Cognitive behavioural therapy reduced the frequency and intensity of medically unexplained physical symptoms


Objective
To compare the effectiveness of cognitive behavioural therapy with optimised medical care in patients with medically unexplained physical symptoms.

Design
Randomised controlled trial with 12-month follow-up.

Setting
General medical outpatient clinic of Leiden University Hospital in the Netherlands.

Patients
79 Dutch-native patients between ages 18 and 64 years (mean age 37.5; 50% women) with unexplained physical symptoms who had an intensity score of ≥ 5 or a score of ≥ 10 on anxiety or depression scales. Patients were excluded if they had organic psychiatric disorders, chronic alcoholism, psychosis, or suicidal ideas or if they were currently receiving psychological or psychiatric treatment. 96% completed 12 months of follow-up.

Intervention
39 patients were allocated to cognitive behavioural therapy. Depending on the severity of the problem, the number of treatment sessions varied between 0 and 16 (mean of 12). The maximum duration of therapy was 6 months, and the mean duration of therapy was 21 weeks. 40 patients were allocated to the control group, which received optimised medical care.

Main Outcome Measures
Recovery rate, frequency and intensity of symptoms, psychological distress, functional impairment, hypochondriacal beliefs and attitudes, and number of visits to the general practitioner.

Main Results
At 6 months of follow-up and after adjusting for the effects of differences in frequency of presenting symptoms and the presence of psychiatric disorder at baseline, patients who received cognitive behavioural therapy had a higher recovery rate (odds ratio [OR] 0.32, 95% CI 0.12 to 0.83); less frequent symptoms during the previous month (OR 0.32, CI 0.13 to 0.77); a lower mean intensity of physical symptoms (mean difference [MD] −1.4, CI −2.3 to −0.5); fewer limitations in social (OR 0.35, CI 0.14 to 0.85) and leisure activities (OR 0.36, CI 0.14 to 0.93); activities; less illness behaviour (MD −2.5, CI −4.6 to −0.5); and less impairment of sleep (OR 0.24, CI 0.09 to 0.65) than did those in the control group. At 12 months of follow-up, the adjusted ORs were 0.43 (CI 0.17 to 1.08) for recovery rate, 0.35 (CI 0.15 to 0.84) for frequency of symptoms, and MD −1.2 (CI −2.3 to −0.2) for mean intensity of symptoms. Functional impairment in terms of social interactions and sleep and illness behaviour remained lower in patients who received cognitive behavioural therapy at 12 months of follow-up.

Conclusions
Cognitive behavioural therapy reduced the frequency and intensity of physical symptoms, impairment of social interactions and sleep, and illness behaviour in patients with medically unexplained physical symptoms at 12-month follow-up. The recovery rate was higher with cognitive behavioural therapy at 6 months but not at 12 months of follow-up.

Most patients who use medical outpatient clinics do not have a conventional biomedical explanation for their symptoms. In ambulatory care in the United States, < 1 in 5 patients received an organic diagnosis. Although most investigations were unhelpful, the cost was considerable, especially for symptoms such as headache and back pain (1). When organic diagnoses are excluded, physicians frequently do not know what to do next. Many patients do not have formal psychiatric disorders, and, even for those who do, psychiatric referrals are rarely popular.

In the study by Speckens and colleagues, cognitive behavioural therapy was both acceptable and effective. Most patients were not “cured” of their physical symptoms, but clinically meaningful reductions in symptom intensity were achieved, coupled with substantial improvements in functional ability.

Cognitive behavioural therapy is relatively straightforward in its theory and practice. It involves cognitive techniques that examine the way that conscious thoughts and beliefs perpetuate disability and behavioural programmes aimed at interrupting the vicious cycles of symptoms and their behavioural consequences (2). Cognitive behavioural therapy, however, still requires training and supervision. Few medical clinics have access to either psychologists or nurse specialists who are able to deliver effective treatment, and, outside the research setting, no clinic is able to offer this approach to every patient with persistent medically unexplained symptoms. This study adds to the clinical and economic evidence in favour of cognitive behavioural therapy (2), but the lack of appropriate personnel will continue to limit the availability of this useful treatment.

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References