorders" led to the unforeseen consequence that "some public health systems have excluded people seen as having less serious conditions and have erroneously equated severity with diagnosis rather than *level of need and disability*" (our italics). They concluded that funding systems must ensure that there are no financial disincentives to general practitioners, consultation/liaison services and other health professionals participating fully in the mental health care system.

The third reason is more prosaic: most psychiatrists do not work in general hospitals and therefore have limited experience of patients with medically unexplained symptoms. Those that do work in these settings, however, find that such patients comprise between one-third and one-half of all referrals to the liaison psychiatry service (Katon *et al*, 1984).

The final reason these patients do not consult psychiatrists is a consequence of stigma. Because they have physical complaints for which they generally seek a physical cause, a psychological assessment is low on the list of the patient's priorities. The College's recent campaign against stigma (Changing Minds) has done little to address this substantial group of patients (Crisp, 1999).

## STEPS TOWARDS REDUCING THE NEGLECT OF SOMATOFORM DISORDERS

If we are to move somatoform disorders nearer to the centre of psychiatric practice (where they belong) there need to be changes: in the training of health professionals, in research and in service delivery.

### Training

Because somatoform disorders are the most common psychiatric disorders to present in non-psychiatric settings, it is important that training about them begin at undergraduate level. It should also be incorporated in the training of a wide variety of non-psychiatric specialists, both medical and non-medical.

#### Medical undergraduates

Recent suggestions about modification of the psychiatric component of the undergraduate curriculum have been proposed by Sharpe *et al* (1996a). These proposals include teaching medical students more 'psychological medicine' that will prepare them more adequately for their future medical careers. Specific curriculum themes identified by the General Medical Council, such as Man in Society, also underline the impact of psychological factors in health and disease (General Medical Council, 1993).

#### Psychiatrists in training

Physician and surgeon colleagues tell us that seeking psychiatric opinion and advice on the management of somatising patients is rarely worthwhile. This state of affairs is likely to continue unless psychiatrists gain more experience in the management of somatoform disorders. Somatisation disorder is almost as common as schizophrenia, yet most psychiatrists will pass through their training schemes without any experience of it.

Establishing more training posts in liaison psychiatry would be one way to ensure that psychiatrists acquire the appropriate skills and knowledge to manage this diverse group of disorders. Current figures recommended by the Royal College of Psychiatrists in the UK are one consultant in liaison psychiatry for 400 000 of the population (Royal College of Psychiatrists,

1992). In reality the availability of consultants who have the requisite experience in the management of these patients is well below the College recommendations.

#### Training of non-psychiatrists

There is enormous scope for the training of non-psychiatric personnel, who are usually the patients' first port of call. The Section of Liaison Psychiatry at the College has actively encouraged collaborative ventures with other Royal Colleges, and this has led to the publication of guidelines on the management of patients with somatoform (and other) disorders who present in general hospitals (Royal College of Physicians & Royal College of Psychiatrists, 1995; Royal College of Surgeons & Royal College of Psychiatrists 1997). Including a knowledge of these patients in the core curricula for examination of physicians, surgeons and gynaecologists in training would also ensure that these disorders are addressed, and the Section is preparing a curriculum for non-psychiatrists, to help generate interest in that process.

There are important educational opportunities for liaison psychiatric nurses, working on a 'hub and spoke' model, to educate specialists in other hospital departments and help them to identify and manage some of these patients. There is also potential for training general nurses to acquire the appropriate therapeutic skills, working in out-patient clinics alongside those run by their medical colleagues (Mayou *et al*, 1999), as well as scope for clinical psychologists, especially those with experience of cognitive-behavioural therapy (CBT), to provide services and expertise in the management of these patients.

#### Research

High-quality research has already been carried out in this field. Of particular importance is the research demonstrating the efficacy of psychologically based treatments in patients with relatively homogeneous somatoform syndromes such as chronic fatigue syndrome (Sharpe *et al*, 1996b) and intractable irritable bowel syndrome (Guthrie *et al*, 1991). A recent systematic review of 31 controlled trials (29 randomised) has compared the effectiveness of CBT with control therapy for unexplained symptoms and symptom syndromes in a total of 1689 patients with symptoms that had lasted anything from 3 to 17 years (Kroenke & Swindle, 2000).

In 71% of the studies, physical symptoms improved to a greater extent in patients treated with CBT than in those in the control groups. Furthermore, psychological distress decreased with CBT in 38% of studies and functional status improved in 47%.

Even though patients with chronic and intractable symptoms and impairments have been shown to benefit from psychologically based treatment (Guthrie *et al*, 1999), early intervention is desirable. The next round of clinical trials needs to include good economic analyses, looking for cost benefits as well as clinical efficacy. This will greatly facilitate service development, particularly where definite cost offsets can be demonstrated (Feldman, 2000). Once purchasers of health care and primary care groups become more aware of the financial implications of these chronic and intractable disorders, they may be more willing to provide funding for treatment services.

#### Services and health policies

In our opinion psychiatric services need to be developed for the provision of treatment for patients with these chronic and disabling disorders. But before this can occur a collaborative working relationship needs to be established between psychiatrists and physicians with common clinical interests, preferably working on the same site.

A few successful centres have been developed in general hospitals along these lines. In one unit developed for the treatment of patients with chronic fatigue syndrome the service has been partly funded by the hospital's department of medicine. This makes economic sense, as the cost savings of such a service will accrue to the department of medicine (and in theory primary care). The availability of in-patient liaison psychiatry beds in the general hospital is also very desirable; patients with somatoform disorders require a specialised multidisciplinary treatment which is not appropriately administered in either a psychiatric or general hospital (Protheroe & House, 1999). Regrettably, with psychiatric services moving into the community away from the general hospital, these developments are unlikely to occur (Wessely, 1996).

Whether primary care groups will show interest in purchasing services for these patients remains to be seen. Recent surveys of general practitioner training needs reveal that patients with chronic somatisation, frequent consulters and 'heartsink' patients

are top of their educational agendas (Kerwick *et al*, 1997). Although an association between frequent consulting and somatisation has been demonstrated (Lin *et al*, 1991), the evidence indicates that few frequent consulters conform to the 'heartsink' stereotype (Gill & Sharpe, 1999). To date, however, there has been little conspicuous interest in the purchasing of services from liaison psychiatry with the specific function of the management of high users of health care with somatoform disorders.

What is really needed is a joint business case between the medical and psychiatric providers, and general practitioners need to include this in their own submissions to the local health improvement programme. One possible model is of joint clinics focused on particular problems such as chest pain, fatigue, pelvic pain, functional bowel disorders etc., with joint providers and a 'stepped-care' approach described above (Mayou *et al*, 1999), with ready availability of psychiatric skills for assessment and treatment. Evidence-based research of cost offset is needed and both health care gains and reduction in health care costs need to be communicated to organisations such as the National Institute for Clinical Excellence.

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## CLINICAL IMPLICATIONS

- Every trust should have access to a service for patients with somatoform disorders.
- The training of psychiatrists should include experience of somatoform disorders supervised by a specialist in their assessment and management.
- Mental health planners should equate severity with level of need and disability rather than psychiatric diagnosis.

## LIMITATIONS

- We have not addressed somatoform disorders in children.
- We are liaison psychiatrists and do not represent the views of clinical psychologists.
- Physicians and primary care doctors find it difficult to discuss referral of these patients to psychiatrists. This topic deserves more attention.

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