

## Article

# Coping style in primary care adult patients with abridged somatoform disorders

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## ABSTRACT

**Background and objective** Empirical data are scarce regarding the adaptive response to stress for patients with somatoform disorders. Our objective was to identify the preferred coping strategies of patients with abridged somatisation, a common condition in primary care. Because of the functional impairment associated with somatisation, we predicted a preference for less effective, emotion-focused coping strategies over more effective, problem-focused adaptations.

**Design** We conducted a cross-sectional, observational study of physician referred primary care patients who presented with persistent, medically unexplained, physical symptoms. Patients were classified into two abridged somatisation groups by symptom frequency and duration, as determined by the *Diagnostic Interview Schedule*. The groups were compared with each other and with a non-clinical reference group; outcome variables were eight emotion- and problem-focused strategies, as measured by the *Ways of Coping Questionnaire*.

**Results** Of the 72 eligible individuals, 48 participated in the study. Median age was 48 years and 75% of patients were women; 26 had somatic syndrome and 22 had a subthreshold somatising level. Patients with abridged somatisation disorders preferred emotion-focused coping strategies – typically detachment and impact minimisation, wishful thinking and problem avoidance.

**Conclusions** Patients with abridged somatising disorder responded to stress with predominantly emotion-focused strategies, which may be associated with a lower level of positive adaptive outcome. Our findings suggest that patients with abridged somatising disorders might benefit from emphasis on problem-focused coping strategies, delivered through primary care, to improve quality of life and decrease healthcare utilisation costs.

**Keywords:** abridged somatisation, abridged somatoform, diagnostic interview schedule, *Ways Of Coping Questionnaire*

## Introduction

Stress and coping are conceptualised as dynamic interactions between individuals and their environment. The perception or appraisal of the stressful event, rather than the event itself, predominately determines coping behaviour.<sup>1,2</sup> In the context of stressful and threatening internal or external demands, coping has been defined as the synthesised emotional, cognitive and behavioural style one uses to manage or escape from the stressful event.<sup>3</sup> A desirable coping outcome is resilience (i.e. the capacity to attenuate long-term consequences of stressful encounters).<sup>4</sup> An equally important coping outcome is the development of anticipatory, proactive strategies to facilitate pre-emptive actions that prevent or minimise the potential impact of a detected potential stressor.<sup>5</sup>

This dynamic, interactional model of stress and coping is theoretically and clinically important because stress appraisal and subsequent coping responses affect psychological adjustment,<sup>6</sup> medical outcomes and health-related quality of life in both clinical<sup>7,8</sup> and non-clinical adults.<sup>9</sup> Furthermore, identifying distinct coping strategies that are associated with positive outcomes in specific chronic illnesses addresses the disease-specific imperative to focus on translational therapeutic actions that promote meaningful clinical change in resilience and quality of life.<sup>10</sup> Thus, the identification and the strategic application of unique coping strategies are critical in the development of effective interventions for specific chronic illness such as diabetes mellitus, cardiovascular disease, chronic pain, rheumatoid arthritis and somatoform disorders.<sup>11,12</sup>

In this interactional model, coping flexibility has been functionally defined as variability in coping style, depending on the situation. A person's ability to cope with stressful situations depends on the perception of a good fit between available coping strategies and a particular situation, as well as the prediction of their effectiveness in attaining the desired goal.<sup>13,14</sup> For example, an individual may cognitively appraise a situation as highly threatening and unlikely to dissipate on its own; thus, that person might choose to expend a high level of effort and energy to resolve the threat by using a solution-focused, problem-solving approach. In other words, the goal is to seek resolution through active problem solving. In contrast, another individual's cognitive appraisal might indicate that the threat is transient and therefore the individual responds (copes) by using a distancing strategy that aims to detach the person from the situation and minimise the its importance. For some, this is a good strategy-situation fit because a more passive response minimises

expenditure of psychological resources on a future threat, while still fulfilling the goal of handling the particular situation.

