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PSYCHIATRIC CONSULTATION FOR SOMATIZING PATIENTS IN THE FAMILY PRACTICE SETTING: A FEASIBILITY STUDY*

CHRISTINA M. VAN DER FELTZ-CORNELIS, M.D.

DIRK WIJKEL, PH.D.

Vrije Universiteit Hospital, The Netherlands

PETER F. M. VERHAAK, PH.D.
NIVEL, The Netherlands

DORINE H. COLLIJN, PH.D.

FRITS J. HUYSE, M.D., PH.D.

RICHARD VAN DYCK, M.D., PH.D.

Vrije Universiteit Hospital, The Netherlands

ABSTRACT

Objective: The purpose of the study was to assess the feasibility of a psychiatric consultation intervention for somatizing patients in the family practice setting in terms of 1) patient compliance, 2) patient satisfaction, and 3) compliance and satisfaction of general practitioners (GPs). *Method*: In a period of nine months, forty-six patients were selected for psychiatric consultation in six solo family practices in a semi-urban area in the Netherlands. The consultation included an interview with the consulting psychiatrist, the patient, and the GP. A written summary of the consultation was provided to the GP and the patient. A booster session with a GP and psychiatrist was included to evaluate and reinforce the recommendations. *Results*: The majority of the selected patients agreed to participate after informed consent.

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An intervention was implemented containing interpersonal techniques, reattribution, clarification, and structuring. GP compliance with recommendations was 100 percent, patient compliance 75 percent. *Conclusion*: A standardized psychiatric consultation for somatizing patients in a family practice setting can be implemented. Several levels of implementation can be distinguished.

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Key Words: consultation-liaison psychiatry, family practice, general practitioner, somatoform disorders, biopsychosocial model, interpersonal techniques, reattribution, compliance

INTRODUCTION

Unlike the case in general hospital wards, psychiatric consultation is not commonly performed for somatizing patients in a family practice setting. Accordingly, research in this field is lacking. This research is compounded by methodological problems concerning the selection, definition, and comorbidity of somatizing patients [1-3] which hamper the development of standardized interventions in the heterogeneous primary care population. Another reason is a lack of motivation on the part of both the general practitioner (GP) and the patient to turn to a psychiatrist for consultation. However, interest in this kind of research is growing, as is the belief that psychiatric consultation for somatizing patients in the family practice setting might be useful [4]. The early detection and treatment of somatizing patients, particularly in primary care, could prevent doctor shopping and superfluous, costly treatment when psychiatric morbidity such as somatoform disorder, depressive disorder, or panic disorder go undetected [5-8]. Research performed in the United States has been reviewed extensively. European research started as Balint [9] promoted consultation with and in primary care practices. Two collaboration models have been suggested. In the United States, the replacement model is preferred, in which a psychiatrist resides in the primary care center and replaces the GPs role for mental problems [10-13]. In Britain, collaboration by the liaison attachment model is preferred in which the psychiatrist gives consultation to the GP, who has the patient in treatment, as this conforms to the view of the GP as the cornerstone of community health care [14-18].

The Dutch situation resembles both the British and American ones. Comparable to the American situation is the "American bypass" formed by Community Mental Health Centers directly accessible to patients with mental problems. However, the general health system is not accessible without referral by the GP. In the case of somatizing patients, who generally want to be referred to a medical specialist, the Dutch situation can therefore be considered similar to the British one. Consequently, in the Netherlands just as in Britain, research on a liaison attachment model of collaboration is preferred to the American

replacement model. The possibilities of psychiatric consultation for primary care patients have been explored [19] and attention has been devoted to psychiatric screening of somatizing patients in secondary care [20, 21], but research on psychiatric consultation for these patients in a family practice setting has not yet been performed in the Netherlands.

