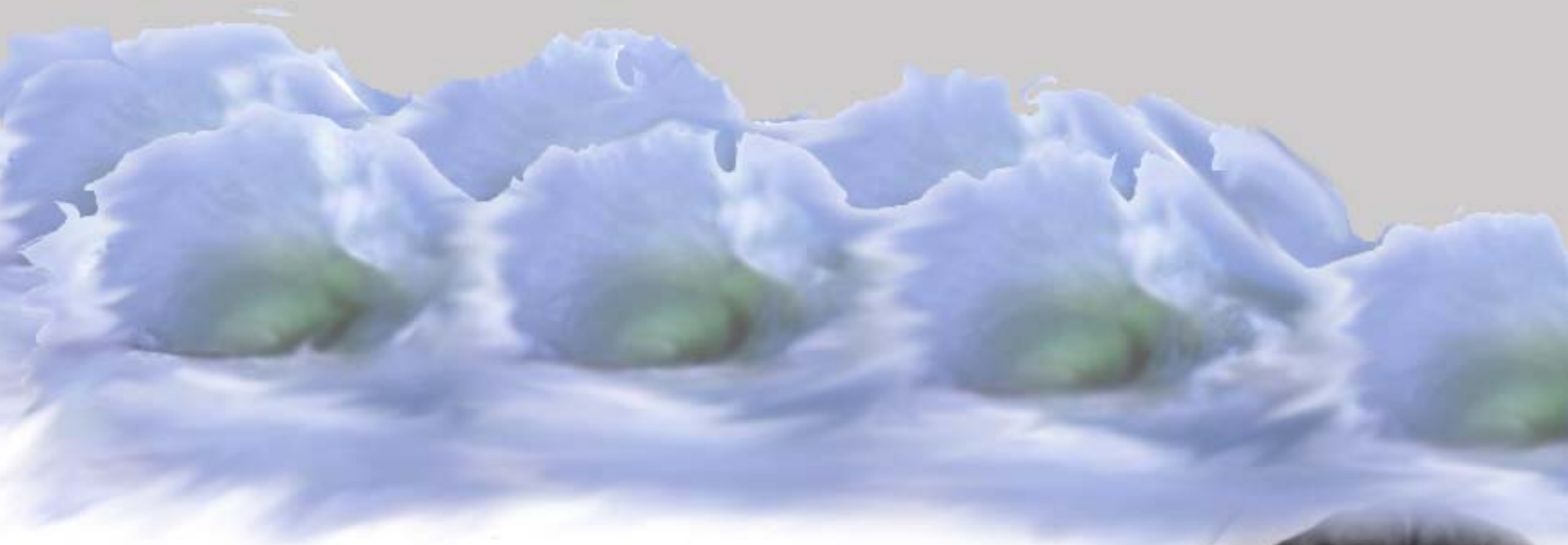
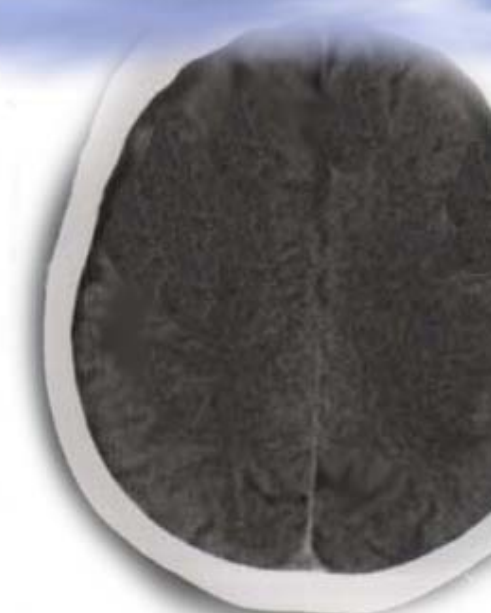


Management of Patients with **Medically Unexplained Symptoms**

A Practical Guide



Athula Sumathipala
Sisira Siribaddana
Sonia Mangwana
Padmal de Silva



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This book is dedicated to
Professor Diyanath Samarasinghe
and
Professor Anthony Mann

“Translating fifteen years of Sri Lankan research on medically unexplained symptoms into service development”

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Foreword

Management of Patients with Medically Unexplained Symptoms: A Practical Guide

Medically unexplained symptoms (MUS) are the bane of primary care and community health practitioners: they are common and perplexing, defying our current medical classifications and appearing to many to be a figment of the patient's imagination and being untreatable. It has often been assumed that these complaints are seen mainly in richer societies, and that primary care physicians in less developed societies have their hands full with 'real' medical problems. We now know that this assumption is false. Irrespective of the patterns of burden of disease, perhaps with the exception of some countries where HIV/AIDS is a major cause of sickness, physical complaints for which no obvious physical diagnosis can be found, account for a major proportion of morbidity in primary care. This fact should come as no surprise to a health practitioner if one considers the wide and diverse variety of such complaints, ranging from those which affect the entire person, such as tiredness and generalized body-aches, to those affecting specific organ systems, such as irritable bowel symptoms, vaginal discharge and chest pain. In many parts of the world, amongst the commonest medicines (both allopathic and alternative) in current use are targeted at such medically unexplained complaints; in south Asia, where the authors of this manual are based, the mind-boggling variety of nutritional supplements and tonics, ostensibly marketed to counter fatigue and restore 'vitality' are testimony to the burden of such complaints. Though evidence suggests that these complaints have multiple aetiologies, including psychological and physical health factors, the reality is that the practitioner will probably find no specific cause in many patients. The recent natural disasters in the region, as highlighted by the authors in a chapter in this manual, show that such complaints can even occur as a consequence of exposure to extreme life-threatening events.

Although diverse in nature, there is now robust evidence showing that there is much in common between the different clinical forms of medically unexplained symptoms: thus, they often occur together; they are often, but not always, associated with depressive and anxiety disorders; and simple psychological and pharmacological treatments are effective for many complaints. Despite the evidence of what helps patients with these complaints in primary care, pretty much all the evidence (that is, barring the evidence produced by the authors of this manual) is derived from the well-resourced health systems of Europe and North America. How well does this evidence translate to less resourced systems? How do psychological constructs and treatments work in non-Western cultures? The authors of the manual have played a leading role in modifying, implementing and evaluating psychological treatments for medically unexplained symptoms in primary care in developing countries. They have shown that sophisticated psychological treatments, such as cognitive behaviour therapy, can be adapted and taught to general practitioners in Sri Lanka. Their rich clinical and research experience is the basis for this splendid, and much-needed, manual which provides a comprehensive, clinical, guide to medically unexplained symptoms in primary care or general practice.

This manual should be a *vade-mecum* for any self-respecting primary care practitioner who wishes to address the health needs of such a large proportion of patients in their clinic using the best evidence available. This would, of course, mean abandoning old habits of prescribing placebo medications, spending a bit more time explaining and guiding patients, using effective medications judiciously, and, when needed, providing structured psychological treatments. What this manual does is to provide the practitioner with simple and clear information regarding the specific interventions needed to achieve the goal of relief for our patients, and the skills needed to implement these interventions. I am delighted that the authors have produced this manual: it fills a huge, and very relevant, gap in health training materials for practitioners in developing countries.

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Preface

This book intends to provide information on the subject of medically unexplained symptoms in order to stress the gravity of this clinical problem. It will also describe the skills required to identify and manage these patients at the level of presentation.

Medically unexplained symptoms can be a common presentation following disasters, so increasing awareness and developing skills in their management has become relevant since the tsunami. We have tried to use the experience of the tsunami as an opportunity to convert 15 years of research in Sri Lanka on medically unexplained symptoms into practice. This manual is a part of that endeavour.

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We are indebted to our colleagues on the project without whose assistance, the data collection and follow-up would not have been possible. We would specially like to note Suwin Hewege, the research assistant, for his dedication and help; and Drs Raveen Hanwella, Dhamsa Gunewardene, Shanthi Liyanage, Rozana Cassim, Champa Karunaratne, Neela de Silva, Gayathri Gnanathilake, Renuka Pathirana and Amala de Silva, all of whom extended much needed support.

We are tremendously grateful to Anthony Mann. He provided long-term guidance and unstinting support. Every credit should go to him, not only for the guidance for this particular research project but also for other collaborative research in Sri Lanka we have now established. Two other people who influenced this research were Diyanath Samarasinghe and E.K.Rodrigo. We take this opportunity to thank them. Martin Prince, the current Head of Section of Epidemiology, at the Institute of Psychiatry, King's College, London continues to support all our initiatives and we are grateful to him. We also like to thank Michael E. Dewey who provided statistical help.

Manouri Wimalasekera and Lakshmi Abeygoonawardane have contributed in numerous ways to make our work a success. Lakshmi was also responsible for the layout of this book and along with Sisira designed the book cover. We are also grateful to John Mahoney, T. Suvendran from the WHO and Kamal Senanayake at Y. N. Printers (Pvt) Ltd, for making this book a reality. Our heartfelt gratitude to Padmal De Silva who especially guided us on CBT component of the research and drafting this manual. Finally we would like to extend our sincere thanks to Sonia Mangwana, a psychiatrist from UK who critically reviewed the manuscript and made a valuable contribution to the final product.

How to use this book

To promote greater clinical relevance of the information provided here, we recommend that readers begin by completing the exercises in chapter 15: self-evaluation. Then the book may be read from start to finish, and the self-evaluation done again in order to help gauge learning and consolidate knowledge.

Information in the chapters is organised so that it can be easily read by all clinicians irrespective of their particular expertise. Basic, core information is provided in the standard text. More detailed and background information is provided in shaded boxes for those readers who are interested to know more.

We have used a singular gender; he, instead using he/she and his/her to improve readability.

For optimal application of the information provided here, practical experience and specific skills training are recommended.

