

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

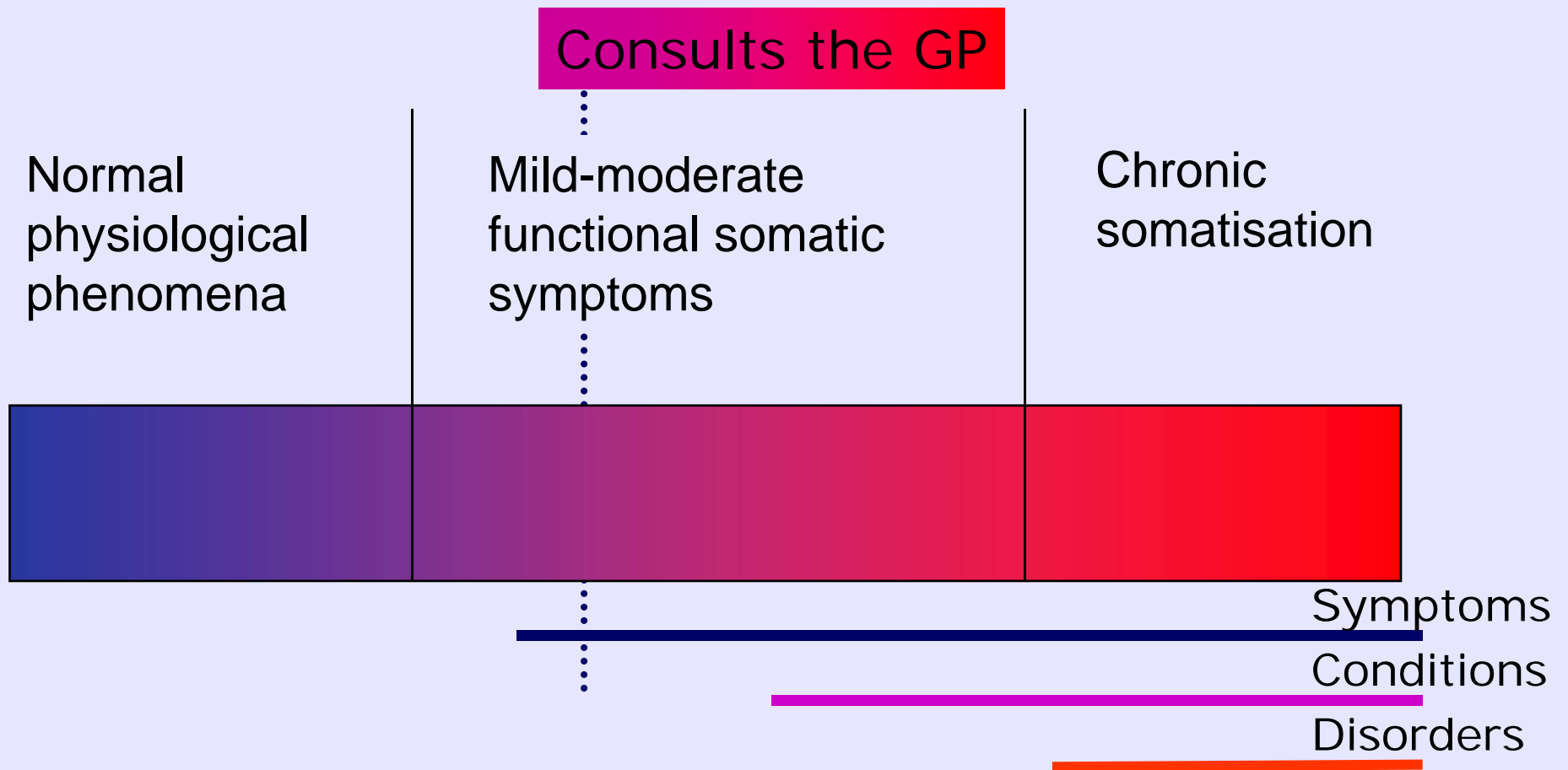
Mild-moderate
functional somatic
symptoms