Assessment of coping style has focused on measuring multidimensional descriptions of an individual's self-reported, situation-specific, adaptive thoughts and behaviours.<sup>3,6</sup> Despite clinical and research interest in psychological theories of stress and adaptive (coping) style associated with emotional well-being and somatic health, no suitable, validated assessment techniques were available before the *Ways of Coping Questionnaire (WCQ)* was published.<sup>15</sup> The WCQ consists of empirically derived coping scales that reflect the two-dimensional model of problem-focused and emotion-focused coping. A conventional interpretation of the difference between problem-focused and emotion-focused coping is that the former is used more often in situations considered changeable, whereas the latter is reserved for threatening circumstances judged not amenable to change. Thus, problem-focused coping aims at directly altering or solving the stressor, whereas the goal of emotion-focused strategies is to change the feeling or attitude associated with the stressor.

Demographic variables may affect the developmental course and expression of coping style preference, depending on the patient sample. Gender differences were reported as insignificant in an early study,<sup>16</sup> but recent work has shown that women may choose not to use select coping strategies that would benefit their health because of perceived social pressures.<sup>17</sup> Hampel and Petermann<sup>18</sup> found that adolescent females tended to cope more often by seeking social support and relied less on problem-focused strategies compared with males. Women are more likely to use emotion-focused and avoidance-based coping strategies, which may partly explain the greater incidence of depression and anxiety disorders in women.<sup>19</sup> One explanation for this positive relationship is that overreliance on emotion-focused strategies (e.g. suppression and avoidance) may prevent habituation to stressful events by only temporarily reducing negative emotional and physiological arousal, resulting in even stronger negative reactions in the long term.<sup>20</sup> Age differences generally yield mixed results<sup>21</sup> or support the contention that older people use fewer coping strategies overall,<sup>22</sup> ostensibly to conserve energy. Some evidence suggests that lower educational level is predictive of a greater use of emotion-focused strategies.<sup>23</sup>

Regarding the coping style of clinical and non-clinical groups, Beasley and colleagues<sup>24</sup> reported that emotion-focused coping (e.g. distancing or self-control) was associated with higher levels of somatic symptoms and distress, whereas problem-focused coping (e.g. solution-focused problem solving) was

more prevalent in a non-clinical sample. In a sample of patients with digestive cancer, greater preference for emotion-focused coping was associated with lower quality of life.<sup>23</sup> In a clinical sample of somatising patients,<sup>25</sup> the three most common coping strategies were problem-solving, avoidance and seeking social support, as assessed by the Folkman and Lazarus<sup>15</sup> model. Coping style identification in clinically distressed groups is worthwhile because evidence indicates that a brief intervention can induce positive change in a person's adaptive pattern in response to depression and anxiety,<sup>26</sup> metastatic breast cancer<sup>27</sup> or chronic pain.<sup>28</sup>

The unabridged, criterion-based definition of somatisation disorder (Table 1), as it appears in the *Diagnostic and Statistical Manual*,<sup>29</sup> is rare in primary care because the lifetime prevalence rate ranges from 0.2% to 2% for women and less than 0.2% for men. In contrast, patients with abridged somatoform disorders have substantially fewer medically unexplained symptoms; nevertheless, they have comparable functional impairment,<sup>30</sup> use of healthcare services<sup>31</sup> and psychiatric comorbidity,<sup>32</sup> and they

commonly present in primary care (prevalence rate ranges from 10% to 22%).<sup>30</sup> Abridged somatisation is clinically challenging, and the excessive use of healthcare resources results in increased medical costs, independent of comorbid psychiatric or medical conditions.<sup>33</sup>

In this study, we investigated coping style of patients with abridged somatoform syndromes who commonly present in primary care. Characteristics of the two abridged somatoform syndromes, defined by the number of medically unexplained symptoms, were compared and contrasted with those of a non-referred, non-clinical group with similar demographic features (the reference group). This study contributes to the somatoform literature, as our search did not identify a prior study that specifically had examined the relationship between coping style and abridged somatisation in primary care. On the basis of prior research examining the relationship between coping style and functional outcome, we predicted a preference for emotion-focused strategies in our sample of patients with an abridged somatoform syndrome.

