

Treatment of functional somatic symptoms in general practice

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Outline

- Background about FSS
- The intervention
- Project design and measures
- Results
- Conclusion



Definitions of FSS

- Physical symptoms that lack an obvious organic basis (Mayou 1991)
- Conditions where the patient complains of physical symptoms that cause excessive worry or discomfort or lead the patient to seek treatment but for which no adequate organ pathology or patho-physiological basis can be found (Fink 2002)
- ICD-10: Somatoform Disorders
Physical symptoms and persistent requests for medical investigations, in spite of negative findings and reassurance
Duration > 6 months (WHO)



FSS in primary care

A spectrum of disorders

Normal
physiological
phenomena

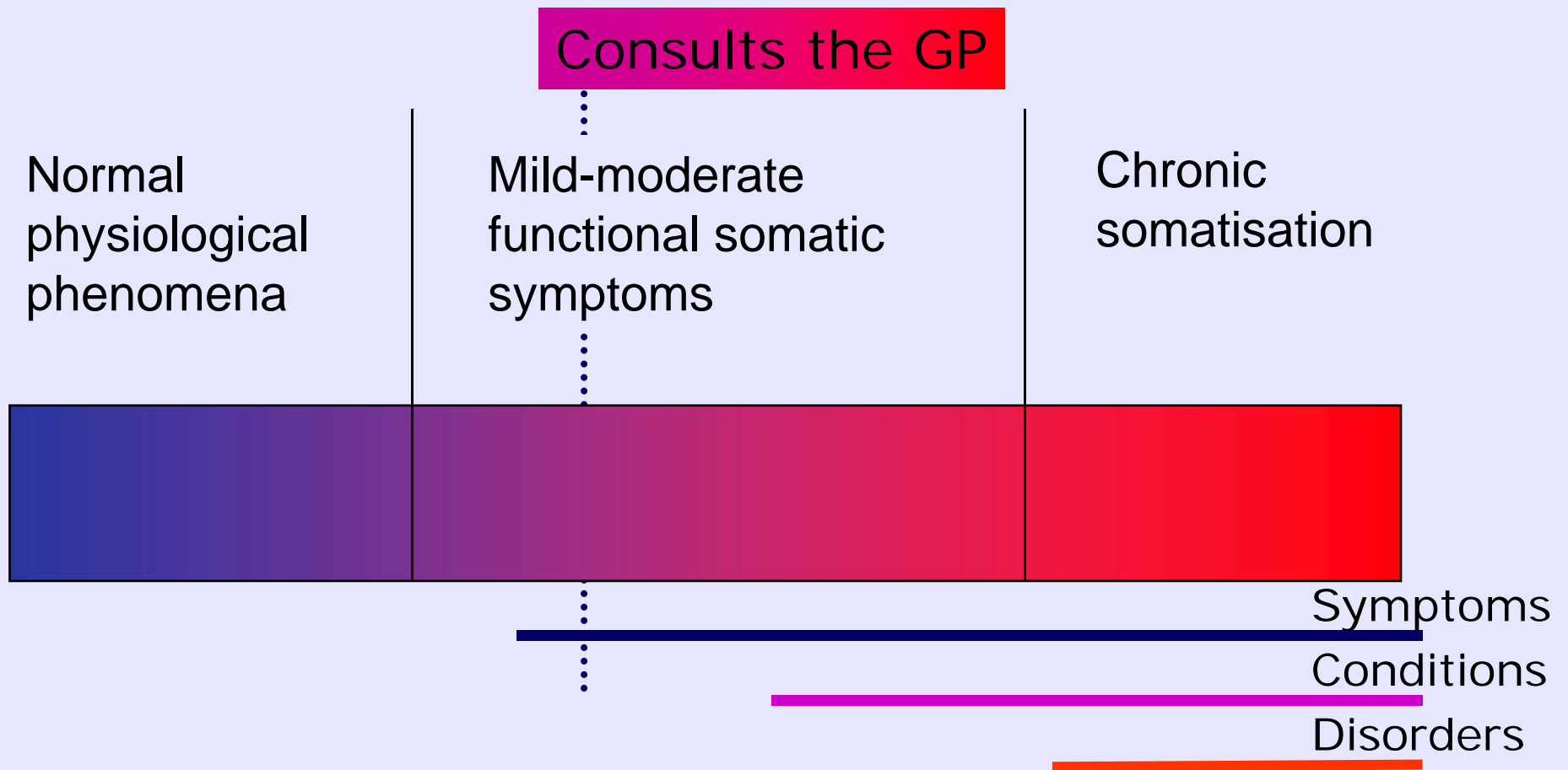
Mild-moderate
functional somatic
symptoms

Chronic
somatisation



FSS in primary care

A spectrum of disorders



FSS - prevalence in primary care

60-74% of common physical symptoms remain unexplained

20-30% fulfil ICD-10 criteria for somatoform disorders

6-10%
chronic
somatisation
disorder

Kroenke 1989

Fink 1999

Toft 2004

Toft 2004

de Waal 2004

Fink 1999

Toft 2004

Fink 1999

Intervention



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Why intervention in primary care?