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

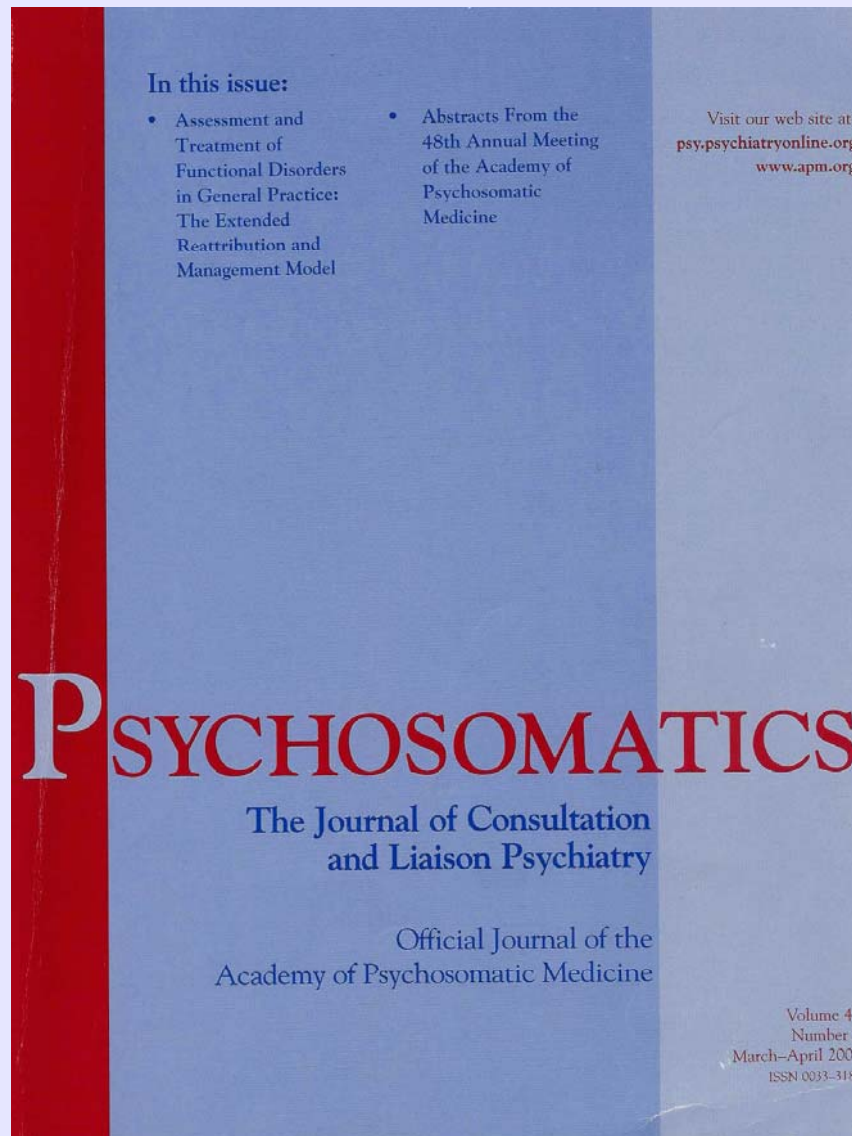


Basis for the treatment programme

