

# Everyday Practice

## A simple protocol to manage patients with unexplained somatic symptoms in medical practice

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### INTRODUCTION

Patients with distressing physical symptoms, without known medical causes, frequently present to primary care physicians. The absence of physical causes for such problems often results in the physician downplaying their importance or ignoring the distress. Many patients are often dissatisfied with the consultation and consequently 'shop' for different treatments. Despite the high prevalence of such presentations in medical practice, most teaching programmes rarely discuss issues related to the management of such patients. There are no simple protocols for use in busy clinical settings. Consequently, many physicians are uncomfortable with managing such patients in their practice.

### THE MAGNITUDE OF THE PROBLEM

Several studies have examined the mental health needs of patients attending primary care in India and have documented common mental disorders (CMD).<sup>1,2</sup> The available data suggest that about 17%–46% of patients attending primary care facilities suffer from CMD. Irrespective of the aetiology, the presence of somatic symptoms is often associated with social and psychiatric morbidity, and CMD are particularly common among such patients.<sup>3</sup> Such patients are of public health concern as they cause great burden to themselves, their families, healthcare services and society.

### DIFFERENTIAL DIAGNOSIS

Traditionally, psychiatric diagnosis is based on identification of a clinical syndrome. Physical symptoms that cannot be explained by medical causes are reported by patients with many organic diseases, psychotic illnesses and substance dependence. Consequently, these conditions will have to be excluded. Unexplained somatic symptoms are also reported by patients who suffer from depression, anxiety and other stress-related and personality disorders. However, such classical syndromes are infrequent in primary care, with the majority of patients having milder forms and mixed presentations. Consequently, managing such patients in primary care using a common approach is much easier than treating specific syndromes employing specialist intervention protocols.

### THE APPROACH

The '10-step' approach described is based on the 'retribution model' and available literature on the subject.<sup>4-6</sup> This method has been successfully employed in primary care and taught to physicians, medical students and psychiatrists at the Christian Medi-

cal College, Vellore, India for the past 6 years. The steps, the sequence and their rationale are briefly described (see Box).

#### *Step 1: Acknowledge distress*

Acknowledging the distress caused by the physical complaints reassures the patients that their symptoms have been carefully considered. It also reflects an empathetic attitude, and contributes to establishing an effective rapport. These are essential for facilitating improvement. Failure to do so is often interpreted by patients as an indication that the physician has not understood the problem or that he/she does not believe that the symptoms are genuine.

#### *Step 2: Elicit the patient's perspective on the symptoms*

Providing appropriate reassurance is an important part of the medical consultation. It is most effective if based on the patient's actual concerns. Asking patients what they think or fear is wrong with them is useful in addressing specific concerns (e.g. 'It could be cancer.'). Many of the beliefs held by patients with unexplained physical symptoms contradict the biomedical model of their illness.<sup>7</sup> The patient's beliefs need to be discussed before presenting alternative biomedical explanations. Failure to elicit the patient's beliefs about the illness or the outright rejection of their perspectives early in the consultation often proves disastrous. Eliciting such explanations will also allow for focused examination, investigations and specific reassurance.

#### *Step 3: Focused history-taking, physical examination and laboratory investigations*

To exclude physical disease, focused history-taking, physical examination and laboratory investigations are necessary. A review of the investigations done, medical records and previous prescriptions/medications taken and their effect on the symptoms also helps in clarifying issues. These strategies reassure the patient that medical causes have not been overlooked. On the other hand, patients often interpret a cursory examination as an indication that a serious attempt was not made to rule out medical disease and this usually leaves them dissatisfied with the consultation.

### **The '10-step' protocol for managing patients with unexplained medical symptoms**

#### *Build a therapeutic relationship*

1. Acknowledge distress
2. Elicit the patient's perspective on the symptoms
3. Focused history-taking, physical examination and laboratory investigations

#### *Provide alternative explanations*

4. Reassure patients about their symptoms
5. Discuss alternative interpretations of symptoms

#### *Suggest therapeutic options*

6. Prescribe medication
7. Suggest general coping strategies
8. Discuss specific measures to reduce stress
9. Discuss the individual's responsibility for improvement

#### *Offer continued support*

10. Give a specific appointment for review

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*Step 4: Reassure patients about their symptoms*

Reassurance is crucial in allaying the patient's concerns and changing their help-seeking behaviour.<sup>8</sup> A common expectation among patients is a better understanding of their symptoms. Being told that there is no serious medical problem underlying their symptoms is effective in reducing the health concerns for many patients. However, for a substantial number of patients such reassurance alone is not helpful, resulting in further needless consultations. Evidence suggests that for reassurance to be effective, the patient's concerns need to be elicited and appropriate explanations provided. Worry about their health is bound to recur if the symptoms persist, especially if the patients have not been given a satisfactory explanation that enables them to interpret their symptoms as benign. Consequently, it becomes necessary to manage the patient's beliefs, misconceptions and concerns about health.

Explanations that completely deny all disease often make the patient wonder if the doctor disbelieves the symptoms. The emphasis should be on reassuring the patient about the absence of serious physical disease while acknowledging the reality and distress of the symptoms. It should be reiterated that a catastrophic event or incapacitation is highly unlikely to occur. Alternative explanations for these symptoms (i.e. the individual's tendency to interpret innocuous bodily sensations as bodily dysfunction or the relation of the symptoms to stress) are useful.

*Step 5: Discuss alternative interpretations of the symptoms*

It is necessary to discuss various non-physical causes of such symptoms. The reinterpretations include: (i) altered body function with normal body structure; (ii) the role of stress and personality; and (iii) the social context and its pressures. Many unexplained symptoms, especially of the gastrointestinal tract, can be explained by altered body function. It is necessary to emphasize that such symptoms are not indicative of pathology. The acceptance of such symptoms as unusual but normal is essential.