Two primary types of consultation can be discerned. In the first, originating from community psychiatry [22], the psychiatrist does not meet the patient but supervises the GP [23, 24]. In the second type of consultation, the psychiatrist actually sees the patient, within the liaison attachment model. The difference with psychiatric referral [25] is that the consultation occurs in the family practice setting and in the presence of the GP. The psychiatrist does not take over the treatment, but advises the GP. This confirms the position of the GP as a cornerstone in community health care and, by lowering the threshold for psychiatric treatment, enhances possibilities for the psychiatric treatment of somatizing patients. This study explores the feasibility of the latter type of consultation according to the C-L model in the Dutch situation.

METHOD

Subjects

The setting for this study was a semi-urban area with eight GP practices, two of which refused to participate because of lack of time or motivation. Thus 75 percent of the GP practices in the area participated in the study. The target population included patients between the ages of eighteen and seventy-five, enrolled in the family practice for at least one year, who visited the family practice with physical complaints that seemed inappropriately severe and chronic as compared to their physical condition as found in the case history, physical examination and laboratory findings by the GP. In cases of doubt, the patient was referred by the GP, but physical examination and diagnostic interventions such as endoscopy, X-ray analysis, etc. by the specialist had not yielded organic pathology, OR if organic pathology was found, it was insufficient to explain the complaints of the patient. Also the patients had to have a history in the previous year with at least three periods of a similar presentation of complaints. Exclusion criteria were mental health treatment or schizophrenia, bipolar disorder or dementia, and insufficient mastery of the Dutch language. These patients were identified by the GP as they visited his practice during the nine-month period of the study. They were asked to give their informed consent to participate after it was explained to them that this study was being conducted in order to evaluate the connection between physical and mental complaints, and that in some cases a psychiatrist would give a consultation to patients with the GP present. If the patient consented, the GP decided whether he wanted a psychiatric consultation for this particular patient or not.

A total of forty-nine patients were asked to participate. Forty-six (92%) patients were seen in consultation with the psychiatrist. One patient moved after the initial consultation so the final sample used in this study consisted of forty-five patients.

Procedure

A new intervention was developed for this study by the authors. The focus was integrated treatment with cooperation between the GP and the psychiatrist in the family practice office. The treatment was administered to somatizing patients selected by the GP by the above mentioned criteria.

The theoretical basis of the intervention, including the consultant's letters to the GP, is a biopsychosocial model as discussed by Engel [26], Schwartz [27], and Leigh [28, 29]. Use of this approach for an intervention in somatizing patients was judged appropriate for outpatients based on successful use with medical inpatients with a combination of physical and mental complaints [30-32].

The general aim is to evaluate the physical condition of the patient as well as the possible presence of psychiatric symptoms. Attention is devoted to psychiatric disorders as well as to related risk factors such as life events, vulnerability such as hereditary factors, and potential strengths such as social factors. After a diagnostic formulation, treatment recommendations are made. After preparation, the intervention contains two phases.

Preparation: Practice Level

In order to get thoroughly acquainted with the GP's routine, the psychiatric consultant visits the family practice twice. The recognition of somatizing patients, inclusion and exclusion criteria for the study, and the way to propose psychiatric consultation are discussed. In a forty-five minute semistructured interview developed by the authors for this study, the GP's attitude and expertise in this field are explored and goals are set to enhance expertise and ameliorate any identified barriers to refer patients to the experimenters during the study. The referral patterns of the GP are also explored. Furthermore, in this phase the practical use of a biopsychosocial model is demonstrated in a joint meeting of all participating consultant psychiatrists and GPs, and during the above mentioned visits to the practice on the basis of patient contacts. A minimum of two patient contacts per GP was required for this purpose. Finally, a time is set for weekly consultations.

Intervention: Case Level

This phase contains the actual consultation with a planned duration of seventy-five minutes, and a booster session of fifteen minutes six weeks later.