- 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



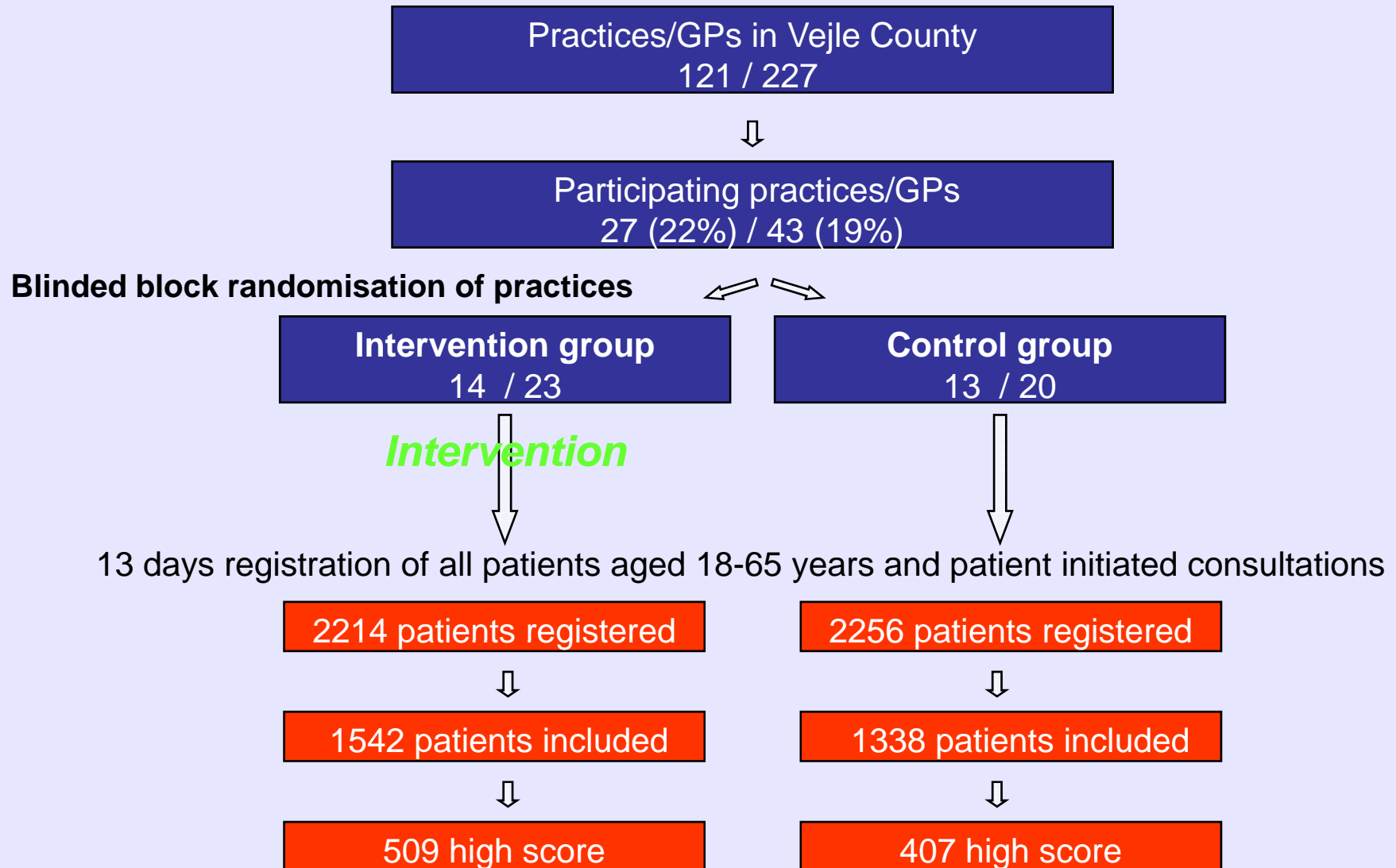
Material

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