**Table 1** DSM-IV-TR criteria for somatisation disorder

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- A) A history of many physical complaints beginning before age 30 years that occur over a period of several years and result in treatment being sought or significant impairment in social, occupational, or other important areas of functioning.
- B) Each of the following criteria must have been met, with individual symptoms occurring at any time during the course of the disturbance:
- 1) Four pain symptoms: a history of pain related to at least four different sites or functions (e.g. head, abdomen, back, joints, extremities, chest, or rectum; during menstruation, during sexual intercourse, or during urination)
  - 2) Two gastrointestinal symptoms: a history of at least two gastrointestinal symptoms other than pain (e.g. nausea, bloating, vomiting other than during pregnancy, diarrhea, or intolerance of several different foods)
  - 3) One sexual symptom: a history of at least one sexual or reproductive symptom other than pain (e.g. sexual indifference, erectile or ejaculatory dysfunction, irregular menses, excessive menstrual bleeding, or vomiting throughout pregnancy)
  - 4) One pseudoneurological symptom: a history of at least one symptom or deficit suggesting a neurological condition not limited to pain (conversion symptoms such as impaired coordination or balance, paralysis or localised weakness, difficulty swallowing or lump in throat, aphonia, urinary retention, hallucinations, loss of touch or pain sensation, double vision, blindness, deafness, seizures; dissociative symptoms such as amnesia; or loss of consciousness other than fainting)
- C) Either 1 or 2
- 1) After appropriate investigation, each of the symptoms in criterion B cannot be fully explained by a known general medical condition or the direct effects of a substance (e.g. a drug of abuse or a medication)
  - 2) When there is a related general medical condition, the physical complaints or resulting social or occupational impairment are in excess of what would be expected from the history, physical examination, or laboratory findings
- D) The symptoms are not intentionally produced or feigned (as in factitious disorder or malingering)
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Abbreviation: DSM-IV-TR – *Diagnostic and Statistical Manual of Mental Disorders* (4e) text revision  
Adapted from American Psychiatric Association.<sup>29</sup> Used with permission

## Methods

We note that the coping-style information presented in this article was included in a larger data set that was recently published in a study that focused on the association between somatisation and alexithymia.<sup>34</sup>

### Patient population and study site

The target population consisted of outpatient adults (18 years or older) whose primary medical care was provided at a family practice clinic located in a micropolitan community with a census population of less than 30 000. Clinic personnel consisted of nine family practice staff physicians (100% white; 78% men; post-residency experience ranged from early career to near retirement) and 24 medical residents on rotation. The clinic attends to about 60 000 patients, with 45 000 clinic visits per year. The micropolitan study setting is one of five outpatient primary care medical clinics within the Department of Family Medicine of an academic medical centre located in a metropolitan area of the Upper Midwest region of the USA. This particular primary care clinic was selected because of its mix of rural and suburban patients.

### Selection of study participants and reference group

The study protocol was reviewed and approved by the Mayo Clinic Institutional Review Board and the research committees of the Department of Family Medicine and the Department of Psychiatry and Psychology. Nine family practice staff physicians were invited to refer their adult patients who presented with recurrent, multiple somatic concerns and met the following criteria: 1) patients lacked an identifiable, organic, pathologic or pathophysiologic mechanism that could account for their symptoms, or patients showed social or occupational impairment that grossly exceeded what might be expected from the physical findings; 2) patients were viewed by the family physician as 'frequent clinic attenders'; and 3) medically unexplained symptoms had persisted for six months or longer.

The referral invitation sent to each family physician was a one-page document delivered to the physician's clinic mailbox three times during a one-month recruitment period. Five doctors opted to participate in the study; their referred patients were mailed a letter of invitation to participate in

the study. Patients who agreed to participate were assessed in one-on-one, face-to-face interviews by a trained research assistant in the family practice clinic. Signed informed consent was obtained before any data were collected. The assessment instruments were presented in a counterbalanced fashion to control for possible ordering or carryover effects such as fatigue or acquiescent responding.

The reference group selected for this study<sup>15</sup> was consistent with our intent to compare the coping style of clinically referred somatising patients with a non-referred, non-clinical, community-based sample. To minimise bias, these patients were similar to the referral group with regard to race and ethnicity, socio-economic level and sex.