Phase one: Consultation — In the first fifteen minutes, the psychiatrist and GP summarize the patient's history and actual complaints and explore the questions of the GP for this particular consultation. In the following thirty minutes, the patient

is asked in. The GP introduces the psychiatrist and gives a short summary of the reasons for the consultation, including his own questions for the psychiatrist. After this the psychiatrist conducts the interview, explains the length and structure of the consultation, and asks the patient to set forth his own view on his symptoms, their possible connection with mental symptoms, and interactional aspects with the GP as well as his own considerations for treatment. A semi-structured psychiatric interview and mental status examination are conducted.

During the short timespan of the interview, an effort is made to summarize the problems by viewing them from different perspectives formed by several psychotherapeutic frames of reference. After that, an integral diagnosis is made and recommendations to the patient are formulated. Perspectives that are used are the following:

- An effort is made to form a *cognitive-behavioral reconstruction* that links the physical symptoms with psychosocial problems and resulting emotional symptoms of the patient. The focus is especially on conscious motives and behavioral patterns that can be described by the patients themselves.
- Information is given about somatization and its mechanism and prognosis. For example: stress due to relational problems evokes stomach complaints by way of the autonomic nervous system. This aspect is therefore of a *clarifying, instructive* nature and implies *reattribution* of the meaning of the symptom.
- Techniques from interpersonal therapy (IPT) [33, 34] are used to explore the role of the interaction pattern between the patient and the GP in the somatization process. Expectations and assumptions of the patient and GP about their relationship as well as expectations about the consultation are explored.
- *Control* is placed with the patient by explicitly offering him the choice to emphasize symptomatology as well as treatment options in his interaction with the GP. This creates the self-image of an individual who makes free choices instead of the helpless person many patients see themselves as.

After this interview, the patient withdraws to the waiting room for about fifteen minutes to consider possible treatment options, while the GP and psychiatrist discuss diagnosis and treatment options, as well as preferable interaction patterns.

In the following fifteen minutes, the patient, GP and psychiatrist discuss the recommended treatment and the frequency and method for the GP to interact with the patient. This aspect of the consultation therefore is of an open, communicative nature. The probable prognosis of continued somatizing or dealing with psychosocial problems is discussed, as well as possible treatment options. A positive treatment recommendation is always given to the patient.

Afterwards, the psychiatrist writes a summary of the treatment recommendations for the patient and the GP.

Phase two: Booster session — Six weeks after the consultation, the GP and psychiatrist evaluate the consultation and effects as well as the practicability of the treatment recommendations given; if needed, further treatment recommendations are given or the GP is reinforced to continue the present approach.

Assessment

(1) Baseline

The somatizing patients were assessed for health care utilization, satisfaction with care and also completed several symptom scales. Results comparing this group to non-somatizing patients have been reported elsewhere [35].

The GP filled out a form for every selected patient, with questions about their attitude and perceived demand of physician time. Questions were asked as well about the GP's own feelings about his interaction with the patient, and his motivation to request consultation.

(2) Follow-Up Data

Consultation — Before consultation, the expectations of the patients who consented were assessed.

After consultation, ICD-10 diagnoses established by a short semi-structured psychiatric interview, treatment recommendations, the number of consultation meetings, number of canceled meetings, number of specialist referrals per meeting, timing and duration of the consultation were assessed.

Booster session — Two weeks after the booster session a survey was sent to the patients to assess their psychological status, health care utilization, compliance and satisfaction with the given treatment recommendations. The GP's compliance, and satisfaction with the psychiatrist's recommendations were assessed by the survey as well. The GP's expertise and attitude towards somatization were assessed again by a semi-structured interview at the end of the study.

Three implementation levels assessing the process of the intervention were distinguished:

1. *no implementation*: no application of recommendations,
2. *semi-implementation*: changing the doctor-patient relationship,
3. *full implementation*: full application of treatment recommendations.

RESULTS

Sociodemographics

The mean age of the patient group that received consultation was 43.4 years. Age, educational level, and work situation did not differ between the groups, but there were more women than men and fewer people who lived alone in the patient

group that received consultation. These findings are described extensively elsewhere [35].