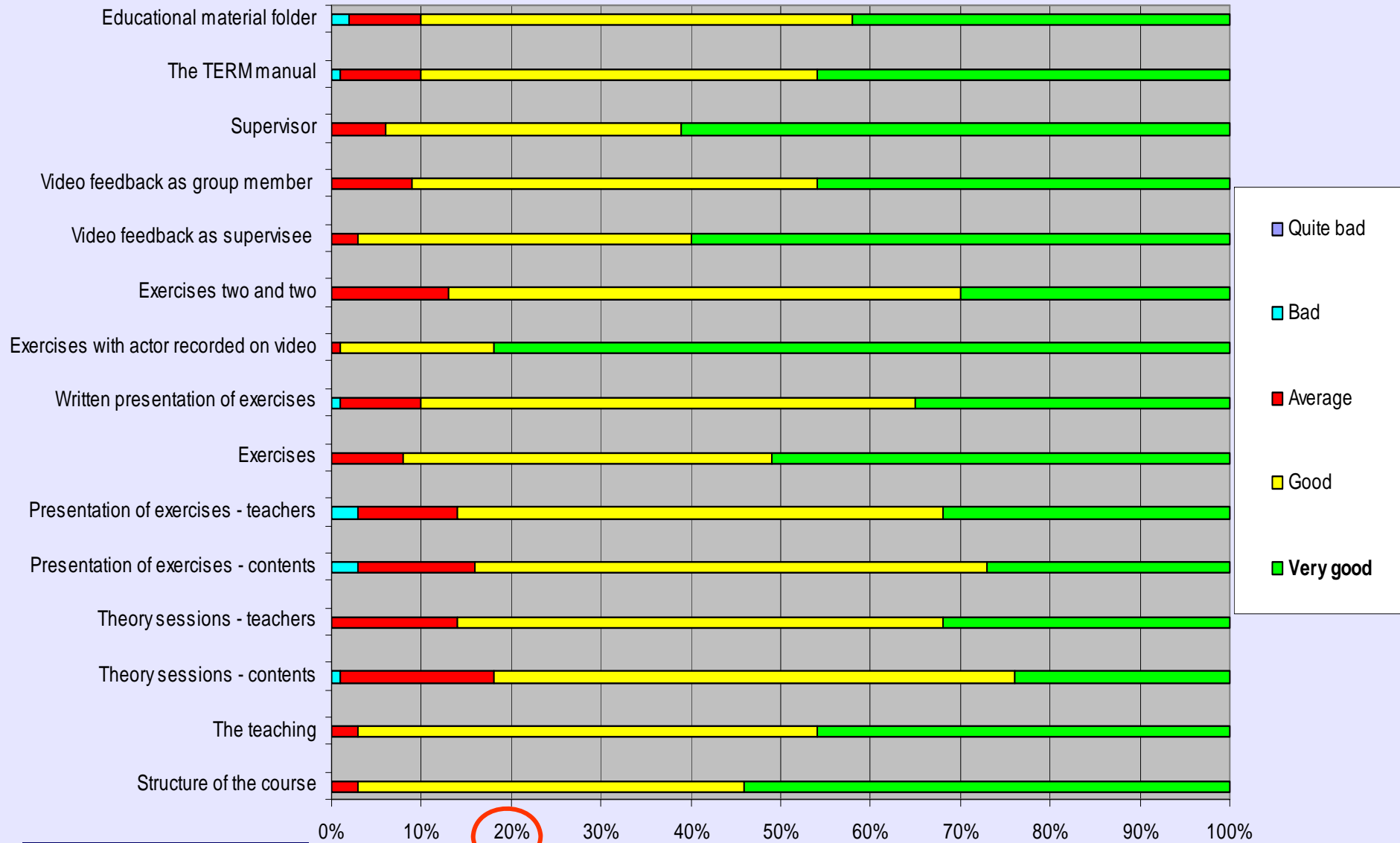


Evaluation - outcome

- 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

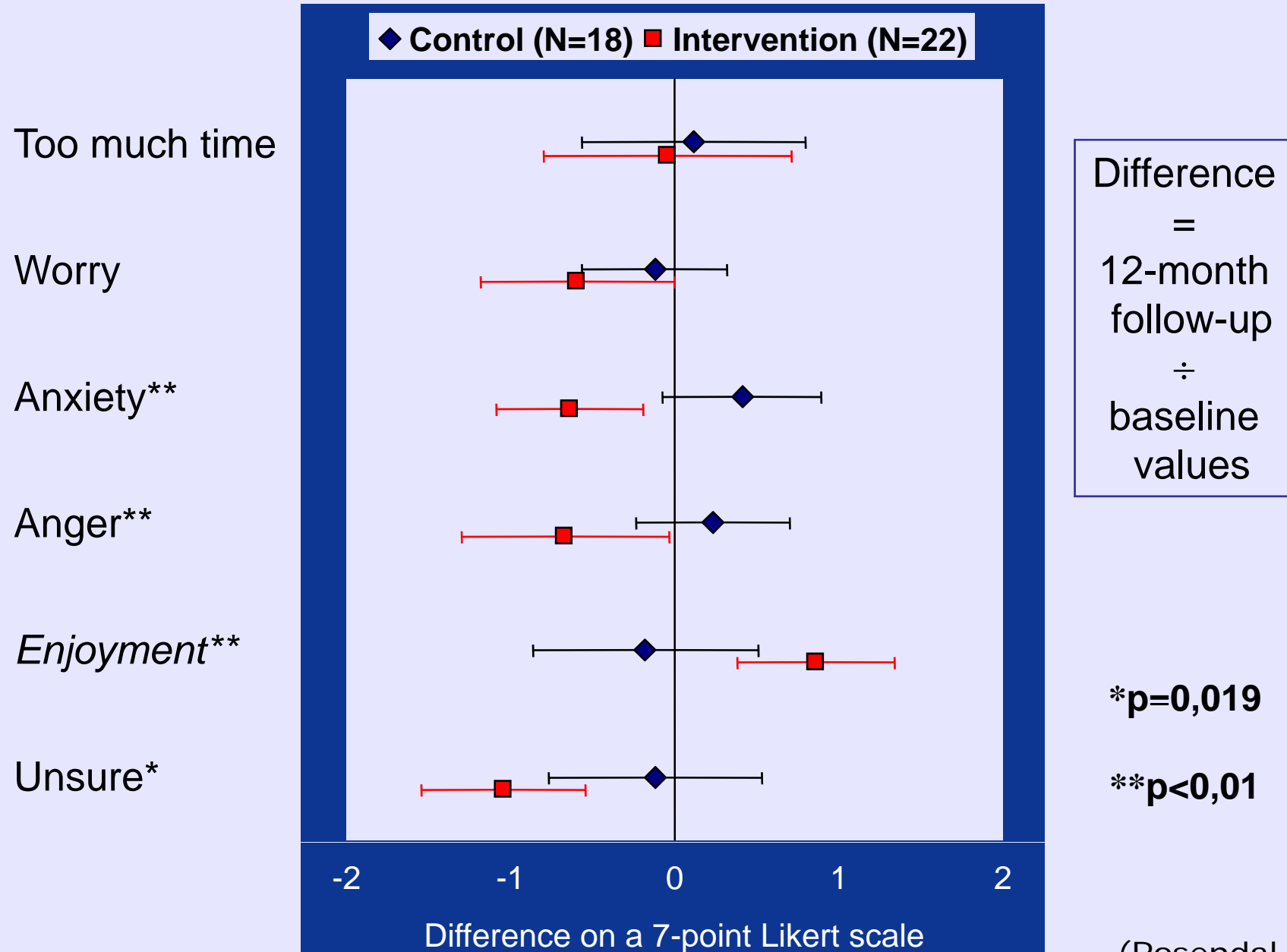