Discussing the link between physical symptoms and stress is crucial. Simple explanations of possible links between anxiety and stress and physical symptoms, or how depression lowers the pain threshold, are useful. Asking if anyone else in the family or among friends has suffered from similar symptoms also helps patients identify such mechanisms. Interpersonal problems, financial difficulties, alcohol dependence in the spouse and physical abuse are commonly reported by these patients, usually on enquiry. Other problems that cause anxiety include sexual misconceptions and dysfunction in men, and fear of unwanted pregnancy in women who are not practising contraception. Discussing the role of stress and exploring the psychosocial context is important. The role of the patient's personality, and long-standing and habitual reactions to the different aspects of the environment are useful. The long duration of symptoms, normal physical examination and laboratory investigations, and the absence of obvious physical disease can be used to tactfully emphasize the possibility of misdiagnosis by medical practitioners who were consulted in the past. In fact, discussing the role of previous misdiagnosis and extensive investigations in reinforcing the patient's belief about possible serious medical disease should be highlighted.

*Step 6: Prescribe medication*

Most patients expect medication. Not prescribing any medication often results in patient dissatisfaction. Antidepressants are useful and can be prescribed if depression and anxiety are present, and in conditions where pain is incapacitating (e.g. headache, irritable

bowel syndrome, atypical chest pain, etc.). Selective serotonin reuptake inhibitors are generally preferred to tricyclic antidepressants as they have fewer side-effects. However, tricyclic antidepressants are better for patients with insomnia. Benzodiazepines are best avoided as they produce dependence. Patients without such symptoms can be given vitamins and the placebo response often helps them cope with their circumstances. Discussing the specific role of each of these medications (including vitamins) in improving coping is helpful. In addition, medicines can also be prescribed to provide symptomatic relief for incapacitating symptoms. However, it is important to focus on coping instead of cure for such symptoms.

*Step 7: Suggest general coping strategies*

Recommending general psychological measures such as yoga or meditation, regular physical exercise, involvement in religious activities, hobbies and leisure improve coping skills and are especially useful for those under stress. Incorporating such activities into the patient's daily routine is essential for success. In addition, shifting from a model of cure to one of coping is mandatory.

*Step 8: Discuss specific measures to reduce stress*

Specific education and treatment for sexual misconceptions and dysfunction or advice on contraception is helpful for these conditions. However, while some forms of social adversity can be easily altered, many require a change in philosophy, attitude and lifestyle. Patients with specific difficulties will need help with problem-solving skills. Often, life situations may be difficult to resolve, and may require acceptance as well as change in coping strategies. Asking patients to look for specific solutions for their difficulties and giving them time to examine the issues are obligatory.

*Step 9: Discuss the individual's responsibility for improvement*

Most patients expect cures from doctors and come back with the same or new complaints for the physician to resolve. The individual's role in, and responsibility for, improvement should be gently but firmly discussed. The offer of psychological support will help patients cope with stress. On the other hand, the promise of miracle cures for such symptoms usually proves ineffective and results in the patient seeking alternative physicians and treatments.

*Step 10: Offer continued support—give a specific appointment for review*

Regular review of progress is necessary for most patients, with scheduled, brief appointments every 2–4 weeks (i.e. avoiding 'as-needed' appointments). The physician may need to briefly go through the steps of the management protocol at each visit to re-emphasize the issues. A brief, focused physical examination must be performed at each visit as this helps to rule out any new or worrisome condition, and provides the patient with the important benefits of 'laying on of hands'. The physician should gradually shift the focus away from the patient's physical symptoms and medication to the management of the psychosocial context and stress. Restoration of function must be the goal of treatment rather than the complete elimination of symptoms. Most patients will accept this when they realize that their life circumstances contribute to their symptoms. These visits can be used to provide psychological support and discuss alternative coping strategies for the stress and related symptoms.

### SOME PRACTICAL CONCERNS

Physicians often worry that the management of psychosocial problems takes time. With practice, the efficiency of the technique used improves and such counselling can be used in real-life situations. Most interviews usually last for 10–15 minutes. Physicians also hesitate to get involved because of the fear that they will not be able to solve the patient's troubles. The realization that it is not the physician's responsibility to solve the patient's social difficulties but to empower patients to resolve these themselves comes with experience. The specific solution to social adversity has to be the patient's own. Such realization is liberating and allows the physician to help people with stress without feeling compelled to solve their problems.

The patient's family can also be involved in therapy. They may be able to recognize the patterns of symptoms and specific triggers of stress. Involving them in reducing the stress of changing adverse circumstances is often useful. The presence of understanding relatives usually goes a long way in relieving distress and improving coping.

Referral to specialists should be avoided as these patients are best managed in primary care. Specialist management may be necessary for those with incapacitating and persistent symptoms, intractable interpersonal difficulties, and for persistent sexual dysfunction. Patients with classical psychiatric syndromes and substance dependence not responding to adequate therapy in primary care would also require specialist intervention.

### CONCLUSION

Acknowledging the distress, reassuring patients about the absence of physical disease, exploring and managing the sources of stress, and recognizing and treating psychiatric syndromes are necessary components of treatment packages for patients with

unexplained physical symptoms. Providing alternative explanations for the symptoms within the supportive context of a doctor-patient relationship, and encouraging patients to pursue alternative coping strategies will help change knowledge and attitudes related to the illness and consequent practice.

While knowledge of the treatment process can be easily assimilated, mastering the skills required to manage such patients comes with experience. With regular practice, physicians acquire competence and confidence in their ability to handle patients with such presentations. Mastering the technique increases the satisfaction physicians derive from the process. Such success reinforces their behaviour, and they consequently recognize and treat more patients with such presentations.

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