

ABSTRACT

This thesis addresses an important but conceptually difficult area of psychiatry - namely the nosological status of common forms of somatic distress, such as persistent fatigue - in older people. Despite ongoing controversy, their study is relevant to this age group given the increased onset of medical illness and the increased use of primary care health services in later life.

The traditional approach to these syndromes is hierarchical. Diagnostic systems exclude first, all patients in whom somatic symptoms may have a medical aetiology, and second, those with depression and anxiety. That is, the notion of somatoform is restricted to patients without any concurrent medical illness or psychological disorder.

This approach has a number of flaws. There is no gold standard for identifying “medically unexplained” symptoms and syndromes. Variables such as culture, patient access to health care and the quality of medical assessment, including practitioner access to investigative tools, may influence diagnosis. Contrary to their conventional theoretical basis, pathological changes have been identified in so-called “functional” syndromes such as chronic fatigue and irritable bowel.

Further, the conventional belief that somatic syndromes may be subsumed within depression or anxiety disorders has been challenged by recent literature in younger people. This work has suggested that discrete forms of fatigue may be identified and differentiated from psychological disorder on the basis of genetic determinants, longitudinal course and patterns of treatment response. In addition, distinct somatic and psychological symptom dimensions have been found to underlie common patient complaints.

The failings of the traditional model, and the results of these recent studies, have led to the promotion of an alternate conceptual model in the international literature which seems more appropriate for use in this thesis. Without the imperative to *initially* exclude medical illness, it permits the formal study of patterns of medical and psychological comorbidity in somatic distress. Importantly, *there is no suggestion that this alternate model simply overturns the need to assess medical comorbidity*. It is more consistent with the way that other neurotic disorders have been treated in community and primary care studies. For instance, in studies of depression, diagnosis is recorded first and aetiology determined thereafter.

The alternative conceptual approach recognises that whilst the most common psychiatric presentations (that is, phenotypes) involve an admixture of somatic and psychological phenomena, distinct forms may also occur.

Aims and hypotheses

The central aspect of this thesis was to determine the nosological status of somatic distress - that is whether there is evidence for discrete illness forms or symptom dimensions - in older people attending primary care services. In particular, relationships with psychological distress and medical illness were explored.

Two possible models which may explain the relationship between somatic and psychological distress were tested. That is, could somatic distress be viewed as a variant of psychological distress (unitary illness model), or are there some discrete forms (overlapping, non-contiguous illness model)? A related question is the extent to which medical variables contribute to any model explaining relationships between somatic and psychological distress.

On the basis of previous work in younger people, this thesis primarily used persistent fatigue disorder as a relevant phenotype for somatic distress.

The specific aims were to determine in older people attending primary care

- (i) the prevalence of persistent fatigue;
- (ii) the socio-demographic and medical correlates of persistent fatigue;
- (iii) the longitudinal relationship between persistent fatigue and psychological disorder over 12 months; and
- (iv) the symptom dimensions that underpin somatic and psychological symptom reporting.

The hypotheses to be tested were that in older people attending primary care

- (i) persistent fatigue is common, and occurs as both a discrete disorder and comorbidly with psychological disorder;
- (ii) persistent fatigue is predicted not only by factors that are shared with psychological disorder, but also by other independent factors such as medical comorbidity;
- (iii) persistent fatigue will tend to follow a longitudinal course independent of psychological disorder; and
- (iv) common presentations of distress are best described by a series of somatic and psychological dimensions, rather than one common or mixed symptom dimension.

Method

The thesis consisted of two studies. The central study was a longitudinal clinical examination of ambulatory, community dwelling patients aged 60 years and over presenting to general practice. Self-report questionnaires and semi-structured interview were used to determine the rate, clinical correlates and 12 month course of persistent fatigue disorder.

Also, separate cross-sectional data from a large nationwide sample of older general practice patients were subjected to exploratory factor analysis to determine the dimensions underlying somatic and psychological symptom reporting.

Results

In the **longitudinal general practice study**, some 27.4% of the sample of 124 patients presented with fatigue. Pure forms of both persistent fatigue (10.5%) and depression and anxiety (9.7%) were present, but were less common than comorbid fatigue/psychological disorder (16.9%).

Cases of persistent fatigue (including pure and comorbid forms) were predicted by female gender (OR 2.96, 95% CI 1.05-8.32), psychological disorder (OR 8.43, 95% CI 2.98-23.88) and medical morbidity (OR 4.74, 95% CI 1.63-13.85), but not by age or psychotropic drug use. Cases of psychological disorder (including pure and comorbid forms) were predicted by persistent fatigue (OR 9.64, 95% CI 3.37-27.57) and psychotropic drug use (OR 4.01, 95% CI 1.26-12.77), but not by gender, medical morbidity or social resources.

Most importantly, persistent fatigue and psychological cases followed courses independent of each other over 12 months (overall kappa 0.68, $p < 0.001$). Pure forms of each failed to predict the onset of the pure form of the other.

In the **nationwide general practice study**, somatic and psychological symptom reporting by 11 670 older patients was underpinned by separate mood, cognitive, musculo-skeletal and fatigue dimensions, explaining 37.6%, 9.9%, 5.2% and 4.8% of the variance respectively. Whilst all four factors were strongly inter-correlated, psychological and somatic items loaded onto distinct symptom dimensions.

There was a negative correlation between general practitioners rating that patient presentation was due to a medical reason and factor scores on all dimensions. That is, fatigue and musculo-skeletal symptoms were not more likely to be reported by patients deemed to have a medical presentation.

Conclusions

Persistent fatigue is common in older ambulant general practice patients.

Importantly, pure forms of fatigue were noted, as well as forms comorbid with psychological disorder. A discrete form of fatigue persisted over time and did not predict the onset of pure forms of psychological disorder. Distinct somatic and psychological symptom dimensions could also be differentiated.

The overall pattern of results was consistent with previous cross-sectional and longitudinal studies of persistent fatigue in younger people, and largely supports the notion that phenotypes of persistent fatigue and psychological disorder may present independently of each other. That is, an overlapping, non-contiguous illness model may best explain the relationship between these forms of distress.

Whilst there is evidence for limited separation between somatic and psychological distress in older people, medical variables, such as total illness morbidity and medication use, remain an integral part of this overall model. Specifically, this demonstrates the difficulty of distinguishing medical illness from somatic distress, and underlines the importance of a multidimensional rather than reductionistic model for understanding somatic distress.