very much



Hartmann 1989

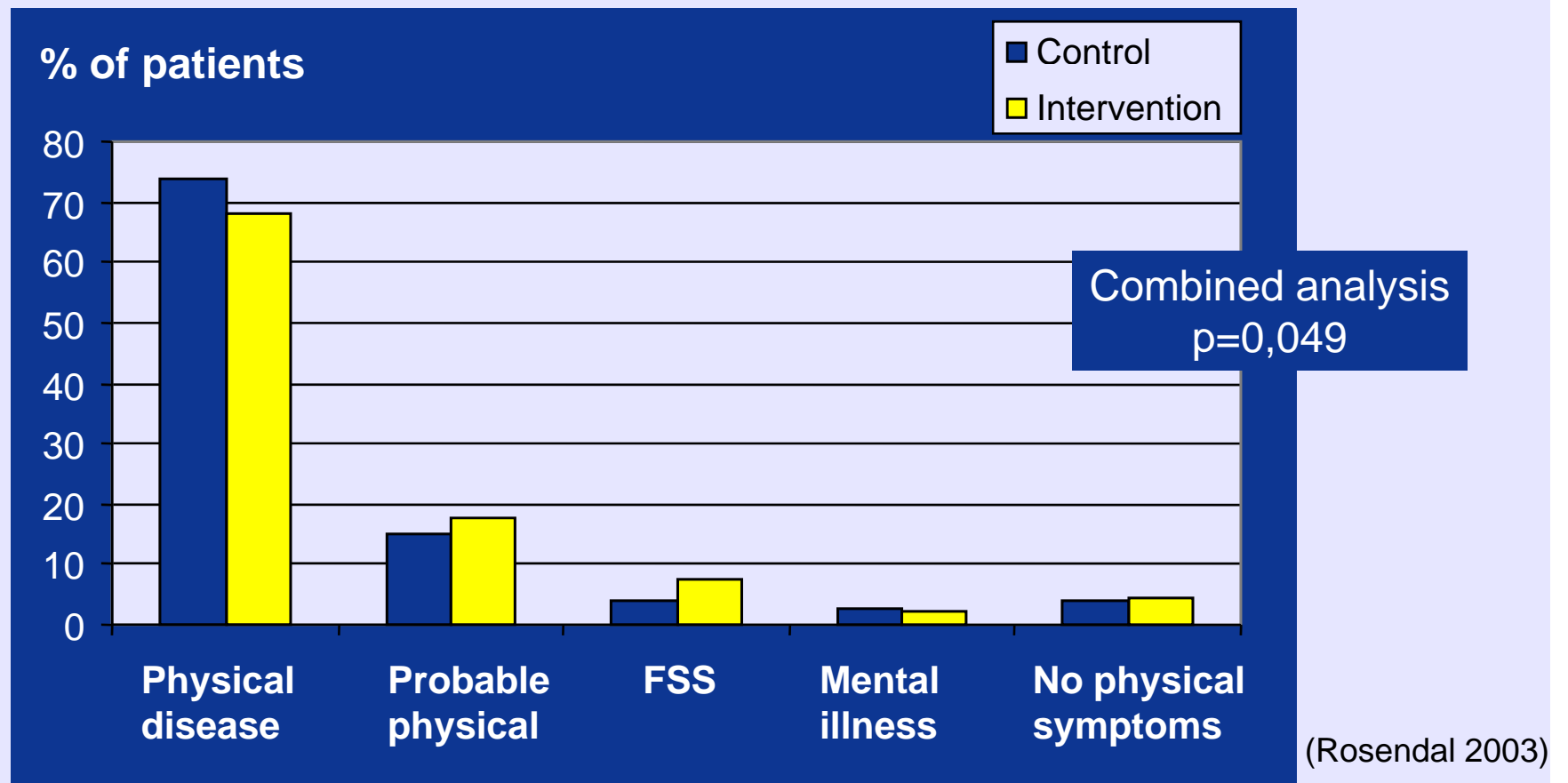


GPs' change in attitudes

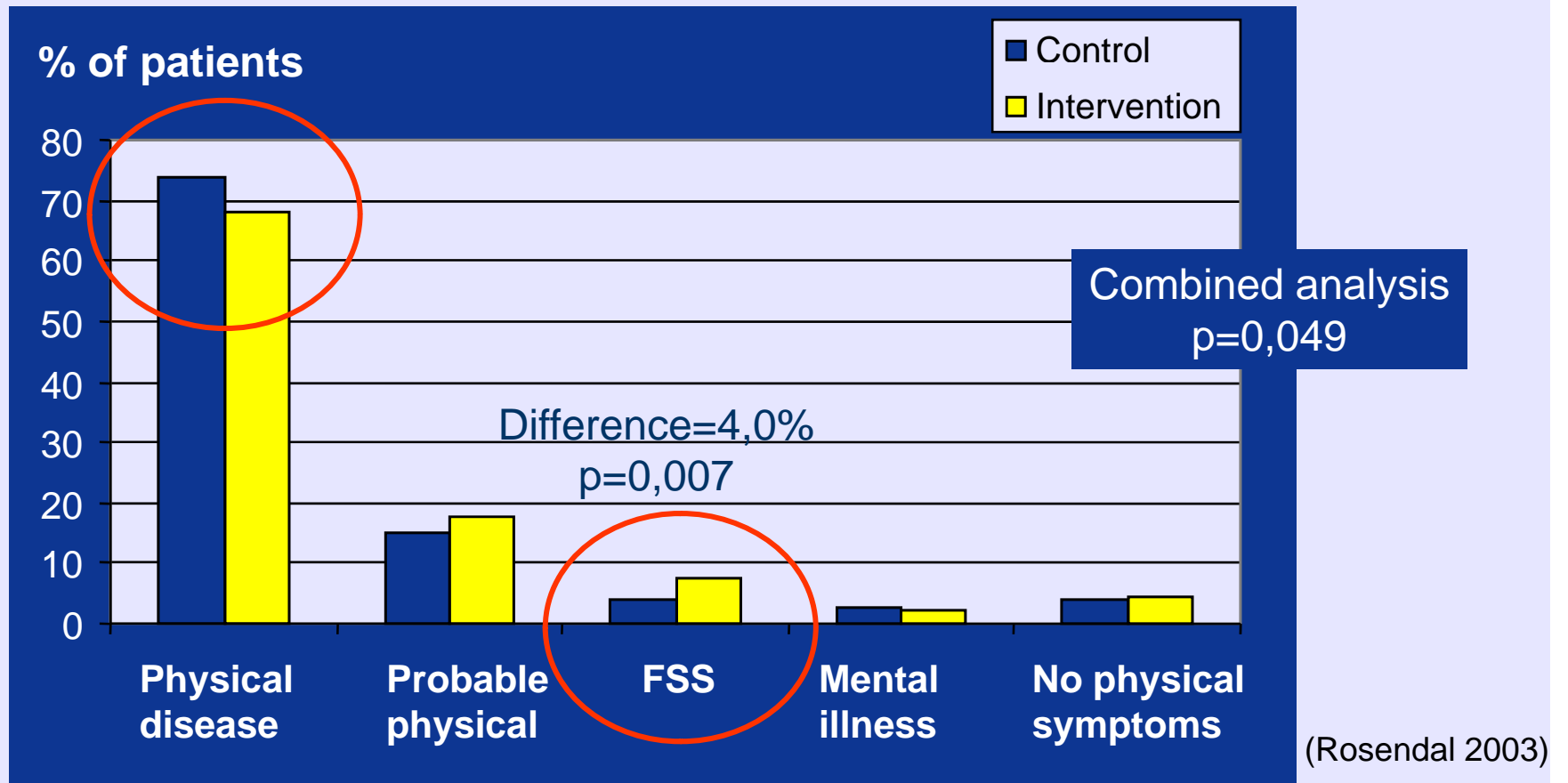


(Rosendal 2005)