Key messages

- Patients with medically unexplained symptoms are common all over the world in primary care, specialist clinics and inpatient care. They can be transient or chronic. The patients are usually distressed, disabled, dissatisfied and heavily investigated. They are overusers of health services and incur health care costs disproportionate to their income. Therefore this morbidity has implications for the patient, family, society, care providers and the health care system.
- People who have faced disasters describe more physical symptoms than those who have not.
- An effective intervention should not only contribute to the clinical outcome of the patients and their families. It should also reduce the direct and indirect health care costs incurred.
- Neither physicians nor psychiatrists are well trained for the task of managing these patients. Non-psychiatric physicians lack assessment skills and psychiatrists are often unable to negotiate treatment with patients whose concerns are somatic.
- Patients with medically unexplained symptoms should be detected at the level of presentation and preferably managed at the same point of care.
- A comprehensive assessment including history, physical examination, and patient explanatory model using SEMI should be done. This alone can be therapeutic.
- Anti-depressants, structured care, and CBT can be effective in managing these patients.
- Instead of being concerned with the possible causes of illness, cognitive behavioural therapies focus on teaching people how to deal with their present complaints of disturbed emotions, thoughts and behaviour. In large part its success has come out of the simplicity of one of its basic premises: that a person's thoughts, ideas, and beliefs underpin their emotional reactions and behaviour.
- This book provides an evidence-based approach following three research projects conducted in Sri Lanka, including two randomised controlled clinical trials which are the only ones reported from the developing world.

Introduction

Patients with psychiatric disorders presenting with somatic symptoms in non-psychiatric settings are common all over the world^{1,2,3}. They have been well described in the developed world^{2,4,5} but less well so in the developing world^{3,6,7}. Patients who present repeatedly with multiple somatic complaints form an important sub-group^{3,6,7,8,9}. They usually place a heavy burden on the health care delivery system through disproportionate consumption of resources and its costs^{10,11,12}.

Even in the developed world research on the management and outcome of treatment of this clinical problem is somewhat limited^{13,14,15,16,17,18}. Proposed interventions are pharmacological¹⁷ or psychological^{14,15}. Of the psychological interventions, cognitive behavioural therapy (CBT) appears to be more acceptable to the patients, and more efficacious, than other therapies¹⁹.

Patients presenting with multiple somatic symptoms are a heterogeneous group, some with an underlying Common Mental Disorder (CMD), others with an unrelated medical illness and still others with neither^{1,20}. The advantage of using CBT for their treatment is that, instead of being concerned with possible causes of illness, it focuses on teaching patients how to manage their presenting complaints of disturbed emotions, thoughts and behaviours²¹. It takes an explicitly integral approach to the patient's complaint; i.e. an approach in keeping with evidence that the perpetuation of unexplained somatic symptoms is best understood in terms of an interaction between physiological processes, psychological factors, and social context²². The importance of the detection of these patients at the level of presentation, and of managing them at the level of detection, is stressed in the

recommendations of the International Study of Mental Illness in General Health Care³. They recommended the development of techniques for treatment and demonstration of their effectiveness when applied in primary health care. The intervention strategy has to be simple, feasible and effective, and it should be one that could be used by a person without specialised psychiatric skills³.

Such an intervention was designed and tested in a randomised control trial (RCT) in Sri Lanka and was found to be efficacious in reducing somatic symptoms, patient initiated visits, patients distress, and in increasing patients satisfaction when given by a psychiatrist²³.

In a follow-up study it was revealed that a comprehensive assessment using Short Explanatory Model followed by structured care without CBT is also efficacious when given by a primary care physician²⁴.

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Chapter 2

Definition, Detection and the Range of Symptoms

What are ‘medically unexplained’ symptoms?

Symptoms are defined as medically unexplained when “the clinical presentation and the symptoms are incompatible with a known physical illness, and/or absence of relevant positive physical signs and/or absence of laboratory investigations supporting a diagnosis of a physical illness”.

In our research a **symptom** was defined as a distinctive subjective sensation or a personal observation in relation to the body, which the patient describes as abnormal. If the same symptom (e.g. pain) was experienced at different anatomical sites it was counted as a separate symptom. Different symptoms in the same anatomical site were also counted as separate¹.

To elicit medically unexplained symptoms we suggest asking two questions, as follows:

- (i) What are your symptoms/problems? (or a probe such as: Why are you here today?)
- (ii) Are there any other symptoms/problems ?

The second question should be asked only after the first is answered. This strategy will help to standardise the manner in which the complaints are elicited.

How to elicit medically unexplained symptoms?

The number of complaints elicited will depend on how much probing is done and on the method used to elicit the symptoms. If eagerly questioned, patient may go on giving a long list of even minor symptoms. Similarly, if given a symptom checklist the patient will indicate all perceived symptoms. This is one of the problems in using symptom checklists. On the other hand, if left without pursuit, they may mention only one or two symptoms that they think are important despite having several. However, patients do not volunteer all perceived symptoms. They will present only with the symptoms they believe are important and relevant. Our strategy, in which the complaints were elicited by asking two specific questions, provides a way of standardising the method for clinical use.

Common symptoms reported

The nature of the common presenting complaints detected in the three studies carried out at Sri Jayewardenepura Hospital Outpatients Department in 1990, 1997 and 2000 are described^{1,2,3} below.

Aches and pains were the commonest complaints, followed by numbness and lifelessness. None of the patients volunteered psychological symptoms.

Common symptoms reported

1. Chest pain including pain at the back of the chest
2. Abdominal pain including lower abdominal pain
3. Abdominal cramp
4. Pain in the limbs
5. Pain in the joints
6. Numbness over various parts of the body
7. Headaches
8. Lifelessness
9. Pain along spine
10. Lower backache
11. Faintish feeling
12. Shortness of breath
13. Burning sensation over various parts of the body
14. Loss of appetite
15. Sleep disturbance
16. Puffiness of the abdomen (bloating)
17. Fatigue

In one of our studies of 68 patients², 24% patients reported having symptoms for less than six months, 19% for six months to two years, 29% for two to five years, 21% for five to ten years and 7% for more than ten years. Thus the majority of patients (76 %) reported having symptoms for more than six months.

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However, these symptoms can also be seen in patients with physical illness.

Medically unexplained symptoms could be acute (transient), sub-acute or chronic (persistent). Acute is usually less than four weeks, sub-acute less than six months and the chronic refers to symptoms lasting for longer than six months.

Chapter 3

Burden of Medically Unexplained Symptoms

As previously mentioned for many of the patients these symptoms can be severe, persistent and disabling. Their overuse of, and dissatisfaction with, the health services adds to their distress. It is this disproportionate distress and the disability which has a major impact on their lives. These patients will present repeatedly to various care providers seeking reassurance and treatment. Inevitably, the burden of their illness spreads far beyond the patient alone.

The tendency is for them to consult medical specialists and alternative care providers but not psychiatrists. Psychiatric referrals are usually

unpopular with these patients and rarely result in effective treatment. These patients place a heavy burden on the health care delivery system in terms of disproportionate consumption of resources.

This over-utilisation of services is one of the main contributors to the great economic cost of psychological disorder in primary care. Patients with medically unexplained symptoms are more likely to go on sick leave and/or show more restricted activity than patients without such symptoms. These patients are generally considered 'difficult to manage' by the doctors.

Epidemiology

The WHO¹ carried out a comprehensive study in which 25,916 consecutive primary care patients participated from 14 different countries. This study demonstrated that the frequency of medically unexplained symptoms did not clearly vary according to geography or level of economic development. It also showed that these patients suffered significant disability caused by the symptoms.

Impact on the family

The family may become enmeshed and overinvolved as attempts are made to relieve the patient his usual day-to-day duties. Such actions tend to reinforce the patient's beliefs and dysfunctional behaviours rather than helping to resolve them.

Impact on health services

These patients have a tendency to consult specialists and alternative care providers^{2,3}. However, they seem to dislike psychiatric referral^{4,5}. Psychiatric referrals are usually unpopular with these patients and rarely result in effective treatment⁵. These patients place a heavy burden on the health care delivery system in terms of disproportionate consumption of health resources^{6,7}. In the study of 52 patients who were referred to a psychiatric clinic with somatic symptoms, the median cost for investigations performed in the general hospital prior to the referral was £ 286 (range £25-£2300)⁷. The

cont

per capita expenditure for health care of patients with somatic symptoms was up to nine times the overall per capita costs⁸. In a Danish study, it was revealed that 1% of the population was admitted to a general hospital 10 times or more presenting with medically unexplained symptoms⁹. This over-utilisation of services is one of the main contributors to the great economic cost of psychological disorder in primary care^{10,11}.

Impact on the professional care providers

Patients with medically unexplained symptoms are considered to be frustrating or difficult by their physicians^{12,13,14,15}. Wileman L et al¹⁶ carried out a qualitative study in primary care to explore general practitioners' attitudes towards patients with medically unexplained symptoms. The general practitioners unanimously accepted the concept of somatization as a product of psychological distress, but negative attitudes dominated their accounts of patients with these symptoms. They described how these patients seemed to dominate the working day even though small in numbers and reported feeling illequipped to deal with these presentations.. They also felt that there was an issue of control in the consultation and acknowledged experiencing difficulties in managing these patients, thereby having a negative impact on the doctor-patient relationship.

Impact on function and productivity

Medically unexplained symptoms strongly predict the frequency of health service use, and functional disability¹⁷. A study of 3132 randomly selected community respondents reported that patients with medically unexplained symptoms were more likely to report recent sick leave or restricted activity than respondents without medically unexplained symptoms¹⁸. This was particularly pronounced in the case of respondents with a psychiatric diagnosis, and those older than 40 years. The WHO¹ demonstrated this phenomenon in terms of number of disability days. When data were pooled from all 14 countries it was shown that patients with somatisation reported being unable to perform their usual role for an average of 7.8 days in the previous month. There was also an association between the number of reported symptoms and the number of days of functional impairment.

Sri Lankan Findings

100 patients with medically unexplained symptoms (index group) had visited 340 practitioners during the previous six months (mean =17 visits/year), and 100 patients without medically unexplained symptoms (control group) visited 143 practitioners (mean = 4visits/year) in the same period.