## Measurements

### *Diagnostic Interview Schedule*<sup>35</sup>

The *Diagnostic Interview Schedule* (DIS) was developed by the Division of Biometry and Epidemiology at the National Institute of Mental Health for use in large-scale epidemiologic studies.<sup>35</sup> It is the forerunner of the *Composite International Diagnostic Interview*.<sup>36</sup> It is a highly structured and in-depth interview with 260 questions, developed for use by trained lay interviewers. Version III-R of the DIS was used in this study.

Somatisation disorder is the only somatoform diagnosis solicited by the DIS. The DIS elicits the elements of a diagnosis, including the presence or absence of symptoms, their severity, frequency and distribution over time and whether they can be explained by physical illness, drug or alcohol abuse (or both), or other psychiatric diagnosis. The DIS lists 37 somatic symptoms, each with a specific set of questions and probes. The unique characteristic of the DIS (i.e. probes that improve the distinction as to whether the symptom origin is totally or partially psychogenic) facilitates collection of data that are more specific than interviews that record symptom counts only.

The *Diagnostic and Statistical Manual of Mental Disorders, Third Edition - Revised*<sup>37</sup> diagnoses (current and lifetime) were generated on the basis of interview answers. If the research assistant had doubts about the origin of a symptom, a brief summary of the patient's response was recorded and subsequently reviewed by one of the study investigators (DCA), who made the final determination of whether a symptom was counted toward a diagnosis of somatisation disorder.

### Ways of Coping Questionnaire<sup>15</sup>

The WCQ<sup>15,38</sup> is a 66-item, self-report inventory that can be completed in approximately ten minutes. It is designed to assess coping processes in response to a specific stressful encounter experienced by the patient during the past week. Thus, a 'snapshot' view of coping style is obtained, rather than a longitudinal analysis across a range of stressful events in multiple encounters.

The WCQ consists of eight empirically derived scales that measure problem-focused coping (aimed at altering the stressful situation) and emotion-focused coping (directed at changing the feeling or attitude elicited by the stressor). The problem-focused scales reflect a deliberate, analytical effort to alter or solve the stressor. A representative test item on the Planful Problem-Solving scale is 'I made a plan of action and followed it'. In contrast, one of the emotion-focused scales (the Distancing scale), gauges effort to detach oneself and minimise the significance of the problem. A representative test item is 'I went on as if nothing had happened'.

The 66 items are scored on a four-point Likert scale: 0 – does not apply or not used; 1 – used somewhat; 2 – used quite a bit; 3 – used a great deal. The normative sample for the WCQ was composed of non-clinical, middle-class, white, married couples who had at least one child living at home. Alpha coefficients averaged over five test administrations ranged from 0.61 to 0.79, indicating adequate internal consistency. Scale intercorrelations ranged from 0.01 to 0.39, with the highest correlations within focus-type category, as expected.

### Classification of participants into somatising syndromes

DIS results were used to classify the patients into two abridged somatising groups:

- 1 the somatic syndrome group consisted of men and women with at least four or six medically unexplained symptoms, respectively, and a minimum symptom duration of six months; and
- 2 the somatic subsyndrome group consisted of men and women with only one to three medically unexplained symptoms for a six-month duration.

The Escobar criteria for classifying somatising patients into abridged categories<sup>39</sup> were selected for this study because this classification system was empirically derived and showed criterion and predictive validity for important outcomes such as functional impairment and use of healthcare services. The criteria for classifying the study participants into the two abridged syndromes are listed in Table 2.

### Study design and statistical analysis

A cross-sectional observational design<sup>40</sup> was used in this investigation. The Fisher exact test was used to analyse unmatched nominal data, the Wilcoxon rank sum test for unmatched ordinal data, and the two-sample *t* test was used for continuous data.<sup>41</sup> *P* values of less than 0.05 were considered statistically significant.