Psychiatric Disorders

Table 1 shows fifty-seven ICD-10 diagnoses established during consultation in the group of forty-five somatizers. A total of thirty patients met criteria for a single ICD-10 category, eight patients met criteria for two diagnoses, two patients met criteria for three, and two patients met criteria for four diagnoses.

Table 1 shows that the majority of diagnoses consisted of the ICD-10 category Neurotic, stress-related, and somatoform disorders such as somatoform disorders, neurasthenia, and generalized anxiety disorder, followed by Behavioral disorders associated with physiologic disorders and physical factors namely muscle tension complaints, Mental and behavioral disturbances due to substance abuse namely alcohol dependency, and Affective disorders namely depressive disorders.

Intervention Effects: Practice Level

Consultation Rate

The average frequency of consultation was twenty-six meetings in nine months, in which forty-six patients received consultation. However the means per GP differed from weekly consultations to consultation every ten to twelve weeks. The mean number of patients seen during a meeting was 1.6 with a range of 1-4.

Intervention

Phase one: The mean duration of the consultation was seventy minutes, with a range of forty-five to 105 minutes. The average timing of the booster-session was 7.7 weeks after the consultation, with a range of five to fourteen weeks. New treatment recommendations were given only once, so that the booster-session mainly acted as feedback and as reinforcement for the GP as well as the psychiatrist.

Compliance and Satisfaction of the GPs

There were no cases of non-compliance of the GPs with the treatment recommendations. The GPs were "very satisfied" with ten consultations (29%), "satisfied" with twenty-two consultations (65%), "a bit satisfied" with two consultations (6%), and dissatisfied with no consultations (0%). These results are discussed more extensively elsewhere [35].

Table 1. ICD-10 Psychiatric Diagnoses in the Somatizers with Consultation (42 Patients, 57 Diagnoses)

Category	*N* (%)
Mental and behavioral disorders due to psychoactive substance abuse	
Alcohol dependency	4 (7.0)
Nicotine dependency	1 (1.8)
Affective disorders	
Depressive disorder	5 (8.8)
Neurotic and stress-related disorders	
Generalized anxiety disorder	2 (3.5)
Panic disorder	1 (1.8)
Agoraphobia	1 (1.8)
Neurasthenia	6 (10.3)
Somatoform disorders	
Somatoform autonomic dysfunction	20 (35.0)
Somatoform pain disorder	5 (8.8)
Undifferentiated somatoform disorder	2 (3.5)
Somatization disorder	2 (3.5)
Behavioral disorders associated with physiological disorders and physical factors	
Eating disorder	1 (1.8)
Psychological or behavioral factors associated with disturbances classified elsewhere	4 (7.0)
Personality disorders and adult behavioral disorders	
Pathological gambling	1 (1.8)
Obsessive compulsive personality disorder	1 (1.8)
Developmental disorders	
Mild mental retardation	1 (1.8)
TOTAL	57 (100.0)

Intervention Effects: Patients

Intervention: Treatment Recommendations

Table 2 shows the fifty-three recommendations of the consultant psychiatrist given to the GP and the patient during the consultations. More than one recommendation per consultation could be given. Referral for specialist evaluation of physical complaints was recommended in 13 percent of the cases. If

Table 2. Treatment Recommendations Given by the Consultant Psychiatrist to GP and Patient during Consultation to Forty-Five Somatizers Seen in Consultation (53 Treatment Recommendations, 45 Cases; Given Percentage is Percentage of the Cases)

Treatment Recommendations	*N* (% of Cases)
Explore physical complaints further in primary care	4 (8.9)
Referral to specialist for evaluation of physical complaints	6 (13.3)
Address substance abuse	1 (1.9)
Referral to alcohol addiction treatment clinic	1 (1.9)
Prescribe psychoactive medication	12 (26.6)
Referral to psychotherapist	19 (42.2)
Secure case management	2 (3.8)
Relaxation exercises	7 (15.5)
Help family of patient	1 (1.9)

psychotropic medication was recommended, it was generally benzodiazepines or antidepressants.