Out of these, 56.5% of the index group visits were to general practitioners, and government hospital doctors, compared with 81.5% in the control group ($p < 0.001$). Conversely, 38% of the index group consultations were to private specialists and alternative healers, compared with 15.2% in the control group ($p < 0.001$). Only one patient in the index group and none in the control group had visited a psychiatrist over the previous six months. Only 5 patients had consulted a psychiatrist during the whole of their lifetime.

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Chapter 4

Medically Unexplained Symptoms After Disasters

Stress reactions are normal and a recognised feature following disasters. These can be behavioural, cognitive, emotional and physical.

Normal stress reactions

Behavioural reactions

- Sleep problems
- Crying easily
- Avoiding reminders
- Excessive activity
- Increased conflicts with family
- Hypervigilance and startle reactions
- Isolation or social withdrawal

Cognitive reactions

- Confusion and disorientation
- Intrusion of thoughts/images about the event
- Recurring dreams or nightmares
- Pre-occupation with disaster
- Problems with concentration or remembering things
- Difficulty making decisions
- Questioning spiritual beliefs

Emotional reactions

- Sadness
- Irritability, anger and resentment

- ‘Anxiety’ and fear
- Despair, hopelessness
- Guilt
- Self-doubt
- Unpredictable mood swings

Physical reactions

- Fatigue, exhaustion
- Gastro-intestinal distress
- Change in appetite
- Tightening of throat, chest or stomach
- Worsening of chronic conditions
- Multiple somatic complaints

Numerous cross sectional studies confirm a link between natural disasters and medically unexplained symptoms^{1,2}. Consensus statement about unexplained symptoms after terrorism and war has reiterated the importance of the recognition and management of these symptoms³.

Post traumatic stress disorder (PTSD) and medically unexplained symptoms⁴

A number of studies have revealed increased reporting of physical symptoms in persons with PTSD^{5,6}. There are a number of possible reasons why reporting of physical symptoms in persons with PTSD might be increased.

- (i) Physical symptoms may be an integral part of the constellation of symptoms that make up PTSD. In examining this possibility, it would be important to know whether there is a constellation of physical symptoms that occur more frequently in PTSD sufferers in contrast to victims of similar events who have not developed PTSD. Specific physical symptoms are related to the diagnosis of panic disorder and generalized anxiety disorder described in DSM-III-R. In these disorders, physical symptoms are often the focus of patients' distress and cause for consultation with professionals.
- (ii) The physical symptoms may be directly caused by the stressor responsible for the development of PTSD. In many instances, the stressors are life-threatening events such as accidents or combat, which cause physical injury to many of those exposed⁷. They described a sample of war veterans with undiagnosed PTSD attending a pain clinic. In all these patients, pain was localized to the site of a former injury. In this situation, the development of a PTSD may influence the presentation of the symptoms rather than their onset.
- (iii) Physical symptoms may relate to comorbid diagnoses. Research has noted the high levels of PTSD comorbidity with anxiety and depressive disorders⁸, a phenomenon which may complicate presentation, diagnosis and treatment. Anxiety disorders and depressive illnesses commonly present with physical symptoms, either as physical concomitants of the disorder (such as shortness of breath or

palpitations in anxiety, and constipation or weight loss in depression) or via somatization (such as pain syndromes in depression). Furthermore, alcohol and drug abuse is common in PTSD sufferers and may be directly responsible for certain physical symptoms. Comorbidity with somatization symptoms is a critical concern in PTSD because of its potential impact on the course of the disorder and the functional disability associated with it.

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Chapter 5

Relationship between Physical and Mental Illness

The relationship between physical and mental illness, has been examined through research in general practice, medical and psychiatric outpatients' clinics and in the community.

The possible relationships are:

1. Psychiatric symptoms are the secondary accompaniments of physical illness.
2. Apparent psychiatric symptoms are entirely due to an underlying physical illness.
3. Psychiatric and physical symptoms co-exist, each with their own causation.
4. Psychiatric illness or psychological disorders present with physical symptoms for which no organic cause can be found.

Psychiatric symptoms are the secondary accompaniments of physical illness

The possibility of developing an emotional or psychiatric disturbance exists for any physical illness. This disturbance is induced by the process of the physical illness and its impact on the patient's life and may range from a mild emotional disturbance to a severe psychiatric disturbance. Almost all known symptoms of psychiatric illness can be seen in organic illness. For example a chronic illness such as diabetes, heart disease or arthritis may increase the likelihood of depression through pain or disability. Emotional or psychotic symptoms may be the manifestation of a physical disease process as in early vascular dementia. Depressive symptoms can be an early manifestation of Parkinson's disease, elation and grandiosity of frontal lobe tumours and psychotic symptoms can occur with epilepsy.

Apparent psychiatric symptoms are entirely due to an underlying physical illness

Physical illnesses can present with symptoms that are the same as or similar to those of a psychiatric illness, causing diagnostic difficulties. This relationship is particularly relevant in endocrine illnesses. Pheochromocytoma and hyperthyroidism may present with symptoms mimicking anxiety. Hypothyroidism and Cushing's Syndrome can present with the symptoms of depression. As these psychiatric symptoms may be the only symptoms the physical illness is masked and often undetected.

Psychiatric symptoms and physical symptoms co-existing each with their own causation

Any physical illness can co-exist with a psychiatric illness just by chance. However, this co-existence of physical and psychiatric illness may have important implications for either, as one could be undetected or one can complicate the treatment or prognosis of the other.

Psychiatric illness or psychological disorder presenting with physical symptoms for which no organic cause can be found

Patients can present with physical complaints for which a medical cause cannot be found even after extensive investigations. The absence of an organic basis may not be recognized early, leading to unnecessary investigations and adoption on sick-role.

Medically Unexplained Symptoms: Terms and Classifications

Terms used to identify this group of patients

In the past the following terms have been used to refer to a patient from this group: “thick folder patient”, “crook”, “hysteric”, “the terror of the doctor”, “problem patient”, “painful woman”, “hypochondriac”; or the patient is described as exhibiting “functional overlay” or “somatisation”¹

These terms are unsatisfactory because they are used imprecisely, may convey aetiological assumptions and have pejorative overtones². Some prefer the term “functional somatic symptoms”. We do not use this term as the cognitive-behavioural model uses the terms “functional” and “dysfunctional” in a different technical sense. We recommend the term “medically unexplained symptoms”. It is important to note however, that this definition “unexplained” does not mean “unexplainable”, “imagined”³ or “psychogenic”⁴.

Classification of medically unexplained symptoms – terminology and definitions

Medically unexplained symptoms have been classified in many different ways. For example, according to the duration of symptoms, location in the body, their association with other illnesses or the number of symptoms reported by the patient or elicited by the clinician.

- (a) Classification according to the duration is: - acute (transient), sub-acute or chronic (persistent)⁵. However, there are no generally agreed thresholds, which separate these three

forms. Acute is usually presentations of less than four weeks duration, sub-acute for those less than six months duration and chronic for those lasting longer than six months.

- (b) Symptoms classified in terms of their location can be described in any of the systems in the body^{6,7}. Symptoms clustered in syndromes such as irritable bowel syndrome, atypical chest pain, fibromyalgia are some examples.

- (c) Classifying according to the association of symptoms with other illnesses gives rise to four different scenarios irrespective of its duration;

1. The symptoms occur in association with, but unrelated to, a demonstrable physical disease.
2. The symptoms are associated with common mental disorders.
3. The symptoms are clustered in syndromes where the presence of a physical disease is uncertain or disputed (so-called symptom syndromes).
4. The symptoms are neither associated with physical disease nor with mental disorder.

1. The symptoms occur in association with but unrelated to a demonstrable physical disease.

This refers to patients with non-specific multiple symptoms complicating major physical illness⁸. Common examples are, atypical chest pain in a

patient who also has proven angina⁹ after myocardial infarction or coronary artery surgery¹⁰; post concussion syndrome after head injury; and many chronic pain syndromes⁸.

2. The symptoms are associated with common mental disorders

The somatic symptoms unexplained by physical diagnosis occur with depressive disorder, anxiety disorder and somatoform disorder^{5, 11, 12}. This is the group of patients, who predominantly or exclusively have a somatic presentation of psychiatric disorders; most commonly depressions and anxiety, now termed common mental disorders¹³.

3. The symptoms are clustered in syndromes where the presence of a physical disease is uncertain or disputed.

Many syndromes are made up of combinations of multiple somatic symptoms where the presence of a physical pathology remains uncertain. Examples are; medically unexplained muscle pain and tenderness as fibromyalgia, medically unexplained abdominal pain and altered bowel habits as irritable bowel syndrome, medically unexplained chronic fatigue and myalgia as chronic fatigue syndrome^{14, 15}.

Thirteen functional syndromes have been identified but on examining their pattern of symptoms, these syndromes cannot be assumed to be independent of one other¹⁴. Overlap between unexplained clinical syndromes is substantial³.

4. Symptoms are neither associated with physical disease nor with mental disorder.

Some patients may neither have a clear-cut physical illness nor a clear-cut psychiatric disorder, although psychological factors such as erroneous beliefs and worries may affect their interpretation of minor physiological sensations^{8, 17}. This group of patients are probably the group Kirmayer & Robin¹³ termed as 'functional somatisation', who report many medically unexplained symptoms arising from different physiological systems but without sufficient evidence for psychiatric abnormality.

Although these four broad groups can describe most patients with medically unexplained symptoms, there are no clear-cut boundaries. More general terms have been proposed which do not prejudice the interpretation or intervention; such as non-organic physical symptoms or medically unexplained symptoms, for use by both psychiatrists and physicians¹⁸. However, because of these conceptual difficulties, the classification of unexplained symptoms has rested entirely within psychiatric classificatory systems, as discussed below.

Medically unexplained symptoms in the context of existing classification systems

Current psychiatric systems for classifying disorders remain unsatisfactory for those patients with medically unexplained symptoms¹⁹. Only half of the patients with medically unexplained symptoms meet the criteria for mood and anxiety disorders^{20, 21}. This leaves a substantial proportion of patients who, following the application of the medical model, lack a clear indication for treatment with medication or psychotherapy. Thus the traditional psychiatric diagnostic categories may

hinder both the understanding of this complex problem and its management⁸.