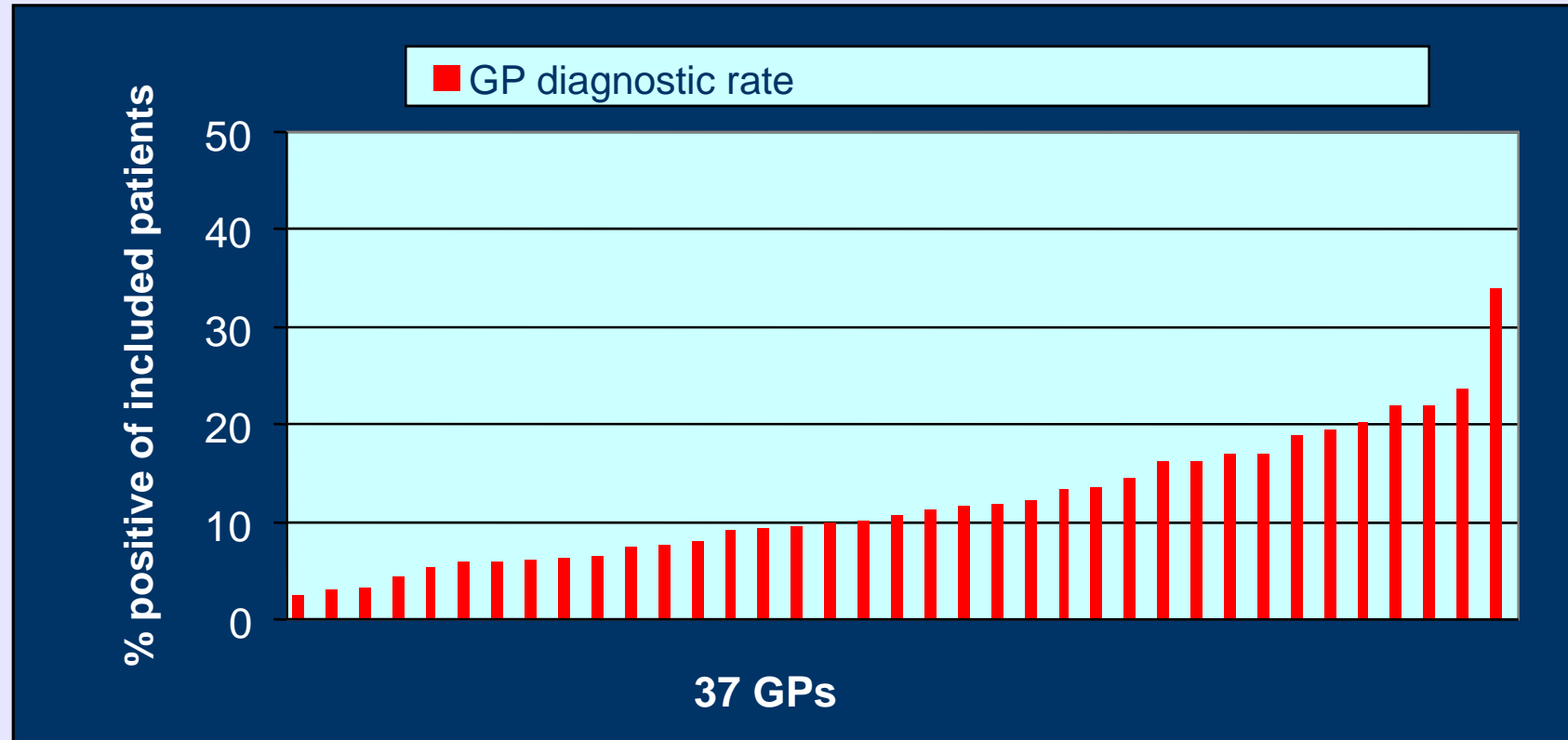
GPs' classification



GPs' classification



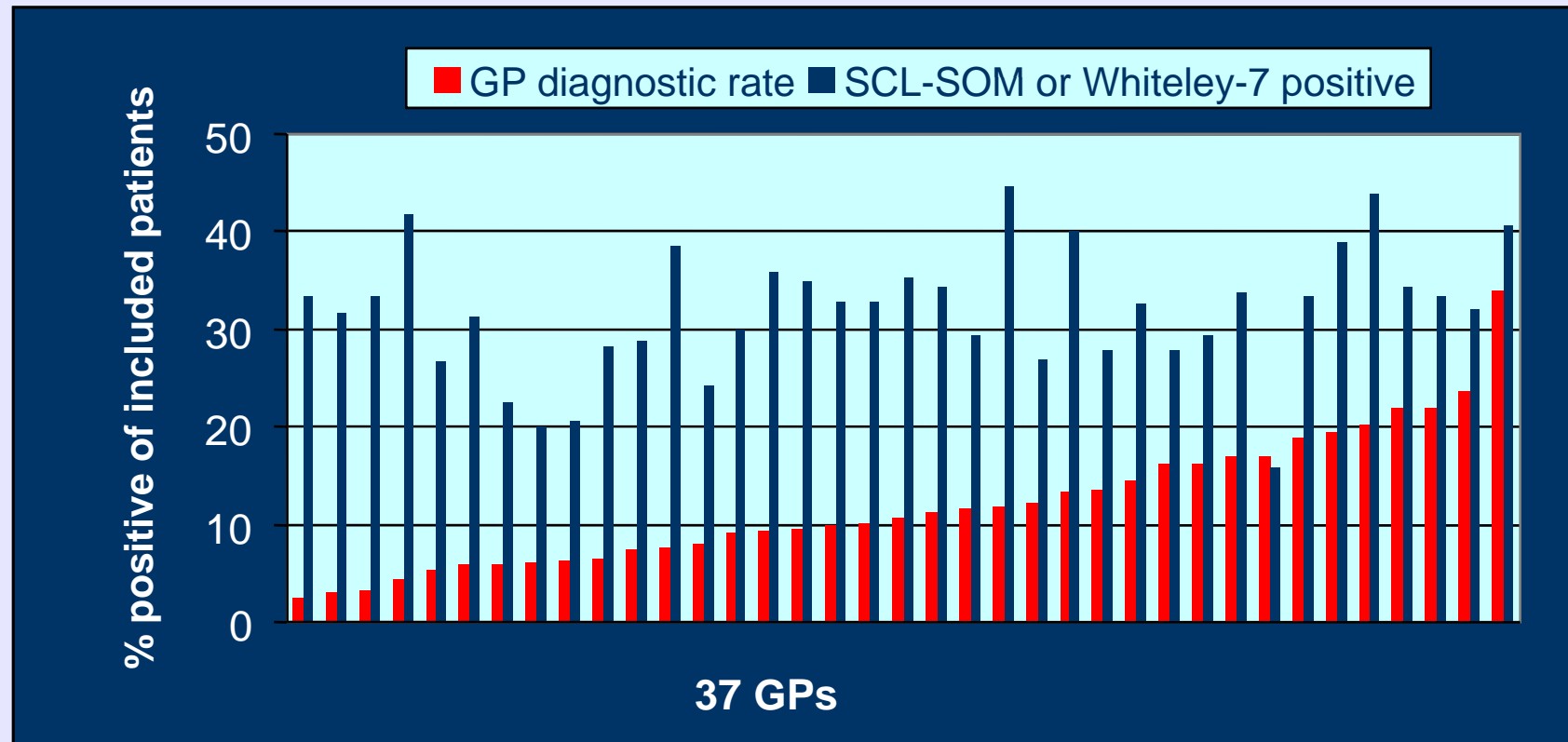
Classification rate of FSS by GPs



(Rosendal 2003)