Table 3 shows the ICD-10 categories in which psychoactive drugs and psychotherapy were advised. Antidepressants were prescribed for depression or somatoform pain disorder. In nineteen cases psychotherapy was advised. A total of fifteen of these patients had only a single diagnosis, i.e., neurasthenia, somatoform pain disorder, or depressive disorder. In four cases of this group, the treatment recommendation to start psychotherapy was combined with the treatment recommendation to take psychotropic medication.

The remaining four cases (21%) that were advised to start psychotherapy had a combination of ICD-10 diagnoses and shared a total of thirteen ICD-10 categories, mostly somatoform disorders. However, in Table 3 only the primary diagnosis is listed.

Summary of Treatment Recommendations for the Patient

As mentioned in Methods, each patient received a summary of treatment recommendations after the intervention. To give an illustration, the following case is discussed.

Case A

The patient, a fifty-five-year-old married woman with grown-up children, visited the GP frequently with vague complaints and insisted on referral. Previous referrals had yielded no evidence of serious disease; the GP found the patient's tenaciousness difficult to handle. It made him feel incompetent.

Table 3. Recommendations Made for Forty-Two Somatizing Patients, by ICD-10 Category

ICD-10 Categories	*N*	Psychotropic Drugs[a]			Psycho- therapy	Psychotherapy and Psychotropic Drugs
		AD	BD	Both		
Single diagnosis:						
Alcohol dependency	4	1	0	0	2	1
Depression	8	3	0	0	3	2
Generalized anxiety disorder	1	0	1	0	0	0
Agoraphobia	1	0	0	1	0	0
Neurasthenia	6	0	1	0	4	1
Somatoform autonomous dysfunction	2	0	1	0	1	0
Somatoform pain disorder	4	1	0	0	3	0
Muscle tension complaints	4	0	0	2	2	0
SUBTOTAL	30	5	3	3	15	4
Multiple diagnoses, Primary:						
Alcohol dependency		0	0	0	2	0
Depression		1	0	0	1	0
Eating disorder		0	0	0	1	0
SUBTOTAL		1	0	0	4	0
TOTAL		12			19	4

[a]AD = antidepressant, BD = benzodiazepine.

During the consultation, the patient turned out to be content if the referral yielded no evidence of disease. It reassured her. For the GP as well as the patient, it was a relief to be able to discuss this during the consultation. A situation ensued that made it possible to negotiate the amount of security that had to be obtained in this kind of situation. In the end the patient was willing to put up with an examination by the GP instead of referral to a specialist, and the GP understood that a lack of positive findings during the examination could suffice to reassure the patient.

During the booster-session, it was clear that the interactional problem had been solved. No further specialist referrals had been necessary. The diagnosis given to the patient was obsessive compulsive personality disorder and somatoform autonomous dysfunction. The summary for the patient included recommendations concerning the interaction with the GP as follows:

> Recommendations in connection with consultation on account of stomach ache and fatigue.
>
> During the conversation, you explained that from time to time you feel the need to be reassured about the nature of your complaints. You think this has to do with your personality and with your upbringing. You need certainty. Also, some members of your family died of carcinoma of the intestines and as you experience stomach aches regularly, you want to be sure they are not due to a malignant disease.
> If people have to endure stress daily, they can suffer from pain in the stomach, breast etc. that results from the reactions of the nervous system on stress. You told us that your mother died recently, and your husband had a heart attack. This made you nervous as you are afraid to lose him as well.
> It is important to keep in mind that you need security, especially if you experience stress in your daily life. This security can only partly be obtained as far as the exclusion of malignant diseases is concerned. You will have to discuss with your GP whether a referral is needed or not. Also you will find that talking about your grief, e.g. about your mother's death, will give relief, mentally as well as physically.