Examples of current classificatory systems are given in tables 6.1 and 6.2. From these, it can be seen that somatisation disorder as defined, involves a constellation of physical symptoms which are chronic and severe, as well as unexplained.

The term “somatoform disorders” in the International Classification of Diseases (ICD-10)²² and Diagnostic and Statistical Manual (DSM-IV)²³ attempts to classify patients with medically unexplained symptoms.

According to the ICD -10 and DSM - IV, somatoform disorders are characterized by “ ...the presence of physical symptoms that suggest a general medical condition and are not fully explained by a general medical condition, by the direct effect of a substance or by another mental disorder”.

In the ICD -10, somatoform disorders are divided into; somatisation disorders, undifferentiated somatoform disorders, hypochondriacal disorders, somatoform autonomic dysfunction, persistent somatoform disorders, other somatoform disorders and somatoform disorders unspecified.

In the DSM-IV, somatoform disorders are divided into seven groups which are not identical to the ICD-10 sub-groups: - somatization disorder, undifferentiated somatoform disorder, conversion disorder, pain disorder, hypochondriasis, body dysmorphic disorder and somatoform disorders not otherwise specified. Both the

cont

ICD-10 and the DSM- IV include somatisation disorder, which originated from a group of psychiatrists in St Louis who in turn attributed the diagnosis to Briquet²⁴.

Table 6.1
**Diagnostic Criteria for ICD-10
Somatisation Disorder**

The main features are multiple, recurrent, and frequently changing physical symptoms, which have been present for several years before the patient is referred to a psychiatrist. Most patients have a long and complicated history of contact with both primary and specialist medical services, during which many negative investigations or fruitless operations, may have been carried out. Symptoms may be referred to any part or system of the body, but gastrointestinal sensations (pain, belching, regurgitation, vomiting, nausea, etc) and abnormal skin sensations (itching, burning, tingling, numbness, soreness, etc) and blotching are among the commonest. Sexual and menstrual complaints are also common. Marked depression and anxiety are frequently present and may justify specific treatment.

The course of the disorder is chronic and fluctuating, and is often associated with long-standing disruption of social, interpersonal, and family behaviour. The disorder is far more common in women than in men, and usually starts in early adult life.

Table 6.2
Diagnostic Criteria for DMS-IV
Somatization Disorder

- A. A history of many physical complaints beginning before age of 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.
 - (2) Two gastrointestinal symptoms: a history of at least two gastrointestinal symptoms other than pain
 - (3) One sexual symptom: a history of at least one sexual or reproductive symptom other than pain
 - (4) One pseudoneurological symptom: a history of at least one symptom or deficit suggesting a neurological condition not limited to pain
- C. Either (1) or (2)
 - (1) After appropriate investigation each of the symptom in Criteria B cannot be fully explained by a known medical condition or the direct effect of substance abuse.
 - (2) When there is a related general medical condition, the physical complaints or resulting social or occupational

cont..

impairment are in excess of what would be expected from history, physical examination or laboratory findings.

- D. The symptoms are not intentionally produced or feigned

Somatisation as a process

Somatisation is a process in which the patient has an inappropriate focus on physical symptoms and psychosocial problems are denied⁵.

According to Kleinman and Kleinman²⁵, “somatisation is the expression of personal and social distress in an idiom of bodily complaints with medical help seeking. It refers to the presence of physical complaints which are not associated with organic pathology or are grossly in excess of what is expected from pathology”. It is not a disease entity but a process.

According to the definition of Lipowski²⁶, “somatization is a tendency to experience and communicate somatic distress and symptoms unaccounted for by pathological findings, to attribute them to physical illness, and to seek medical help for them”.

Bridges et al²⁷ proposed another definition for this process and the following criteria.

- (i) Consulting behaviour – the patient must seek medical help for somatic manifestations of a psychiatric illness and does not present overt psychological symptoms.
- (ii) Attribution- the patient, must consider at the time of consultation that these somatic manifestations are caused by a physical illness.
- (iii) The patient must report symptoms to justify a psychiatric diagnosis when standard research criteria are applied.

- (iv) Expected response to treatment- in the opinion of the research psychiatrist, treatment of the psychiatric disorder would cause the somatic manifestation either to disappear or to revert to the level they were before the episode of psychiatric disorder.

Somatisation is viewed here as a process by which patients with anxiety and depression or other psychiatric illness get to see a doctor, and it has considerable heuristic appeal. However, this notion also suffers from a number of disadvantages. Firstly, it's emphasis upon and restricted to psychiatric disorders and thus it's inability to accommodate the patients without traditional psychiatric illness. Secondly, it implies that patients with psychological distress somehow convert their distress into physical symptoms and thereby experience relief⁴.

The terminology and definitions discussed so far are very much based on the medical model. The difficulties conceptualising these presentations in this way are evident, and can be counter-productive in conceptualising in the management of this difficult group of patients.

The explanatory model provides an alternative model for working with these patients, and is described in the next chapter.

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Chapter 7

Outline of the Management of Medically Unexplained Symptoms

1. Comprehensive history and full physical examination
2. Review of past investigations and medical records
3. If there is a clinical indication the following investigations should be carried out provided they have not been done; Haemoglobin, ESR, Thyroid stimulating hormone assay, Fasting blood sugar

The stepped care approach

1. Carryout an assessment using SEMI which itself can be therapeutic.
2. Use of anti-depressants preferably SSRI, following the SEMI assessment
3. Use of Structured Care without CBT following the SEMI assessment
4. Use of Structured Care with CBT following the SEMI assessment
5. Refer to a psychiatrist or a psychologist who has been trained in CBT for medically unexplained symptoms

Chapter 8

The Explanatory Model and the Cognitive Representation of Illness

What is meant by the explanatory model?

The operational formulation of the illness explanatory model consists of four aspects of patient's presentation: patterns of distress, perceived causes, preference for help seeking and treatment, and general illness beliefs^{1,2}.

Although it is important to understand the differences between the explanatory model and the medical model (also referred to as biomedical model) these two should not be considered as completely opposing models.

The relationship between these two models is not necessarily dichotomous, as professional medical ideology influences popular ideas about illness, either subtly through the patient's interactions with medical professionals or overtly as a result of health education, medical writing and other communications.

Importance of understanding the patient's explanatory model

Cultural beliefs and practices affect nearly all aspects of psychiatry, including assessment and diagnosis, illness behaviour and help seeking, mutual expectations of interactions between patient and practitioners, perceived quality of care, and the design of culturally appropriate psychotherapeutic interventions¹.

Understanding a patient's explanatory model enables a clinician to appreciate the patient's response to illness, develop an empathic relationship and communicate his own explanation

and recommendations for treatment more effectively. By recognising the areas where the patient's and the health care provider's understanding of the problem are different, the clinician can address the differences in a more appropriate manner. This might result in negotiating a shared model but if the differences are irreconcilable, the clinician can acknowledge them and address them in a manner that avoid conflicts and maximise the chances of compliances.

Cognitive representation is a component of the explanatory model and will be described below

What is cognitive representation?

The "Cognitive Representation of Illness"³, describes how an individual constructs an internal representation of what is happening when they experience physical or psychological symptoms. Irrespective of the nature of the symptoms most people organise their thinking around five key components:

- (i) what is it (identity),
- (ii) why has it happened (cause),
- (iii) how long will it last, will it recur (timeline),
- (iv) what effects will it have (consequences), and
- (v) what can I do to make it go away (cure or control).

Interestingly, our research found that the majority of Sri Lankan patients with medically unexplained

symptoms were not concerned about what it was (identity), nor why has it happened (cause). They were concerned about how long it would last, whether it would recur (timeline); the effects it would have (consequences), and what can they could do to make it go away (cure/control)?

Yet it seemed to these patients that the doctors were interested in determining the identity of the symptom and it's cause.

Therefore, the information on cognitive representation contributed to the modifications and application of the cognitive behavioural therapy for majority of patients in the treatment arm of the RCT⁴. For example, 'cognitive restructuring' was directed at providing a simple account of why medically unexplained symptoms do not represent a serious life threatening illness; rather than having to explain as to why more investigations should not be carried out to find a cause. It also provided an opportunity to avoid engaging in unhelpful debates with the patient as to whether these symptoms indicate physical or psychological illness, as managing patients with medically unexplained symptoms poses a significant problem if either physicians or psychiatrists evaluate symptoms as entirely physical or psychological^{5,6}. This was particularly important as most of the doctors previously treating these patients had fallen into this trap: some saying that it was physical illness and others saying that there was no illness. The findings of the explanatory model thus made the task intervention much easier in those patients who did not demand a diagnosis or further investigations. The therapist was able to concentrate on correct strategies to provide

appropriate cognitive challenge, which would have been different for patients who do demand more investigations and diagnosis.

'Cognitive representation model' data (total number 68 patients)

What is it (identity)

The majority of participants (59%) did not offer any specific bio-medical diagnosis for their complaints. A specific physical diagnosis was given by 21% and 19% mentioned non-specific terms indicating a physical aetiology. Only one participant gave a psychological diagnosis.

Why has it happened (cause)

The majority of participants (56%) did not offer any explanation for the cause of their symptoms that could be categorised into internal, external, social, natural or supernatural world. Causes relating to the internal world were reported by 26%, social world by 15% and natural and super-natural world by 3%.

What effects will it have (consequences)

93% of participants felt their illness was serious; 60% very serious and 32% moderately serious.

97% admitted having some form of fear, only two denied any concern, 47% had more than one fearful concern over their illness.

Fear of death was the commonest (40%). 25% had fear of developing cancer or paralysis, and 29% expressed fear of various other serious complications. They had fear of

cont

having incurable serious illness or having an illness with potential serious complications in the future. But they were unable to specify what that would be.

48% visited alternative practitioners. Various other categories of specialists were visited by between 3-10 participants. Only 3% had visited psychiatrists.