- High prevalence of MUS
- Current (biomedical) treatment is insufficient (Fink 1997, Salmon 1999, Barsky 2001)
- GPs are frustrated about lacking knowledge and skills (Reid 2001)
- Specialised care resources are limited

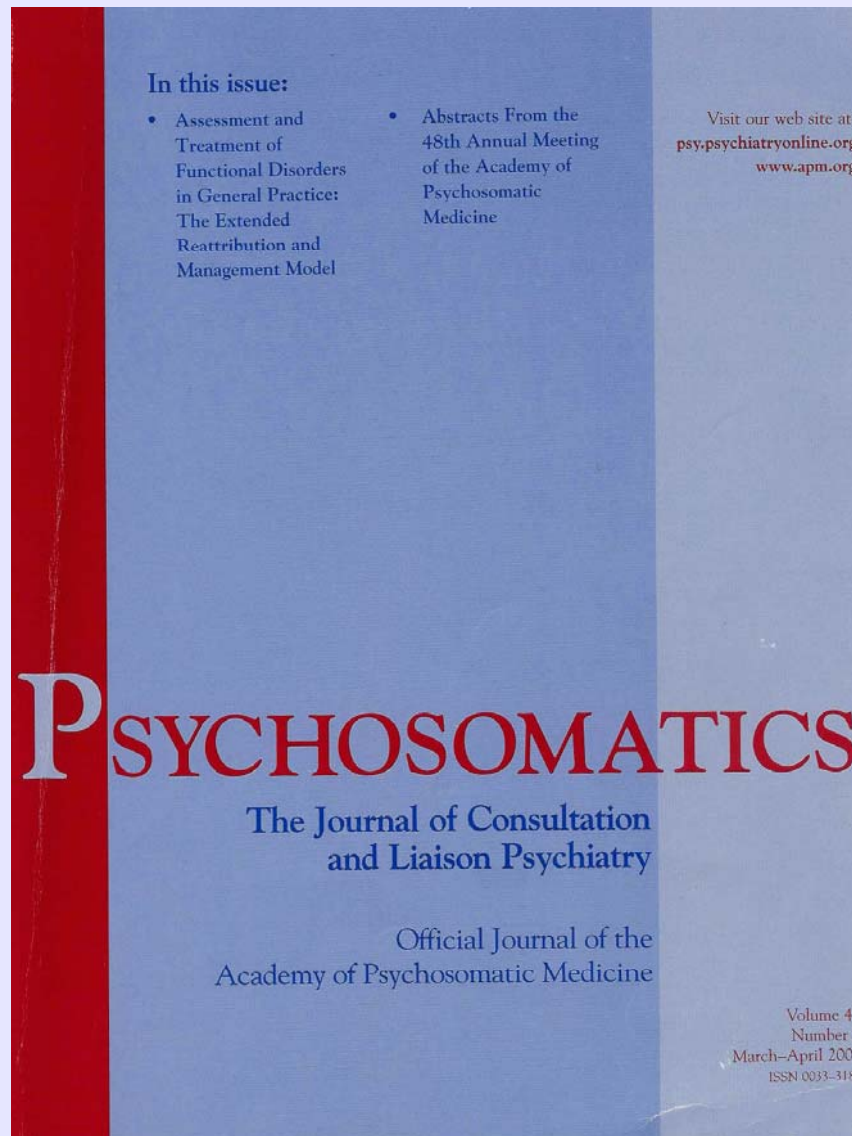


Basis for the treatment programme

- Cover the spectrum of disorders
- Tailored for general practice
- No involvement of specialists
- The intervention included
 - Evidence about various aspects of FSS
 - Evidence on the treatment of FSS



The Extended Reattribution and Management Model



P. Fink, M. Rosendal, T. Toft
Psychosomatics 2002;
43 (2): 93-131

Also available on
www.auh.dk/CL_psych/uk/

TERM Model - objectives

- Improve GP attitude, knowledge and skills
- Concerning assessment and treatment
- Of the whole spectrum of MUS
- Acceptable programme to ALL GPs



TERM Model - content

Interviewing techniques
from cognitive
behavioural therapy

1. Understanding
 2. The physician's expertise and acknowledgement of illness
 3. Negotiating a new model of understanding
 4. Negotiating further treatment
- Follow-up appointments
 - Management of chronic somatisation



TERM Model – training programme

- Residential course 2 x 8 hours
Theory, micro skills training,
video supervision, small group discussions
- Follow-up meetings, weekly 4 x 2 hours
- Booster meeting after 3 months 2 hours
- Outreach visit after 6 months ½ hour

In total 27 hours



Evaluation



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Evaluation – study design

- RCT
- Two-step sampling
 - Practices/GPs
 - Patients with FSS
- Intervention
 - Training at GP level
 - TERM-model at patient level – provided by trained GP
- Primary outcome at patient level