## Results

### Study participants

During the one-month recruitment period, 48 of 72 referred patients agreed to participate in the study. A comparison of study participants and decliners is shown in Table 3. No statistically significant differences were observed between participants and decliners, except that the latter had had fewer outpatient clinic visits in the previous year. This finding raises the possibility that the participants perceived a greater level of medical problems and thus were more persistent in obtaining medical attention and treatment. Another possible explanation is that the family physician may have been less certain when differentiating between medically explained versus medically unexplained symptoms,

**Table 2** Classification of patients with abridged somatisation

Criteria <sup>a</sup>	Somatic syndrome group <sup>b</sup>	Somatic subsyndrome group <sup>c</sup>
Medically unexplained symptoms	No.	No.
Men	≥4	1–3
Women	≥6	1–3
Minimum duration of symptoms	Months 6	Months 6

<sup>a</sup> Based on results from the *Diagnostic Interview Schedule*

<sup>b</sup> Based on diagnostic criteria from Escobar *et al*<sup>39</sup>

<sup>c</sup> Patients had somatising symptoms but did not meet the syndrome threshold for the abridged somatising group

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thereby prompting additional outpatient clinic visits to pursue that distinction.

Figure 1 shows characteristics of the 48 study participants. In brief, the majority of participating patients were women, married and high school graduates. All 48 patients were white.

### Classification of somatising patients

As described in the Methods, DIS results were used to classify the 48 patients into either the somatic syndrome group or somatic subsyndrome group. As expected, a low number of patients ( $n=3$ ) had the unabridged (or full-criterion) somatisation disorder; they were pooled with the patients in the somatic syndrome group ( $n=26$ ; Table 2) because of their fundamental similarities (e.g. comorbid conditions,

functional impairment and health care use). The remaining participants met the classification criteria for the somatic subsyndrome group ( $n=22$ ; Table 2).

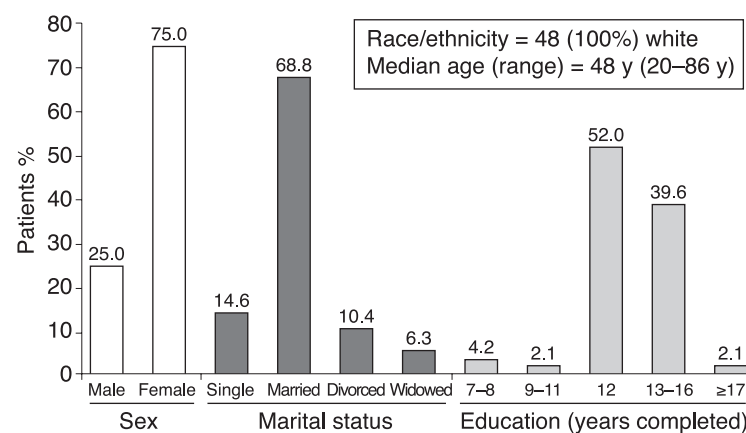
There were no statistically significant differences between the somatic syndrome and somatic subsyndrome groups with regard to demographic characteristics or medical service use (Table 4). The statistically non-significant but clinically noteworthy difference between groups was the number of *distinct* presenting complaints in the past year, which indicates a greater range of discrete, medically unexplained symptoms in the somatic syndrome group. This was an expected trend because the number of distinct presenting complaints normally is higher in patients with a greater number of medically unexplained symptoms.

**Table 3** Comparison of study participants and decliners ( $n=72$ )

Characteristic	Participants ( $n=48$ )	Decliners ( $n=24$ )	<i>P</i> value <sup>a</sup>
Male sex, no. (%)	12 (25)	4 (17)	0.55
Age in years, median (range)	48 (20–86)	53 (22–86)	0.30
Highest education grade completed, median (range)	12 (7–17)	12 (2–20)	0.40
Hollingshead occupational level, median (range)	3 (1–8)	2 (1–8)	0.78
Medical history in past year			
Outpatient visits, median (range)	21 (1–82)	11 (1–44)	0.006 <sup>b</sup>
Distinct presenting complaints, median (range)	20 (1–41)	18 (4–60)	0.81
Hospitalised, no. (%)	14 (29)	6 (25)	0.79
Hospital surgery, no. (%)	10 (21)	5 (21)	>0.99

<sup>a</sup>The Fisher exact test was used for unmatched nominal data and the Wilcoxon rank sum test for unmatched ordinal data

<sup>b</sup>*P* values less than 0.05 were considered statistically significant  
Adapted from Rasmussen *et al.*<sup>34</sup> Used with permission