Summary for the GP; Biopsychosocial Model

The matching biopsychosocial scheme, shown in Figure 1, should be interpreted as follows: from left to right the case history, consultation findings and diagnosis, and treatment recommendations. From top to bottom there are four horizontal axes: the biological one for medical findings and treatment and the psychological axis that contains personality traits, coping mechanisms, psychiatric history and symptoms, the psychiatric diagnosis and the treatment recommendations. The following two axes are the first and second social axis. The first one concerns the general health care system. Both its organizational and consumptional aspects can be qualified and quantified such as: frequency of hospitalization, non-compliance, alternative medical treatment, and so forth. The second social axis mentions family, employment circumstances, life events, etc.

Our conclusion is that in this case, there was clearly an interactional problem. It consisted in uncertainty of the patient leading to referral requests, enhancing the feeling of the GP that the patient would not accept a negative finding, leading to feelings of inadequacy of the GP and more specialist referrals. This interactional problem could be solved by explicit discussion during the consultation as well as by mentioning it in the summary of treatment recommendations for the patient together with hypotheses about the background of the interactional problem as

	History	Consultation Findings	Diagnosis or Conclusion	Treatment
Biological	Female 55 years old Stomach ache	Complaints due to stress	Irritable bowel syndrome	Diet
Psychological	Obsessive compulsive woman	Needs security, certainty	Somatoform autonomous dysfunction; Obsessive compulsive personality disorder	Explain link between stress and physical complaints
Social System I: Health Care System	Referrals to neurologist and internal medicine: no findings	Requests referrals because of insecurity	Insecurity hampers interaction patient-GP	Discuss security and interaction; no referrals
Social System II: Family, Employment	Married, 2 children, colon carcinoma in family	Mother died recently, husband had heart attack	Disease and death in the family	Share grief with others

Figure 1. Biopsychosocial scheme for the cause of stomach ache in an obsessive compulsive woman.

well as recommendations about future management of specialist referrals. This produced a situation with more treatment possibilities.

Patient's Compliance and Satisfaction

Forty-two percent of the recommendations were followed by the patients; 33 percent of the recommendations were partly followed; and 25 percent of the recommendations were not followed.

Ninety-one percent of the patients were "satisfied or very satisfied," 6 percent were "a bit satisfied" and 3 percent were "a bit dissatisfied." These results are discussed more extensively elsewhere [35].

DISCUSSION

The findings of this study give rise to a number of conclusions and some critical comments with regard to the effects of the intervention assessed in psychiatric consultation for somatizing patients in the family practice setting.

Patient Participation

Only 6 percent of the patients refused to cooperate after informed consent, a figure much lower than the 30 percent we had considered acceptable at the beginning of our study. This might be indicative of two factors: first, it might be that the GPs selected the patients they thought would not refuse; however, this is not consistent with our finding that they selected the more serious somatizers for consultation, as was reported elsewhere [35]. Second, it might be that the consultation in the family practice setting lowered the threshold for patients to cooperate. This would be in accordance with previous research. In 1969, Lyons emphasized the advantages of joint consultations where the contact between the psychiatrist and GP was mutually beneficial, since the psychiatrist could get more information than by referral letter, the GP developed more psychiatric knowledge, and the patient found it easier to see a psychiatrist this way [36].

Psychiatric Disorders

The majority of patients selected by GPs for consultation suffered from ICD-10 somatoform disorders, followed by the depressive disorders.

Intervention

It is probably acceptable to expect a consultation rate of two to three patients a month, with a booster-session eight weeks later. The consultation duration of seventy minutes approximates the estimate that was made beforehand.

The *summary in the letter to the patient* proved highly useful, as was noted in another study assessing the feasibility and utility of written summaries of a

consultation to psychiatric out-patients [37]. Smith et al. [38] used a letter to the GP in their intervention with somatizing patients in primary care, informing them about nature and course of somatization in general and giving general treatment recommendations focused on reduction of health care utilization. This produced a drop in health care utilization in their study. The difference with this study is that we sent a letter to the patient as well as to the GP, clarifying the aspects of their specific case and giving treatment recommendations that not only focused on case management, but also gave further treatment recommendations. This method fostered compliance and satisfaction of patients as well as GPs in our study.