How long will it last, will it recur (timeline)

18% reported having symptoms for less than six months and the rest, for more than six months (range 6 months to 20 years). The reported chronicity of the perceived symptoms is indirect evidence that they believed the symptoms were long lasting. As reported above the majority (59%) had fears of potential serious complications in the future, which might imply that they have perceived their symptoms as chronic or recurring.

Explanatory model of the doctors as reported by the patients

This information is helpful to compare the patient's model and doctor's model.

59% said that their doctors mentioned a non-specific illness indicating underlying organic aetiology. 28% said they were given a specific physical diagnosis and 35.2% had been told that there was no illness. 10%, reported that their doctors did not give any explanation and 16% were advised to ignore their illness, another 13% of participants were told 'not to be frightened' and 6% were told that 'everything was in their mind' implying a psychological aetiology. Overall 83% said they had many different explanations given to them.

What can I do to make it go away; cure or control

Most have turned to allopathic doctors (94%), but there was help seeking from alternative practitioners (48%), family (88%), friends (52%) and clergy (4.4 %). 50% wanted the doctors to make them better. Only 13% wanted advice and explanation, 12% medication, 9% a diagnosis while another 9% wanted further investigations to be performed. However, none requested a referral to a specialist.

47% reported at least one hospital admission over the six months before the assessment. The mean number of visits to the health care providers was 7.0 (range 0-30). General practitioners were visited by 92% participants, general physicians by 57% and

cont

Here is a summary from an explanatory model interview

"The patient presented with abdominal pain, headache, chest pain, backache, pain along right upper limb and numbness of fingers of 5 years duration. She was unable to give an exact name for her illness or what exactly was the cause but believed that working too much may be a reason. She also believed that her husband was responsible for the illness, as he never helped her in housework. She believed that her illness is very serious and suspects it might be a cancer. She has

been to eight different doctors of different specialities. They have done ECGs X-rays of chest and spine, blood tests, urine tests and many other tests she is unable to describe. All of these were normal. Most doctors told her that there was 'nothing wrong'. However, she was unhappy as the symptoms persisted and was worried she may never be cured. As a result of these symptoms, she was unable to do any housework and had given up her permanent job as a cashier."

Verbatim responses for each component of cognitive representation model

What is it (identity)

'Cancer',
Excessive 'kapha' (ayurvedic concept referring to phlegm/secreations),
'I can't identify anything specific, it's too difficult to explain, problem with the head',
'A serious illness',
'Amoebiasis',
'Indigestion',
'Increased blood pressure and haemorrhoids',

Why has it happened (cause)

'No idea',
'Don't know',
'Happened after the child birth; caesarean section',
'An evil spell cast by somebody else',
'a poison has got into my body',
'Because of the *Vatha*' (ayurvedic concept referring to wind or gas)
'Because I was in the catering field I developed anorexia for food',

cont

'A fish bone or a metal pin stuck in the throat'
'I have swallowed a metal pin in 1950',
'Due to too much heat in the body',
'Brother got paralysed at the age of 37 years and I think about it'
'Because I breast fed my child while another child was watching',
'Because I was not successful in life'
'Because of an injury to my leg 5 years back',
'Due to de-merits of an earlier birth'
'Because of chewing betel',
'Gastritis',
'Illness of nerves',
'Did not eat my meals on time and neglected myself',

How long will it last, will recur (timeline)

'3 years',
'6 years',
'4 years'
'Indefinite';
'start of a serious illness, with time this illness will become severe'
'I will be always a sick person',
'won't live long'.

What effects will it have (consequences)

'I will develop chest pain and tumours',
'I may get bedridden',
'I may need surgery',
'I will die and if so what will happen to the children?'
'Will it be grave. I am scared because the severity of symptoms may increase',
'I won't be able to conceive a child',
'It may be a cancer, because doctors are saying nothing is wrong and the symptoms are not

cont

responding to treatment. My mother also died of cancer’,
‘It looks like an incurable illness, I might remain ill everyday in the future’,
‘It is the beginning of a serious illness’
‘Will I suffer hemiplegia/stroke because my mother also died of a stroke and I may not be able to walk?’
‘I fear a fainting attack while crossing the road’.

What can I do to make it go away (cure or control)

‘I should take bed rest’,
‘I should rest’,
‘Sleeping’,
‘I should find out the illness I am having’,
‘It should be investigated’,
‘Should take medications’,
‘Should take treatment from doctors’,
‘Should apply medicinal balm’.

Explanations offered by the doctors

‘No illness, no abnormality found in the reports’,
‘Not to draw water from the well’,
‘Not to be afraid’,
‘Gastric illness has gone to your head’,
‘You are too obese’,
‘This is an illness in the mind and to get rid of it we will do some tests’,
‘Tell the gods/spirits’,
‘It is a psyche illness, you are thinking too much’.

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The Short Explanatory Model Interview (SEMI)

Use of interviews allows researchers to gather in-depth information and thus enter into the participant's inner world, gathering information on the person's phenomenological experience. The one we used is referred to as Short Explanatory Model Interview (SEMI)¹. The SEMI played a crucial role in the assessment phase of the intervention during our two RCTs. More specifically the SEMI provided salient information relevant to the cognitive behavioural model of medically unexplained symptoms thereby informing the therapist without having to carry out traditional CBT assessment which consists of antecedents, behaviour and consequence.

In the management of complex clinical presentations such as medically unexplained complaints, exploration of the patients and clinicians explanatory model is crucial in developing or adapting culturally appropriate interventions.

SEMI is based on concepts originally proposed by Kleinman². The interview consists of open-ended questions. It is semi-structured, and uses simple language, avoiding any medical or technical words or phrases. Respondents are encouraged to talk openly about their attitudes towards and experience of the current illness, with the aim of eliciting their beliefs. Probes are also employed to both to clarify any beliefs that are mentioned and to explore areas not volunteered by the patient.

The interview is divided into five sections, which cover the subject's personal background, nature

of presenting problem, help-seeking behaviour, interactions with physicians, healers, and beliefs related to mental illness.

1. The section on background reviews individual and cultural factors. Basic demographic data, interpersonal relationships, housing, work, social-life, religion, life-history and specific cultural beliefs are recorded.
2. The respondent's beliefs concerning the nature of the presenting problem are examined. Also explored are: the reason for consulting, name of the problem, perceived causes, consequences, severity and its effects on body, emotion, social network, home life and work.
3. Help-seeking behaviour, especially contact with alternative non-medical sources (e.g. traditional healers) is then discussed
4. Details of the interaction with the physician/healer are also evaluated in terms of expectations and satisfaction.
5. The final section, which aims to elicit beliefs about common mental disorders, consists of four vignettes describing patients presenting with "depression", "phobia" and "somatization". They are followed by open-ended questions to elicit the respondent's attitudes to the clinical problem, in particular whether the respondent considers the presentation as a problem or an illness; the respondent's views on causation, course of action and the role of the doctor/healer.

Each section of the interview is designed to stand alone, and this allows the interviewer flexibility in the order of questioning.

with common mental disorders. A preliminary report. *Psychological Medicine* 1998; **28**: 1231-1237.

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Chapter 10

Interventions for Patients with Medically Unexplained Symptoms

The evidence on the effectiveness of any intervention is graded on a hierarchical level (I-V) as defined below.

Level of Evidence	Strength of Evidence
Level I	Evidence from at least one systematic review of multiple well designed randomised controlled trials
Level II	Evidence from at least one properly designed randomised controlled trial of appropriate size
Level III	Evidence from well designed trials without randomisation, single group pre and post, cohort, time series or matched case control studies
Level IV	Evidence from well designed non-experimental studies from more than one centre or research group
Level V	Opinion of respected authorities, based on clinical evidence, descriptive studies or reports of expert committees

A comprehensive literature search was carried out using Medline, Psycinfo to search for literature on systematic reviews, randomised controlled trials and non-randomised studies. This was followed by hand searching of the books and papers. Searches were carried out to identify pharmacological and non-pharmacological studies (psychological and non-specific interventions). There was no research evidence reported at level I, II or III, either for pharmacological or for psychological or non-specific interventions, from the developing world. Even in the developed world, in spite of medically unexplained symptoms being common in primary care, there were only 3 studies carried out in this setting using non-pharmacological interventions. There were no studies that compared the effectiveness of pharmacological and psychological

treatments for medically unexplained symptoms.

Pharmacological therapy: antidepressant medication, level I evidence

A brief review supported the use of tricyclic antidepressants, Selective Serotonin Reuptake Inhibitors (SSRI) and Monoamine-oxidase Inhibitors (MAOI) mainly for pain and other somatic syndromes¹. Most clinical trials, in 1970s and 1980s, were on patients with a variety of pain syndromes, but also having depressive symptoms. A recent systematic review was carried out on 94 RCTs looking at six symptom syndromes. It supported the use of anti-depressant medication, concluding that antidepressants could be effective in improving outcome, in terms of symptoms and disability. However, the potential for side effects is

a serious consideration when using anti-depressants in this group of patients. Although efficacious, all tricyclic antidepressants have side effects arising mainly from anticholinergic actions. The patients who are already distressed by their existing multiple symptoms may misinterpret these side effects such as dry mouth, constipation, and tachycardia as part of their illness or worsening of illness. Furthermore, there is no information on the optimum dose of anti-depressants, duration of treatment and long-term outcome².

This meta-analysis included 94 RCTs: - headache (50 trials), fibromyalgia (18 trials), functional gastrointestinal syndromes (13 trials), idiopathic pain (11 trials), and tinnitus (two trials), and chronic fatigue (two). 56 studies used tricyclic antidepressants, 17 selective serotonin reuptake inhibitors (SSRI) and 28 other antidepressants. Meta analysis of all extractable data showed a substantial benefit from antidepressants: for dichotomised outcome of improvements, the odds ratio was 3.4 (95% CI 2.6 - 4.5), and for continuous outcomes, of improvement the standardized mean difference was 0.87 (95% CI 0.59-1.14). The absolute percentage difference in improvement between the antidepressant and placebo arm was 32%, yielding a number needed to treat three to improve ones patients symptoms³.