**Figure 1** Patient characteristics ( $n=48$ ). (Adapted from Rasmussen *et al.*<sup>34</sup> Used with permission)

**Table 4** Comparison of participants in the somatic syndrome and somatic subsyndrome groups ( $n=48$ )

Characteristic	Somatic syndrome group ( $n=26$ )	Somatic subsyndrome group ( $n=22$ )	<i>P</i> value <sup>a</sup>
Male sex, no. (%)	8 (31)	4 (18)	0.50
Age in years, median (range)	48.8 (21–75)	49.8 (20–86)	0.88
Highest education grade completed, median (range)	12 (7–16)	12 (8–17)	0.69
Hollingshead occupational level, median (range)	3.5 (1–7)	3 (1–8)	0.74
Medical history in past year			
Outpatient visits, median (range)	21 (1–82)	20 (5–65)	0.48
Distinct presenting complaints, median (range)	26 (1–37)	16.5 (5–41)	0.14
Hospitalised, no. (%)	8 (31)	6 (27)	0.52
Hospital surgery, no. (%)	6 (23)	4 (18)	0.74

<sup>a</sup> The Fisher exact test was used for unmatched nominal data and the Wilcoxon rank sum test for unmatched ordinal data

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**Table 5** Ways of Coping Questionnaire (WCQ) scores ( $n=48$ )

WCQ scales	Somatic syndrome group ( $n=26$ ), mean (SD)	Somatic subsyndrome group ( $n=22$ ), mean (SD)	<i>P</i> value <sup>a</sup>
Confrontive coping <sup>b</sup>	5.6 (3.7)	5.1 (3.9)	0.69
Distancing <sup>c</sup>	6.8 (4.2) <sup>d</sup>	6.0 (4.0) <sup>d</sup>	0.46
Self-controlling <sup>c</sup>	10.4 (4.5) <sup>d</sup>	8.2 (4.5)	0.11
Seeking social support <sup>b</sup>	6.8 (4.5)	7.6 (4.3)	0.54
Accepting responsibility <sup>b</sup>	4.4 (2.7) <sup>d</sup>	2.9 (3.1)	0.08
Escape-avoidance <sup>c</sup>	7.5 (6.2) <sup>d</sup>	4.3 (4.3)	0.04
Planful problem solving <sup>b</sup>	8.5 (4.7)	8.2 (3.9)	0.78
Positive reappraisal <sup>c</sup>	7.6 (5.3)	9.0 (5.7) <sup>d</sup>	0.38

<sup>a</sup> Calculated using the two-sample *t* test

<sup>b</sup> Problem-focused coping scale

<sup>c</sup> Emotion-focused coping scale

<sup>d</sup> Score is  $\geq 1.5$  SD above the WCQ mean score from a non-clinical, community-based, reference group

### Coping strategies in the abridged somatising groups

The coping style of patients with an abridged somatising pattern, as measured by the WCQ, is reported in Table 5. On the 'distancing', 'self-controlling', 'accepting responsibility' and 'escape-avoidance' WCQ scales, the somatic syndrome

group mean score was at least 1.5 standard deviations above the mean score of the community-based reference sample.<sup>15</sup> On the 'confrontive coping', 'planful problem solving' and 'positive reappraisal' scales, their use was in the average range.

The somatic subsyndrome group scored higher than the reference group on two of the eight WCQ scales. Specifically, the distancing and positive

reappraisal scales showed a mean score that was at least 1.5 standard deviations above the reference mean.<sup>15</sup> These patients as a group scored in the normal range on the remaining six scales and thus were more similar to the non-clinical reference sample than the somatic syndrome group.

The two-sample *t* test was used to analyse differences between the somatic syndrome and somatic subsyndrome groups on the eight WCQ scales. Only one scale (escape-avoidance) showed statistical significance between groups ( $P=0.04$ ); patients in the somatic syndrome group self-reported greater use when compared with the somatic subsyndrome and non-clinical reference groups.