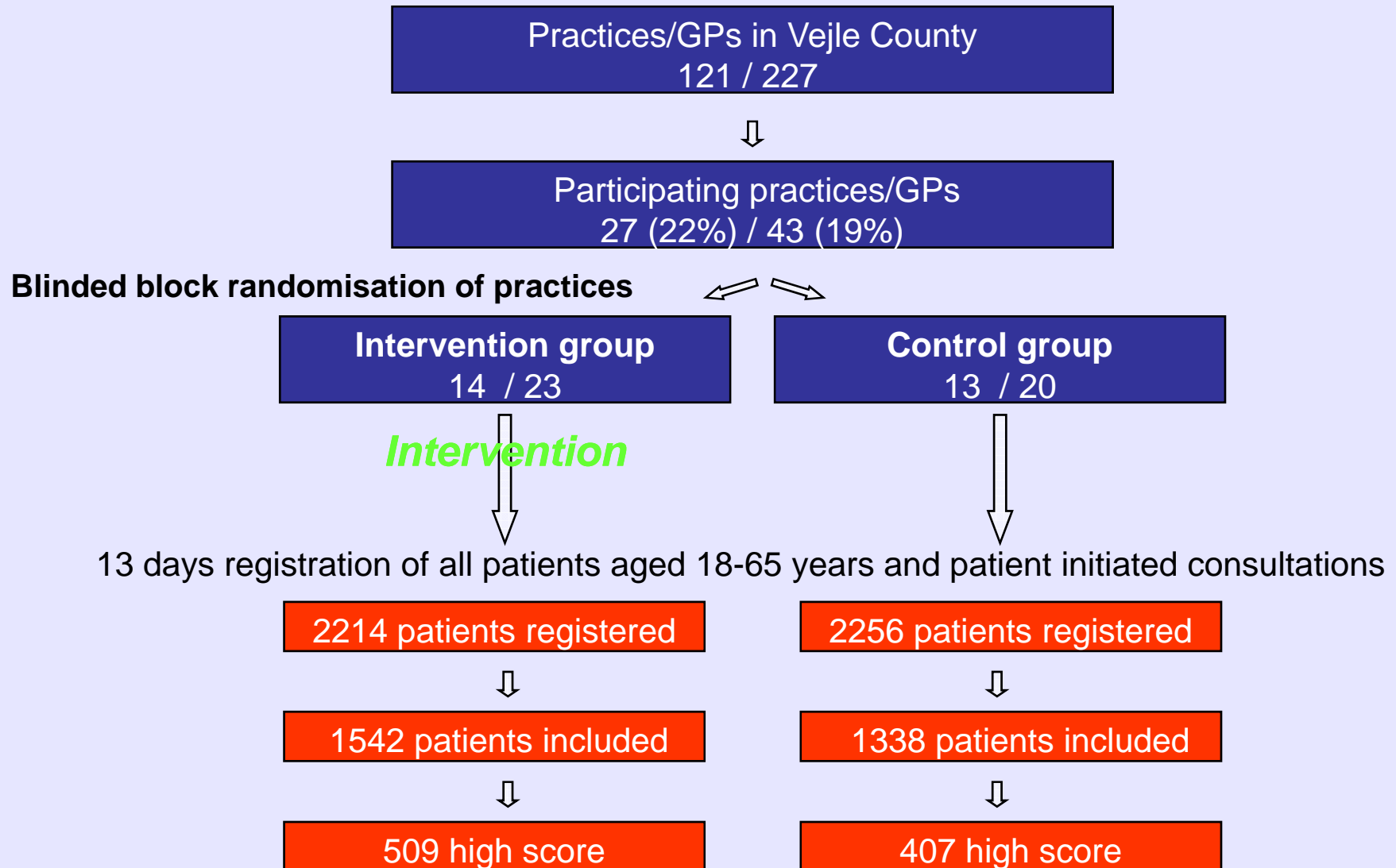
Material

Vejele County

- Year 2000-2003
- 37-40 GPs from 21-24 practices
- Practices randomised
- 2880 patients included
- 911 patients had a high score for somatisation (SCL-som, Whiteley-7)
- Follow-up: 1 year
- Evaluation based on questionnaires



Inclusion

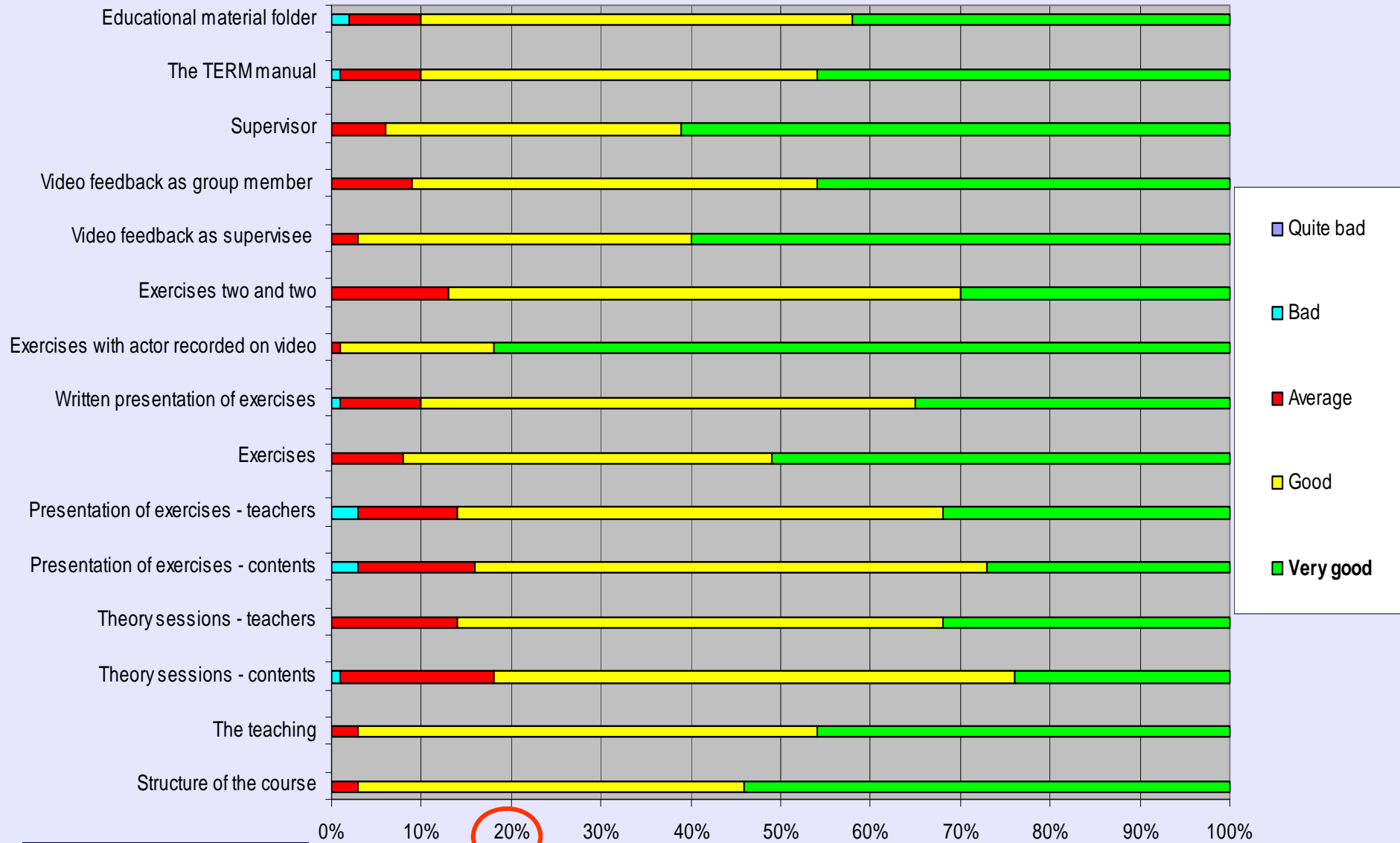


Evaluation - outcome

- Primary outcome
 - Patients' self-evaluated health (physical functioning on SF-36)
- Secondary outcome
 - Patients' satisfaction with care
- Intermediate measures
 - GPs' "happiness index"
 - GPs' attitudes
 - GPs' classification