Only 37% of the studies covered had adequately described the side effects. High withdrawal rates in 63% of studies may be an indicator of problematic side effects.

Psychological interventions; level I evidence for CBT

The evidence base from developed countries^{4,5}

Problem solving therapy, cognitive therapy (CT), cognitive behavioural therapy (CBT), and brief dynamic psychotherapy have been employed in the management of medically unexplained symptoms; the most frequently employed treatments are CBT and brief dynamic psychotherapies. Although medically unexplained symptoms are mainly seen in primary care settings, most trials were carried out in secondary or specialist care. A number of systematic reviews have evaluated the use of CBT in the management of patients with somatic symptoms^{6,7}. Most trials targeted specific syndromes; such as irritable bowel and chronic fatigue syndrome. Thus, only a minority of trials specifically focused on general somatisation, which includes patients with medically unexplained symptoms and those with hypochondriasis. These reviews conclude that CBT, delivered in individual or group format, may be efficacious for somatic symptoms whether defined as symptom syndromes or grouped under the broader headings of somatoform disorders. Trials variously found that cognitive-behavioural therapy reduced physical symptoms, psychological distress, and disability. CBT interventions have produced effects of moderate to large magnitude and are recommended as the first line of treatment. However, optimal and minimum duration of treatment and value of maintenance therapy remains to be established.

The evidence base from developing countries^{4,5,8}

We are aware of only one published and one completed trial from developing countries. These trials were conducted in Sri Lanka.

CBT by a psychiatrist

In the first trial primary care attenders who had 5 or more medically unexplained complaints were randomised to CBT by a psychiatrist or treatment as usual (routine care). The intervention had a positive impact on reducing distress, symptom perception and patient initiated unstructured visits; and increasing perceived satisfaction. Three sessions were found to be the minimum adequate course of treatment. A reduction in symptoms was also found in the control group. The opportunity to participate in a detailed assessment and to express their explanatory model may have had a non-specific therapeutic effect.

Structured care by primary care physician

The second trial involved patients with symptoms of more than six months duration so as to exclude acute somatisers who were likely to remit spontaneously. The CBT intervention was administered by Primary Care Physicians (PCPs). Patients were assessed by a consultant physician at the baseline and at 3, 6, 9 and 12 months to record the number of complaints and visits. Subjects in the control group were also managed by designated PCPs who offered the same number of contacts as for the intervention group (Structured Care), thus controlling for any non-specific therapeutic effect of the CBT intervention. The first 3 sessions of the intervention were mandatory and offered weekly. The remaining 3 were optional and fortnightly. The sessions were for 30 minutes, and the treatment was spread over 9 weeks. This study revealed that CBT provided by PCP after a short course of training, is no more efficacious than structured care offered by PCP, controlled for duration and frequency of treatment sessions.

Psychodynamic psychotherapy

A systematic review of studies using psychodynamic psychotherapy in somatisers⁹ identified three trials; the review concluded that psychodynamic psychotherapy was effective for the management of chronic pain and irritable bowel syndrome. However, the small number of empirical studies made it difficult to generalize these findings to other somatic conditions.

Real et al¹⁰ describe the efficacy of brief family therapy delivered by general practitioners for somatoform disorders. Gask et al¹¹ evaluated the effect of a teaching package on reattribution therapy for general practice trainees in the UK and in Tanzania¹². Although these studies showed that skills could be transferred to general practitioners, there was weak evidence that the intervention led to significant improvement in clinical outcomes. A recent trial of reattribution training was associated with greater endorsement by patients after 1 month; that they received the help they wanted and after 3 months fewer beliefs by patients that their symptoms had only a physical cause. But the training did not change the incidence of investigations initiated by the family doctor, prescriptions for psychotropic or non-psychotropic drugs, or referrals¹³.

Therapeutic benefits of an assessment

Apart from specific psychological treatments, there is a growing body of evidence that patient-health practitioner interaction styles may have benefits for patients with somatoform disorders. For example, Price² noted that an assessment for psychotherapy itself might have therapeutic effects. Simple

cognitive approaches might be able to change cognitions and make meaningful improvements in the outcomes².

Changing patients' beliefs about their symptoms may improve a broad range of outcomes, including the symptoms themselves, disability, distress, and health-care use. A rounded clinical assessment might modify such cognitive factors, such as symptom attribution, and thereby improve outcomes¹⁴. There is evidence from randomised trials to support the therapeutic effect of offering an explanation, utilising only history-taking and consultation. For example, a consultation in which a patient is given a definite diagnosis and reassurance they would be better soon, is more therapeutic than one in which they are told that their diagnosis and outcome is uncertain¹⁵. There is also evidence that the treatment of somatising patients by general practitioners leads not only to improved clinical outcomes, but is also associated with improved physical functioning and reduced health care costs¹⁶.

Justification of the choice of a therapy; advantages of CBT over other interventions

The review of the literature suggests that three types of interventions: anti depressant medication, CBT and other non-specific interventions are beneficial in the management of patients with medically unexplained symptoms. However, there is more level I evidence for CBT compared to the other two approaches. There are other reasons too for the choice of CBT over anti-depressants, even though offering CBT is logistically more complex than offering medication. In a commentary in Evidence Based Mental Health on the above work, Price²

noted that although the short-term improvement was clinically significant if CBT was available there was little to choose between CBT and antidepressants in producing short-term benefit. He also noted that for antidepressants there was no information on the optimum dose, duration of treatment and/or long-term outcome, and that the side effects of medication may be particularly distressing to this group of patients.

In contrast to antidepressant medication no unwanted side effects have been reported following the use of CBT. From the evidence reviewed, CBT appears to be effective in the reduction of a wide range of physical symptoms and associated mood disturbance, as well as producing improvements in overall physical and social functioning¹⁷.

There is no firm evidence for antidepressants or any other pharmaceutical agent to be regarded as the best approach for treating medically unexplained symptoms. Fewer than 50% of patients with chronic diseases maintain compliance in the longer term^{18,19}. Compliance for patients with medically unexplained symptoms will be a particular problem as they seek treatment from many different categories of therapists when they are dissatisfied with the help offered. Bridging the gap between the agenda of the patients and the doctors has changed the emphasis from an authoritarian concept of compliance to a more inclusive concept of concordance; shared decision-making taking into consideration the wishes and beliefs of the patient. Evidence based guidelines on treatment will be useful only if the subjective elements of patient's preferences and values are acknowledged and explored²⁰.

The strength of the cognitive behavioural model is in explaining the psychopathology of medically

unexplained symptoms. The CBT model accommodates each factor that contributes to the patient's distressed states. Working with this model, the therapist is able to go beyond the medical model that searches for a physical cause and treats by prescription, which has so far failed to help the patient.

The cognitive behavioural model in its conceptual framework helps to understand both normal and abnormal aspects of human behaviour and proposes a set of empirically based guidelines by which such behaviours can be changed (Nezu AM, Nezu CM, Lombardo ER 2001). Human behaviour includes not only the overt actions but also the associated internal cognitive phenomena, emotions, biological and physiological changes. As such, a comprehensive understanding of a complex phenomenon is necessary to achieve an effective intervention. Cognitive behavioural therapy seeks to identify and modify dysfunctional thoughts and beliefs, in order to influence emotions, behaviour and physical symptoms.

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Chapter 11

Understanding Basic Cognitive Behavioural Therapy Principles

Theoretical constructs of CBT

Behavioural therapy and cognitive therapy, which originally developed independently, have in the last two decades combined to make what is today known as cognitive behavioural therapy (CBT). Although there are variations of this, they are unified by the proposition that psychological problems can arise and/or be maintained by faulty patterns of thinking. The CBT model emphasizes the links between thoughts, emotions and behaviours. Therapies following the CBT orientation attempt to help patients to identify and modify the faulty cognitions that may have caused or contributed to their complaints. They also help patients to change maladaptive behaviour patterns by specific behavioural strategies.

Delivery of cognitive behavioural therapy

CBT is a time-limited, problem-based treatment, relying on the model relevant to specific illness/disorders. It is a collaborative effort in which the patient has to actively work together with the therapist. As its name implies it uses both cognitive and behavioural techniques.

Cognitive techniques are directed towards identifying dysfunctional beliefs, assumptions, thoughts, interpretations and modifying these by challenging them, by restructuring cognitions, thereby educating the patient.

Behavioural strategies are aimed at modifying dysfunctional behaviours and symptoms directly. Behavioural strategies include relaxation, distrac-

-activity monitoring and rescheduling, behaviour experiments, and exposure and response prevention.

Diary keeping is an important component of CBT that could be used for both cognitive and behavioural work. The patient may be asked to maintain a diary of occasions when symptoms are present and note related factors. Patient is taught to identify and record the thoughts and emotions experienced at the time.

The cognitive model

In its broadest sense, cognition refers to the full range of processes and mechanisms that are involved in thinking, and the contents of these processes. This includes simple thoughts images, as well as more fundamental beliefs and assumptions that people have about themselves and the world¹.

It is useful to be familiar with some of the terms used in the cognitive model.

The term **schema** refers to a cognitive structure. The **schemata** are the “boxes” into which we sort our experiences. **Beliefs** and **assumptions** are two types of informational contents or representations of knowledge, which are stored in the memory structure.

These basic **beliefs** usually have their origins in the person’s early experiences and are also shaped by cultural and family beliefs, as well as person’s own subsequent experience.

Beliefs are constructs that are unconditional in nature (construed in absolute terms) and are taken as truths about the self and the world, and are usually expressed as self-relevant statements. Therefore, these can be considered as **core** or deeper cognitive elements.

Assumptions are conditional and may be thought or expressed as 'if – then' propositions; linking an event and its appraisal.