The structure of the intervention proved useful and practical; the use of a biopsychosocial model had its merits, enabling the consulting psychiatrist to visualize a link between, e.g., life events, psychological reactions, somatic symptoms, and visits to the family practice; however, GPs preferred verbal explanations including a short conclusion about diagnosis and treatment.

Treatment Recommendation: Referral to a Somatic Specialist

As can be seen from the inclusion- and exclusion-criteria, existence of actual somatic disease was no reason to exclude patients. This has played a role in our finding that in 13 percent of the cases referral to a specialist for evaluation of physical complaints was recommended. However, it is important to note that this recommendation was always given together with other recommendations that should be followed in the case that this referral yielded no results.

Treatment Recommendation: Psychotherapeutic Referral

Psychotherapeutic referral occurred in 41 percent of cases. In this group, two categories could be distinguished.

Of the patients who had primary somatization in the form of autonomous somatoform disorder, in six out of twenty (30%) of cases, psychotherapeutic referral was recommended. Our expectation was that most patients of this group would not be suitable for psychotherapy and would benefit more from a one-time reattribution by psychiatric consultation, combined with relaxation techniques that would enable them to endure their complaints. Reattribution worked well for this group, but it turned out that part of the primary somatization group felt the need for psychotherapeutic referral, after reattribution had taken place. It was thought that in such cases the apparently existing latent need for psychotherapeutic treatment had been made explicit by the intervention.

Of the cases of secondary somatization, psychotherapeutic referral as treatment recommendation was given to 80 percent of the patients with a depressive disorder, in all four cases (100%) of alcohol addiction and in 90 percent of the cases where one of the diagnoses was neurasthenia. A troublesome finding is that in four cases of alcohol addiction, only once did the psychiatric consultant recommend referral to an alcohol addiction clinic. This might be inadequate.

Treatment Recommendation: Psychoactive Medication

Psychoactive medication was prescribed for twelve patients. Antidepressants were prescribed to patients with a depressive disorder or neurasthenia; benzodiazepines to patients with a generalized anxiety disorder, neurasthenia, or autonomous somatoform disorder. A combination was prescribed in two of four cases of muscle tension complaints.

Levels of Implementation

As discussed before, three implementation levels assessing the process of the intervention were distinguished:

1. *no implementation*: no application of recommendations,
2. *semi-implementation*: changing the doctor-patient relationship,
3. *full implementation*: full application of treatment recommendations.

In the majority of cases, we reached the semi- or full-implementation level, as would be expected from the high satisfaction of patients (91%) and GPs (94%) with the intervention and from the high compliance: 75 percent of the treatment recommendations were (partly) followed by the patients and there were no cases of non-compliance by the GPs.

Changes in health care utilization did not occur. According to the GPs this was in part due to the fact that patients were usually selected for consultation after a referral to a specialist had yielded no results. Also, the patients were not necessarily excessively high consumers. The selection of the patients therefore played a role in the lack of change in health care utilization.

Our conclusion is that psychiatric consultation for somatizing patients in the family practice setting is feasible and can be fully implemented. The intervention focuses on the treatment of underlying psychiatric disorders in the case of secondary somatization and has specific aspects that make it useful for primary somatizing patients, as it focuses on reattribution, giving information, clarifying and structuring the interaction with the GP, and emphasizing the responsibility and control of the patient.

Further research, including randomized control studies, will have to be conducted to explore the efficacy and costs of this intervention, and to see if the intervention has any lasting impact on GP clinical practice and patient outcomes.

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Direct reprint requests to:

Christina van der Feltz-Cornelis, M.D.
Department of Psychiatry
Vrije Universiteit Hospital
P.O. Box 7057, 1007 MB
Amsterdam, The Netherlands