GP evaluation of 6 TERM seminars



N = 120

GPs' change in attitudes

“How do you typically react when you see a patient with somatoform disorder in your consultation?”

Example

7-point Likert scale

I enjoy working with these patients

Not at all

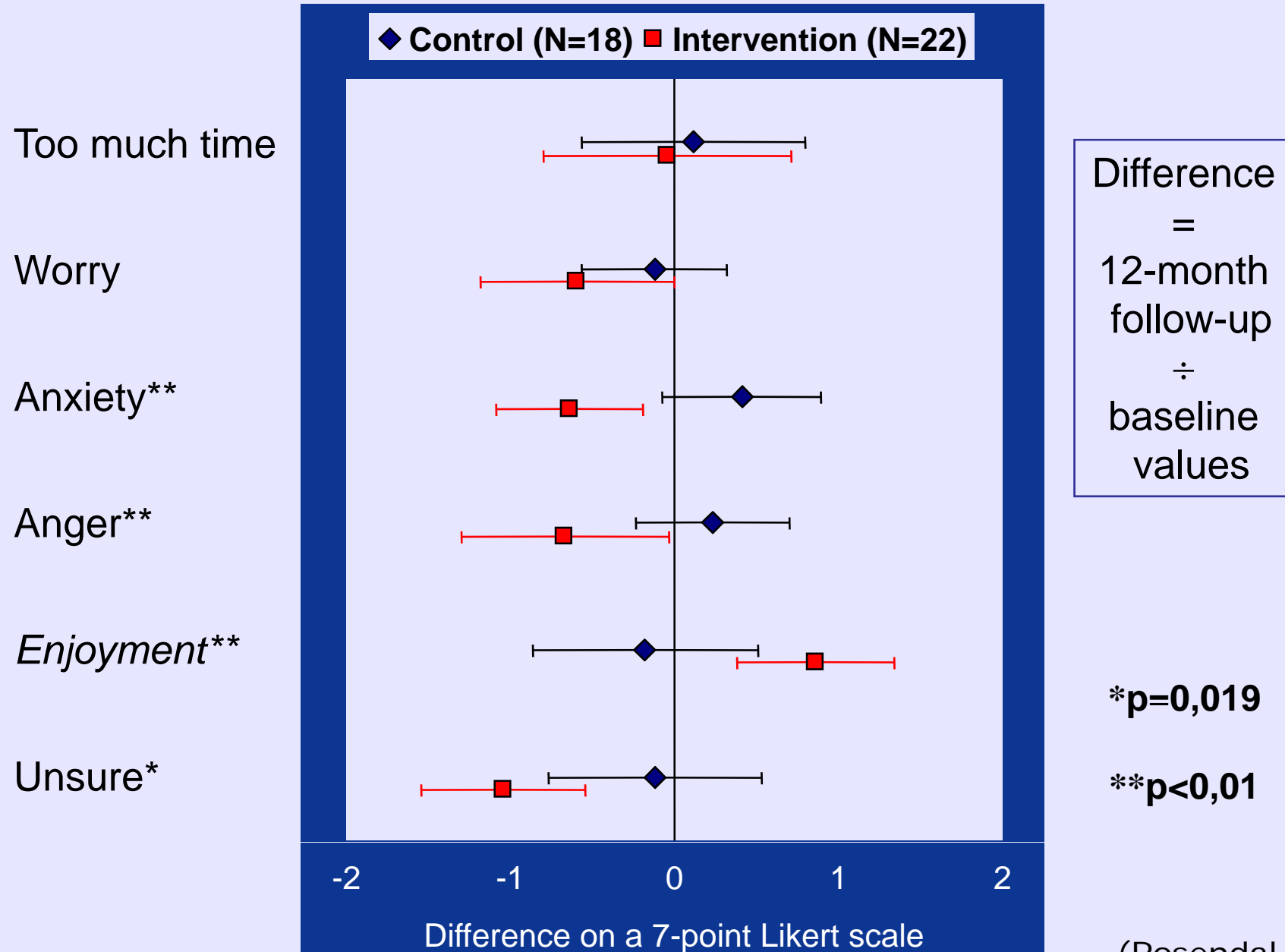
very much



Hartmann 1989

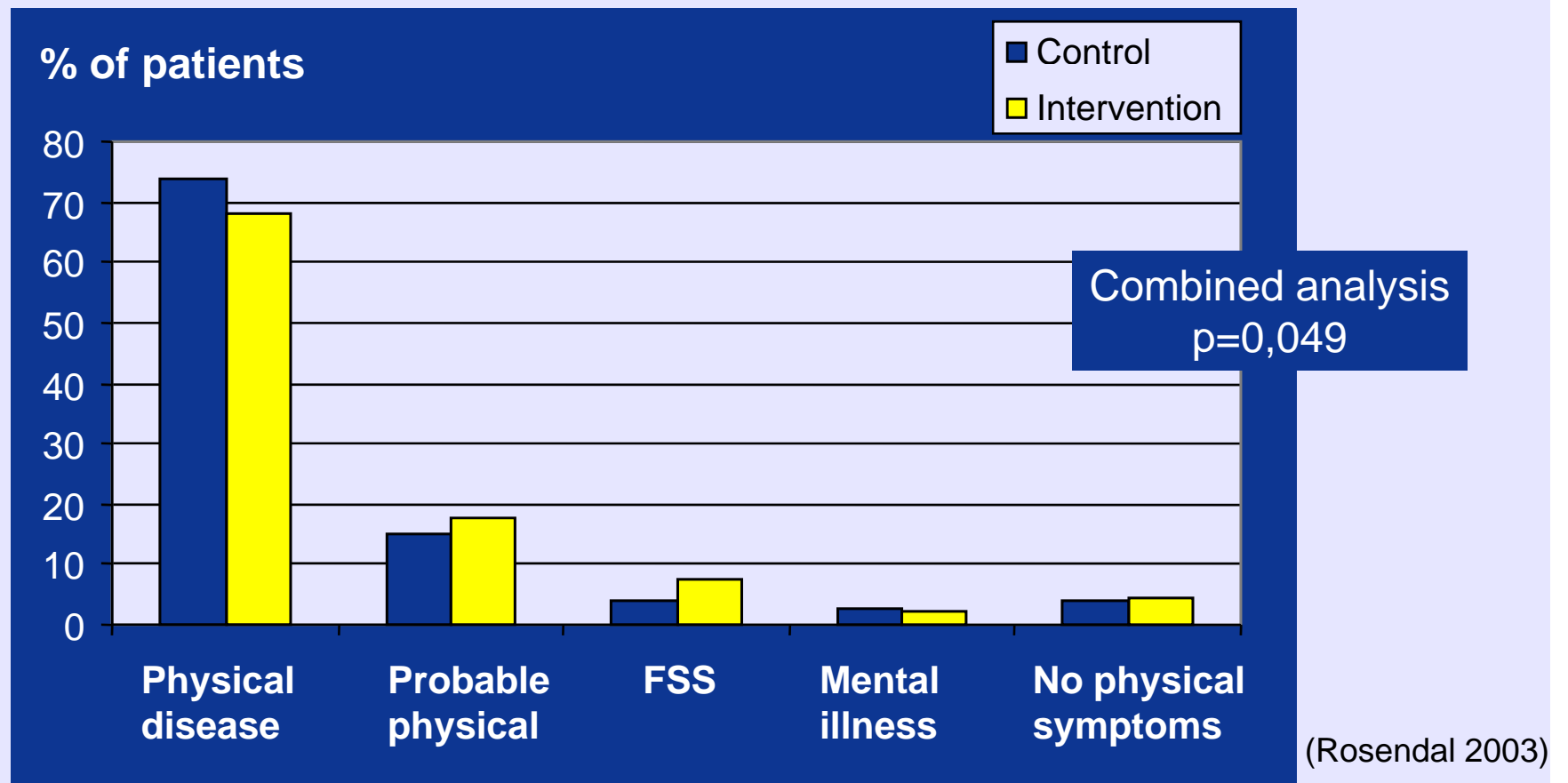


GPs' change in attitudes

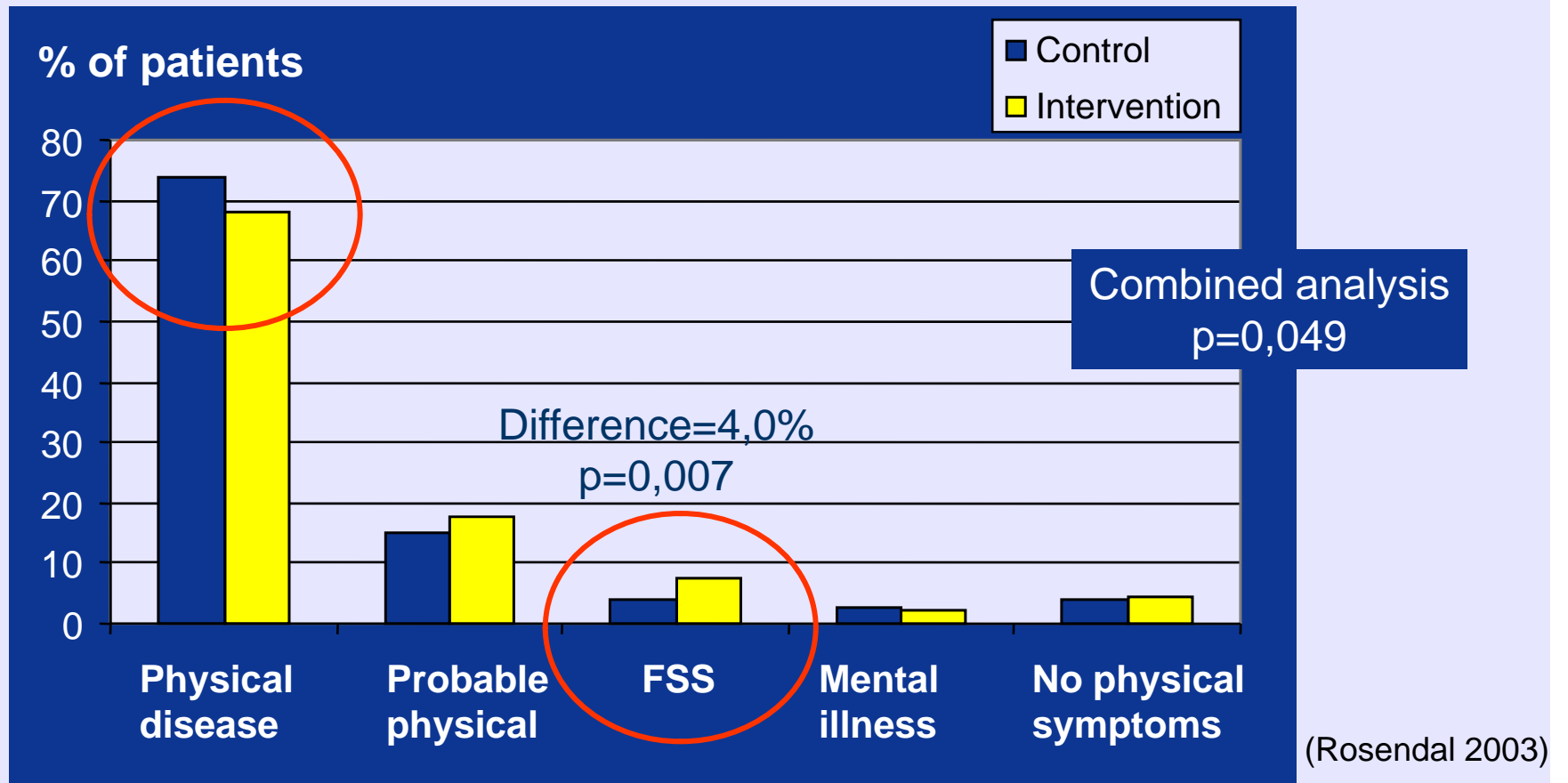


(Rosendal 2005)