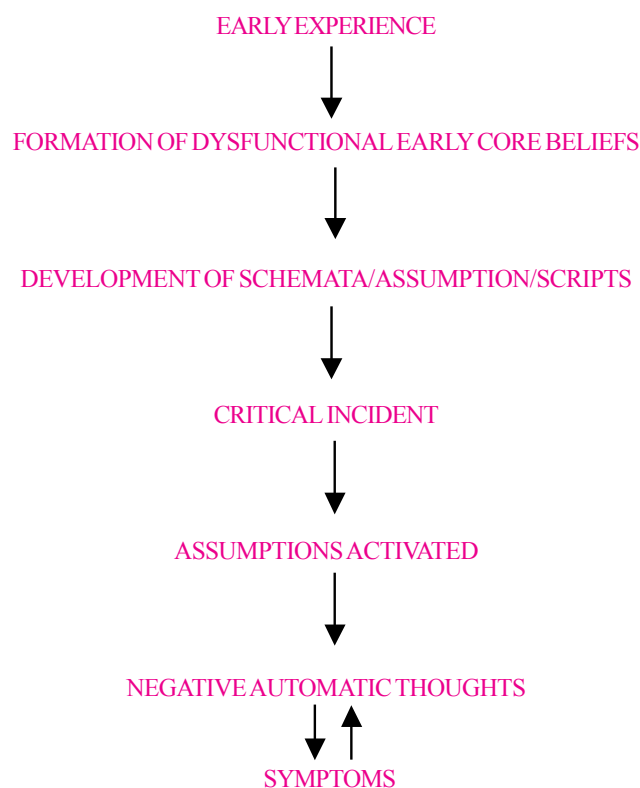
It is now assumed that from the **core beliefs** develop **schemata**, by which the individual constructs laws and regulations for their world. **Schemata** are the ways we screen out, differentiate, and code stimuli that confront us, constituting specific rules that govern information processing and behaviour ².

Schemata may remain dormant until activated. The event that activates the schema is called a **critical**

incident. Once activated, **schema** influences information processing, shape the interpretation of experience, and affect behaviour. Therefore there is a systematic bias as to how the individual notices, interprets, integrates and remembers data². The activation process will lead to certain **automatic thoughts**.

For any given person, cognitions may be **functional or dysfunctional**. Cognitions are termed **functional** if they lead to the effective resolution of problems and to mental and/or physical health.

Dysfunctional cognitions are less effective in solving life's problems and tend to perpetuate excessive and undesirable behavioural, emotional and physiological responses¹. Cognitions which are **dysfunctional** when activated will lead to **negative automatic thoughts**.



Updated cognitive model of illness based on Beck's ideas

These negative **automatic thoughts** are involuntary, distorted and unhelpful and affect and influence information processing, leading to bias in the interpretations, which are also termed as **thinking errors** or **cognitive distortions**.

Further accounts of cognitive behaviour therapy are available in several publications, including Beck^{3,4}.

Cognitive and Behavioural Concepts and Techniques

Negative automatic thoughts are;

- Involuntary - require no effort, just occur spontaneously,
- Distorted – neither arise from reasoning nor fit the facts but seems plausible or reasonable at the time and can occur contrary to objective evidence,
- Unhelpful and difficult to switch off, thinking errors or cognitive distortions.

Common errors or distortions include;

- Arbitrary inference - drawing a conclusion in the absence of sufficient evidence
- Selective abstraction- focusing on one aspect of a situation while ignoring other important and relevant features
- Overgeneralisation - applying a conclusion to a wider range of events or situations when it is based on an isolated situation
- Maximisation / minimisation, amplifying or reducing/ discounting the importance of events
- Personalisation - relating external events to self when there is no basis for this
- Catastrophisation - dwelling on the worst

possible outcome and overestimating the probability that it will occur

Negative automatic thoughts can also produce behavioural responses leading to dysfunctional behaviours and physiological responses such as avoidance and tachycardia; commonly seen on to affective and anxiety responses.

Basic principles of cognitive behavioural therapy;

- It is a form of time-limited, problem-based treatment depending on the model relevant to the specific illness/disorder,
- It is a collaborative effort during which the patient has to actively work together with the therapist,
- It includes cognitive techniques and behavioural techniques,
- Cognitive techniques are directed towards identifying dysfunctional beliefs, assumptions, negative automatic thoughts, interpretations and modifying these by challenging, combating cognitive biases, restructuring, and educating the patient,
- Behavioural strategies are aimed at modifying dysfunctional behaviours and symptoms directly.

Cognitive techniques include

- Identifying and eliciting negative thoughts
- Dealing with negative thoughts
- Exploring the evidence for and against them
- Considering alternative explanations

Behavioural strategies include

- Relaxation,
- Distraction,

- Activity monitoring and rescheduling,
 - Goal setting
 - Exposure and response prevention
 - Desensitization
 - Skill training
 - Stimulus control ,
 - Aversion
 - Use of rewards
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Treatment Manual for CBT for Medically Unexplained Symptoms

This treatment package was developed by modifying the cognitive behavioural model for medically unexplained symptoms so that it could be applied in primary care. The usual CBT course in clinical settings in the West is between 10-12 sessions of one-hour duration. In this project an attempt was made to conduct shorter courses of six sessions of 30 minutes each. One hour sessions are not realistic in already over-stretched primary care settings in the developing world. Further modifications were the innovative use of locally relevant and appropriate psychotherapeutic language, and the use of analogies to simplify complex CBT principles for the lay person. These strategies were simple but conformed to CBT principles. Modifications to the contents were sensitive to local ways of thinking. This was especially important as patients with medically unexplained symptoms are considered to be not very 'psychologically-minded'.

The treatment package was designed so that factors operating at each level of the cognitive model could be identified. Cognitive or behavioural approaches were then employed to address each of these factors. Instructions for this strategy were laid out in a treatment manual. What follows is a modified version of the manual used in a recent clinical trial we conducted in Sri Lanka.

Course

Patients should receive structured facilitation based on the principles of CBT. The optimum number of

sessions will depend on how chronic the symptoms are. It may vary from one session to six. Each session should be no more than half an hour. The frequency can also vary from once a week to once in two weeks. The treatment manual should be used to keep the sessions uniform. However, within that structured framework there should be some flexibility as individual's thoughts, assumptions and attributions will vary.

Contents and delivery of the sessions

The therapy intends to produce a gradual shift away from disproportionate somatic preoccupation. This can be achieved as the symptoms begin to be understood in terms of an interaction between physiological, psychological, and social factors¹. Each session should be an extension of the previous one with the same messages being emphasised in order to reinforce and consolidate what was achieved during the earlier sessions.

Optimum number of sessions

During the first trial the patients who followed three or more sessions remained in the study and showed clinical improvement. Therefore, we have decided that three sessions would be mandatory. However, we have not yet carried out specific research to decide what would be the optimum number of sessions. The number of sessions required may depend on the duration of symptoms and level of distress.

The specific approach we describe here is adapted from the manual utilized in a recent trial of a CBT intervention for somatising patients in Sri Lanka². The treatment was based on the principles of CBT, as described in the earlier trial³ which adapted methods developed by Salkovskis⁴, Sharpe et al⁵ and Goldberg et al⁶. The adaptations included innovative use of culturally relevant and appropriate psychotherapeutic language, and strategies simple enough for use in primary care, whilst still conforming to the CBT principles.

The details of this trial is described previously in chapter 10, under 'structured care by PCP'.

Guidelines for conducting the CBT sessions

First session

Objectives of the first session are;

1. Recapitulate the problem using the patient's own explanatory model,
2. Acknowledge that the patient has an underlying reason for their perception of symptoms, associated distress and disability. Therefore something could be done to help the patient,
3. Orientate the patient on the treatment package,
4. Make a contract with the patient.

1. Recapitulation of the problem

The first step is recapitulation of the problem using the information elicited during the explanatory model interview (SEMI). No medical model is imposed on the patient. It is an important element in the delivery of treatment to show that the patient has been understood, that his distress is appreciated as genuine and not imagined and that, the therapist can empathise with the patient's distress. This is a vital step towards establishing rapport with the patient, which will promote a new strategic alliance and a paradigm-shift from what they have witnessed so far in their protracted search for relief. It is also important to avoid any suggestion of psychological factors or psychiatric illness playing a role at this stage of the treatment.

How is it practically done?

Phrasing: *"You have presented today with abdominal pain, headache, chest pain, backache, pain along right upper limb and numbness of your fingers of five years' duration. You are unable to give an exact name for your illness but believe that working too much caused it. You also feel that your husband is responsible for it, as he never helped you in the house work. You believe that your illness is very serious and suspect it might be a cancer. You are extremely worried about possible death or becoming bed-ridden soon. Your symptoms become more acute in the evenings, particularly after work, and are relieved after some relaxation. You have been to eight different doctors of different specialties. They have done ECG,s X-rays of chest and spine, blood tests, urine tests and some other tests you are unable to describe. All of these have been normal. Most of the doctors told you that there was 'nothing wrong', to 'just forget*

it', and that 'it is really puzzling'. However, you are far from happy as the symptoms still persist and you strongly feel that you should have a full body CT scan. You are extremely upset and worried about the continued illness. As a result of the symptoms, you are unable to do any housework and you quit your permanent job as a cashier.

" You have stopped going out of your residence except to see a doctor. You feel very irritable and you quarrel with your husband frequently. As a result your marital relationship has been affected, and you have had no sexual contact with your husband for about six months. Your mind is always preoccupied with the deterioration of your health. You feel temporarily relieved by talking to numerous friends and to your daughter who offer you advice or help you consult doctors.

"I must emphasize that in our therapy we treat the 'whole' patient and the patient is viewed in the context of his/her immediate family and as a part of larger society. Our concern is not solely with the symptoms but also with you as a person, and as a member of your family and of society".

2. Acknowledging that the symptoms, distress and disability are genuine

The therapist makes a clear statement that the patient's complaints and concerns are understood as genuine, and that malingering is totally ruled out. It should also be explained that any symptom, irrespective of its cause, can make people worry.

Phrasing: *"It is wrong to say that there is nothing wrong. There is something wrong. We will help you find out what it is and guide you to do what is best. We will also help you to try and avoid doing things that could make the situation worse.*

"Most importantly, I can assure you that these symptoms are not indicative of impending death

or permanent disability. So let's now discuss how best to help you. Let me reassure you that you are not 'mad', that these symptoms are not all in your mind and that I believe you are not telling lies".