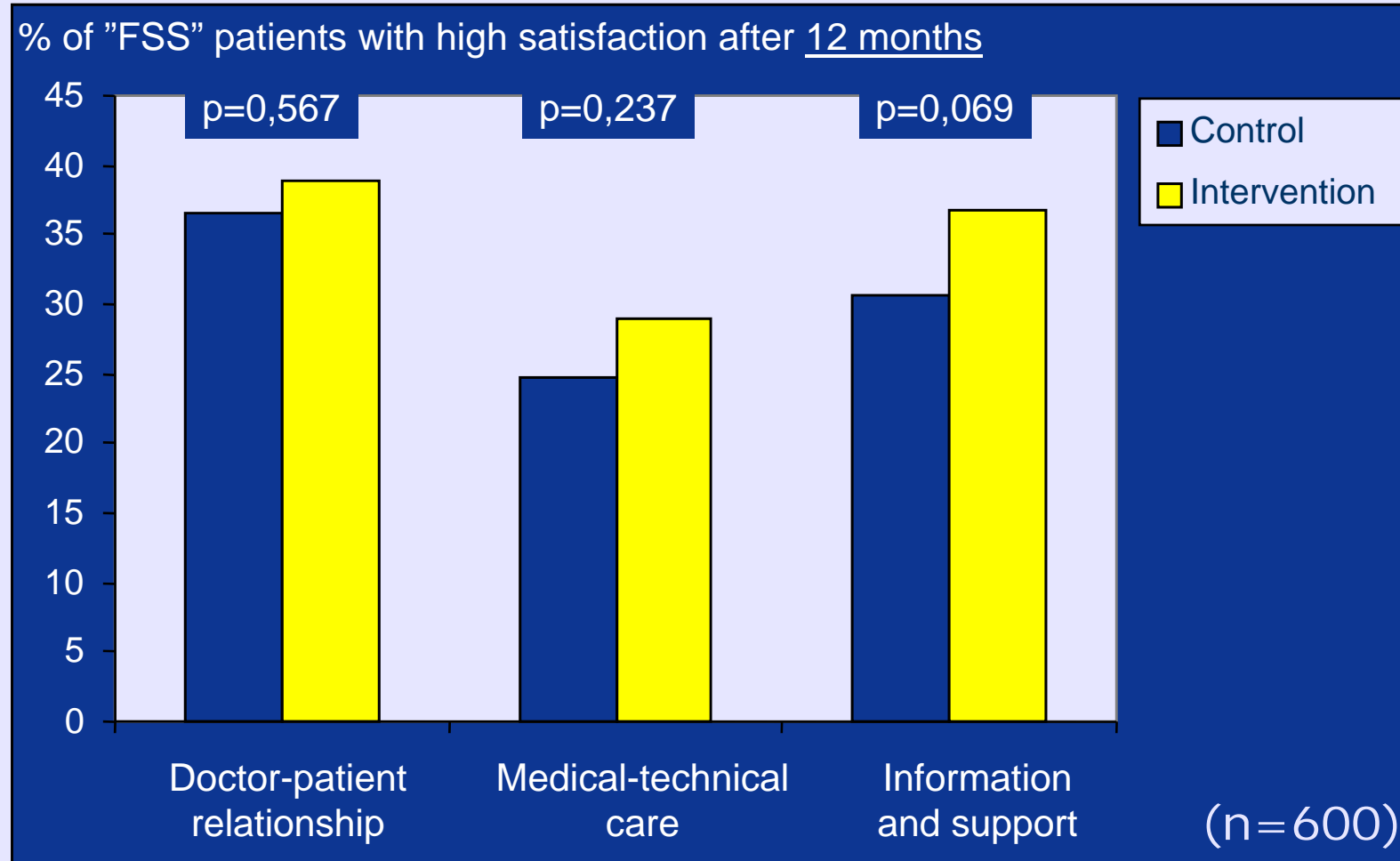
Classification rate of FSS by GPs



(Rosendal 2003)

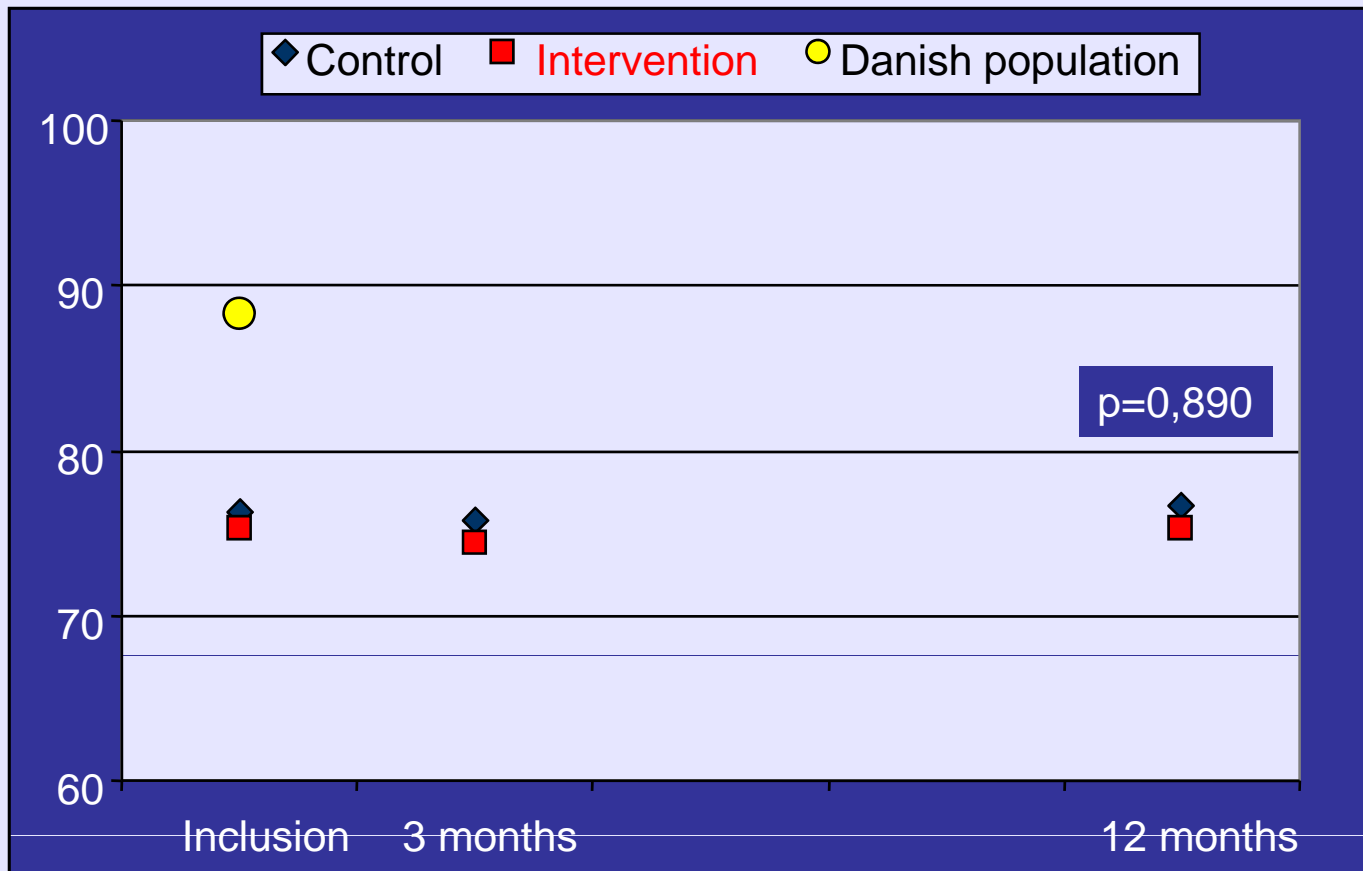


Evaluation - Patient Satisfaction



Patient health

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



Rosendal 2006

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!