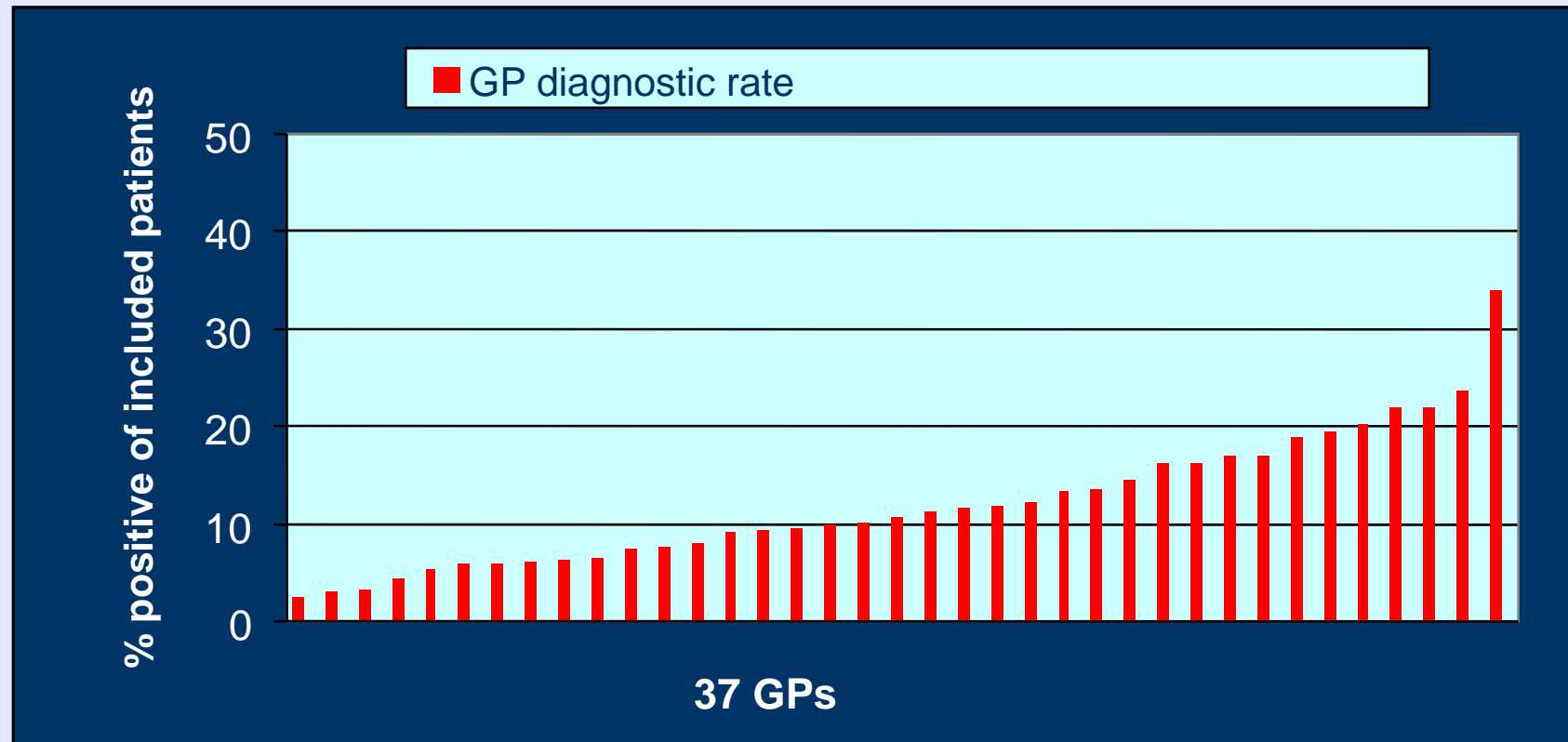
GPs' classification



GPs' classification



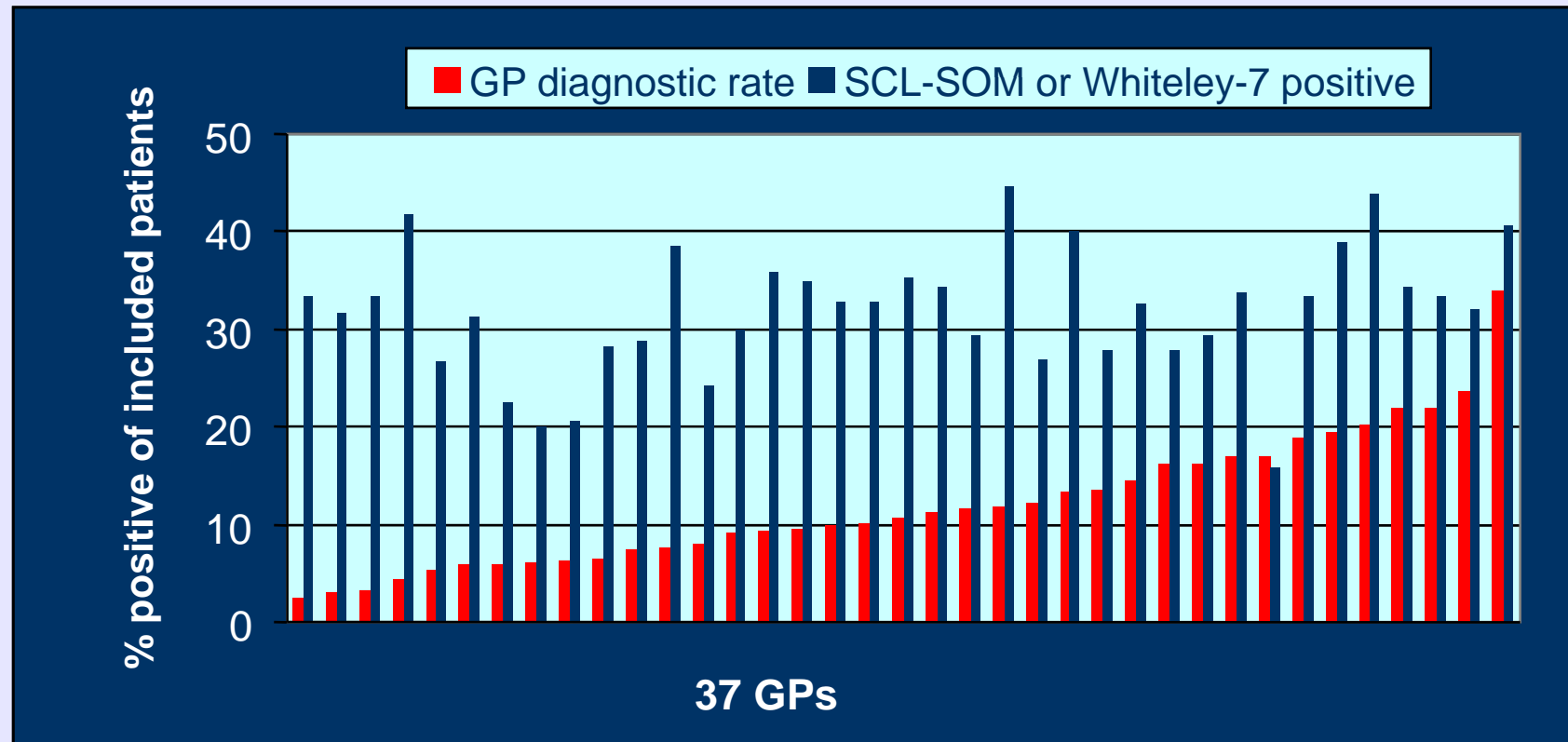
Classification rate of FSS by GPs