## Discussion

This study investigated coping style of patients with an abridged somatising syndrome presenting to a primary care clinic. Our sample of patients with an abridged somatic syndrome were similar to patients with the research-validated multisomatoform disorder,<sup>42-44</sup> which is defined as having three or more medically unexplained symptoms and a history of somatisation lasting two or more years. The somatic subsyndrome group appears similar to and representative of patients with the American Psychiatric Association's description of undifferentiated somatoform disorder,<sup>29</sup> a diagnosis designed for use in primary care during the early stages of determining whether a patient's symptoms are somatoform. The essential diagnostic criterion for undifferentiated somatoform disorder is one or more medically unexplained symptoms of at least a six-month duration that are not better explained by another somatoform disorder. The patients in our somatic subsyndrome group reasonably could be viewed as having the mildest form of somatisation, but they are still clinically relevant because their functional impairment and healthcare service use are similar to those of patients with a greater number of somatoform symptoms.<sup>45</sup>

Relative to managing stress, our patients with an abridged somatising syndrome preferred or tended to overuse emotion-focused coping strategies (e.g. distancing, seeking social support and escape-avoidance). This finding is consistent with research on women regarding resilience in response to stress;<sup>24</sup> it also was compatible with the conclusion drawn by Coyne and Racioppo,<sup>46</sup> in which they stated that the positive relationship between emotion-focused coping and psychological distress was the most consistent finding in the coping literature. The somatising patients in our study relied on detachment, sought

support from others, engaged in wishful thinking and avoided coping with stress. Our findings on avoidance coping were consistent with the literature on other clinical groups such as trauma and psychological distress,<sup>47</sup> panic disorder<sup>48</sup> or chronic pain.<sup>49</sup>

In addition to concerns about human suffering, direct financial costs associated with somatoform disorders must be considered. Healthcare expenditures in the USA for 2008 were about \$7681 per resident, surpassing \$3.2 trillion in total, and accounted for 16.2% of the nation's gross domestic product.<sup>50</sup> Smith and colleagues<sup>51</sup> reported that patients diagnosed with somatisation incur healthcare expenses that are nine times the average in the USA. Furthermore, there are enormous indirect costs to the economy in the form of work absenteeism and decreased productivity.<sup>52</sup> Even modest improvement in the diagnosis and treatment of somatising patients has the potential to save billions of dollars. The coping style pattern of patients with abridged somatising disorder is information that can be used to shape effective clinical treatment; this is of great interest to health policy makers, healthcare providers and health management executives, particularly in the current climate of scrutiny and re-evaluation, where cost containment and quality care improvement are critical goals.

## Study limitations and strengths

The limitations of this study are the small sample size, the lack of racial and ethnic diversity and the analysis of only one type of stressful situation based solely on self-reported data. These factors limit the external validity of the results. We suggest that our findings be applied cautiously in clinical settings with considerably different patient demographics.

Despite these limitations, the study also has notable strengths. First, this study appears to be the first to specifically examine the relationship between coping and patients with abridged somatising disorder in primary care. A second strength is our use of a theoretical model that is appraisal-based and contextual, and it facilitates assessment of an individual's coping style by focusing on what happens cognitively, emotionally and behaviourally.<sup>6</sup> Third, our approach was not limited to assessing a single coping construct such as self-efficacy; rather, it was applicable across a range of adaptive strategies. Fourth, this study reported empirical findings on the relationship between stress and coping style in a common primary care patient group that is challenging to the clinician and associated with excessive use of healthcare services and high cost.



## Conclusion

This study addressed a void in the extant literature by investigating coping style in abridged somatising patients that commonly present in the primary care medical setting. Coping style is a useful construct for the identification of adaptive strategies in response to stress for patients with abridged somatising disorder in primary care. Empirical detection of specific coping strategies is critical for determining the patient's preferred style of adapting to stress. This information must subsequently be used to develop evidence-based and resource-efficient coping enhancement interventions that can be delivered by family physicians or allied mental health associates (or both). Furthermore, interventions should increase patient use of the more effective, problem-focused approach to stress while simultaneously decreasing the use of less fruitful, emotion-focused strategies. One such example might be the *Problem-solving Therapy for Primary Care* approach,<sup>53</sup> which was designed for treating depression but could be applied with adaptations for patients with abridged somatisation disorder.

Future research should focus on longitudinal analyses that elucidate our understanding of coping in patients with abridged somatising disorder by investigating relationships such as age-related coping style differences and changes across the adult life span, the effect of neuroticism on coping pattern and mediators that promote a preference for problem-focused versus emotion-focused coping strategies.

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CONFLICTS OF INTEREST

None.

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