(Rosendal 2003)



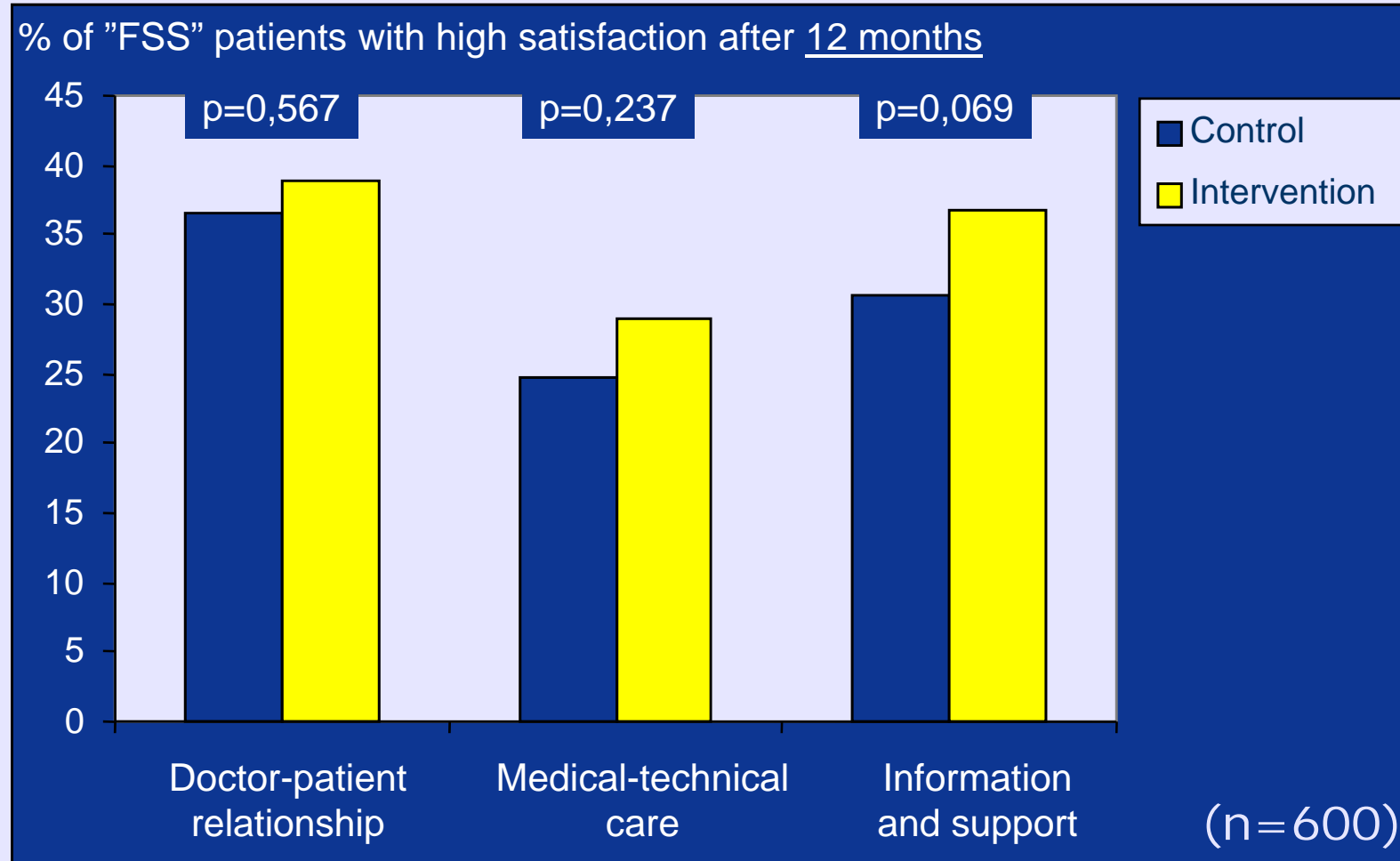
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(Rosendal 2003)

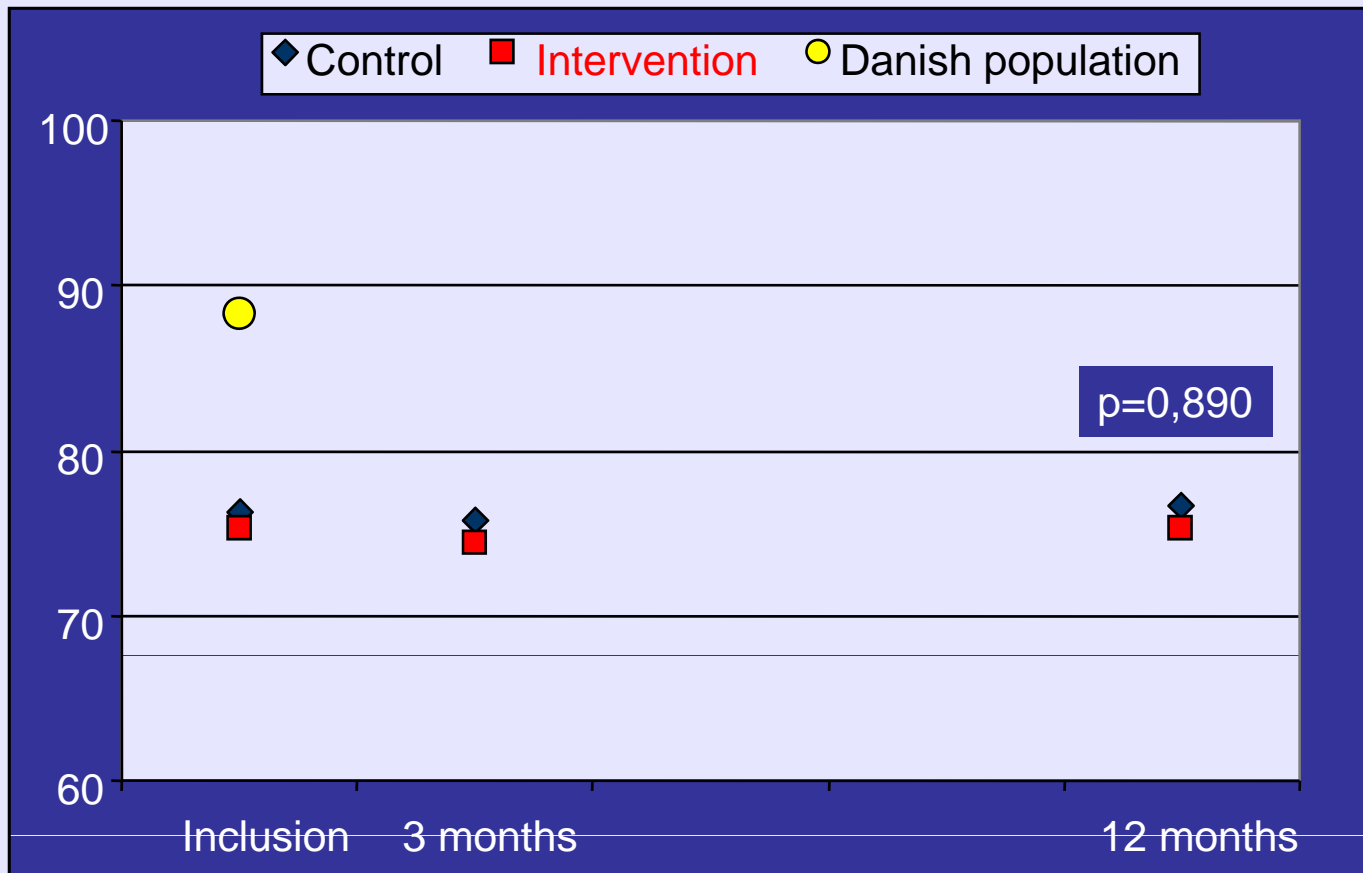


Evaluation - Patient Satisfaction



Patient health

SF-36 physical functioning (n=601-711)



Conclusion



Conclusion - results

The TERM model

- Is accepted by GPs
- Training of GPs induced
 - A sustained positive effect on GPs' attitudes
 - Increased GP awareness of FSS
 - A possible positive effect on patient satisfaction
 - **No effect on patient health**



Problems encountered

- Intervention
 - How do we know whether the training or the model itself failed?
 - Which parts of the intervention could be improved?
 - How did the setting affect the intervention?
 - How does time influence desired behavioural changes in the study (GPs and patients)?
- Sampling
 - How do we sample patients with FSS in general practice?
 - How do we avoid inclusion bias in the practices undergoing intervention?
- Outcome
 - How do we measure relevant patient outcome in relation to FSS?





Thank you for your attention!