3. Orientation on the treatment package

The patient is told that the objectives of the treatment are to:

- i. Reduce distress,
- ii. Reduce symptoms,
- iii. Reduce disability,
- iv. Reduce/limit inappropriate use of medical services and medication.

The patient should be told in simple language about the duration of treatment. The patient should also be made aware of the importance of his/her own role in the treatment to be successful-i.e. the importance of his/her own responsibility for taking control of his/her condition. As a part of their responsibility they are requested to enter into a verbal contract on the treatment.

Phrasing: *"It is very important for you to actively take part in the treatment process. I can only help you do it but I cannot do it for you. Likewise, you cannot do it all by yourself and that is why you are here today, seeking help to overcome the difficult situation you are now in. This is a collaborative partnership in which I can teach you what to do, how to do it and what things you should not do. This will enable you to deal with your symptoms yourself instead of depending too much on medical help, which has not done a great deal for you.*

" Let me explain this a bit more. You would have noticed already that we do spend more time with

you here than the doctors who have seen you so far, and that we also talk more. So, for now, let's call it 'talking treatment'. This is commonly used in other parts of the world. This method enables the doctor and the patient to talk not only about the symptoms but also about the distress caused by the symptoms. It also helps both the doctor and the patient to understand why all these are happening. So we can exchange and share our views and plan and work together to get over these difficulties. Over the next five sessions you will learn the do's and don'ts.

" You will learn to notice what thoughts come to your mind when you have the symptoms. You will also explore the link between these thoughts and what you feel then, and what you then do or feel like doing".

If the patient is on unnecessary medication, which is usually the case, they should be told that you propose to reduce these, but would not do so immediately.

With this understanding the patient can be on a better footing to deal with the problems himself/herself.

4. Making a contract

The contract is for the patient to agree to work with one professional carer, to engage one non-professional carer (the spouse or a family member), and to make regular notes in the diary about the symptoms, associated thoughts (the cognitions) and related behaviour. The diary is designed for this purpose and should be provided by the therapist.

(i) One professional carer to facilitate the process of care

This is to avoid unnecessary visits to other medical

care providers in an unstructured manner, unless there is a medical emergency. The patient should be reassured that if any visits are required to any other specialist, it will be done in a coordinated fashion by the present carer. The patient will be requested to attend only the structured sessions with the designated professional carer.

(ii) One non-professional carer

The aim is to train a relative to be the 'co-therapist', who could reinforce the treatment offered in the therapeutic setting. The role of non-professional carer should be clearly explained to the relative if one is present. This non-professional carer should be helped to learn to provide appropriate advice and help when the patient needs it. The rationale here is to try and discourage the patient discussing symptoms and worries with different people, at different times, which may even add to the confusion with conflicting explanations and advice given in the process. The patient will be instructed not to discuss his/her symptoms with any family member or friends except with the main non-professional carer who is given advice on how to help the patient. He/she will be instructed to discuss his/her condition only with the non-professional carer and/or to write in the diary if and when feeling distressed. The assumption here is that the co-therapist would gather and retain more information during the therapy, as he/she will be less preoccupied with the symptoms.

(iii) Diary

Diary keeping is used as a means of expressing distress, and as a means of identifying dysfunctional cognitions. It is also used as a basis for monitoring symptoms for therapeutic use by encouraging the patient to make regular notes in a

diary of symptoms, other associated thoughts (the cognitions) and related behaviour. A diary designed for this purpose should be given to the patient. In subsequent sessions, the therapist should go through the diary and discuss the entries.

Another specially designed diary which should be given to the patient with a type-written request to the patient's doctor to note the details of consultations and treatment in case the patient visits them. The patient should also be given a generic handout written in simple language detailing objectives for all patients.

Second session

Objectives of the second session are;

1. Reinforce what was done during the previous session,
2. Go through the diary,
3. Explain the link between physical and psychological symptoms,
4. Provide appropriate reassurance using simple language,
5. Explain why no more unnecessary investigations should be conducted,
6. Encourage a return to normal activities,
7. Identify unhelpful cognitions using the diary, and restructure them; and identify dysfunctional behaviours and work on modifying them (This is specific CBT work).

1. Reinforce what was done during previous session

First 5-10 minutes should be devoted to reinforce the messages given in the first session.

2. Go through the diary

It is essential to check what the patient has written down in the diary. Otherwise the patient may

become discouraged to maintain the diary if no attention is paid to what they have written. Tell the patient that you will discuss it more thoroughly later in the sessions. If the patient has not made any notes, then you need to find out if it is due to no symptoms being experienced or whether they failed to keep notes due to any other reason. If the patient has not maintained the diary due to other reasons, it is important to discuss this and attempt to clear any doubts the patient may have.

3. Explain the link between physical and psychological symptoms

So why all these symptoms?

Explain to the patient in simple language the basis of the perception of symptoms. Explain that various perceptions in the body are common but most of the time we do something and ignore them and they disappear. If they persist we get more alarmed and at times even without our awareness we start guessing as to what the significance of these is. It can lead to fear, distress, concern or worry based on our own experience with previous illness episodes or those of our friends and relatives. The more we get concerned, the more we become vigilant and hence the more we notice. This becomes a vicious circle.

Another simple example may be used to explain this. If one concentrates hard, he will pick up faint noises. If we look carefully, we will see things we do not see otherwise. Similarly even with our own body we pick up various sensations if we are preoccupied with it. The more you worry the more you are preoccupied and this will make you notice more and therefore feel more. This should be discussed with the patient as a possibility in his case as well. At this stage ask the patient as to whether he

noticed his own breathing during the last few minutes. Then get the patient to close their eyes and think about the breathing. Ask whether the patient felt his own breathing. Using this experience, explain to the patient, how one would perceive even their normal bodily sensations if they concentrate on them.

Phrasing: *“ Various perceptions or feelings in our bodies are common and, regardless of whether we do something about them or ignore them, in most instances they wane in time. If they persist, we may get more alarmed and often, even without being aware of it, we may start to guess the significance of these symptoms. This can lead to fear, distress, concern or worry, an experience that is often shaped by our own previous episodes of illness or those of our relatives. The more concerned we become the more vigilant we are, and hence the more we notice the symptoms that worried us in the first place and also things we hadn't noticed before.*

“ If we listen hard we pick up faint noises. If we look carefully, we see things we wouldn't see otherwise. Similarly, if we're preoccupied with our own body we'll notice various sensations. For example, you breathe all the time but usually you're not aware of it. But if you close your eyes and concentrate on your breathing you'll feel it. So the more preoccupied you are with symptoms the more you'll notice”.

Another simple example may be used to explain it. If anyone is faced with a frightening experience, which is a normal emotional experience in human beings, then the heart beat will go up, and there will be sweating, shakes, and a lot of physical changes as a result of the emotional change. Similarly, one

might get a headache or there could be some other physical symptom. Such symptoms are at times misinterpreted by people as indicators of serious illness signifying danger. This will explain how emotional arousal can in turn lead to increased perception of bodily sensations.

Phrasing: *“If one increases the attention paid to one's own body one will perceive more sensations. I will demonstrate this now in a simple way. Please close your eyes and concentrate on your breathing. You feel you are breathing now, don't you? But when you were talking to me you did not notice it. This shows that if one concentrates on the body one even feels some of the normal bodily functions, which one would otherwise not notice.*

“ Similarly you hear the sound of a clock ticking in the night but not in the daytime. During the daytime there are many distractions so you do not hear the sound but as the night is quiet you notice this faint sound, which can even be disturbing. The perception of more bodily sensations also happens in this way.

“ So what is the rational thing to do? Try and reduce undue attention towards your body and distract yourself.

“ Going to many different doctors, receiving contradictory and ambiguous advice, repeating unnecessary investigations and talking to different people about your symptoms, will only increase your attention towards your body. That will make you feel more and more symptoms. That is why we tell you not to do any of these things”.

Then explore the relative contribution of physical and psychological symptoms to the distress.

If someone has cancer and he is going to die he will naturally be distressed. Similarly if one believes that he has cancer and will die the distress is the same,

because the perceived threat of potential death is same in both instances.

4. Provide appropriate reassurance using simple language

Discuss the patient's fears and provide appropriate reassurance if there are any specific untoward fears. If there are reasonable fears, which have not been addressed so far, they should be dealt with accordingly. The patient should be told of the limitations of reassurance based entirely on physical/laboratory investigations.

A discussion should be carried out to show how a sympathetic listener could alleviate one's day-to-day worries, but how things could be made worse by talking to a wrong person. Explain how different people are likely to provide different views on the patient's symptoms, which could make him more worried and confused. Therefore the patient should avoid such repeated reassurance-seeking from different health professionals or other people who may provide contradictory and ambiguous advice. Explain how other people's opinions and behaviours can add to the distress. This includes family, friends, relatives, fellow patients and even doctors. This can happen due to misinformation or their undue concerns and worries.

5. Explain why no more unnecessary investigations should be conducted.

The reinforcing effects of unwarranted negative investigations should be discussed. This would be discussed in relation to the limitations of the investigations and their relevance to the symptoms.

If we do irrelevant investigations we will get negative results and then we might say that there is nothing wrong. But the patient will not accept this because their symptoms are genuinely perceived. They may then suspect that there is a very serious illness which has not been detected by the doctor. This leads to more and more searching, and consulting more doctors until an answer is found. This iatrogenic contribution should be discussed. At this stage use the '*Why an elephant is called an elephant*' analogy to explain the basis for no more tests and also to restructure the cognitions.

The therapist should draw a sketch of an elephant and should ask the patient what it is.

Once the patient replies that it is an elephant the therapist should ask why he says it is an elephant. The patient will then describe the reasons – the trunk and tusks etc. So the therapist clarify with the patient how he decided that it is an elephant based on specific features of an elephant. It was not by excluding other animals that he came to the conclusion that it was an elephant. In other words, "*the elephant is an elephant not because it is not a cat, a cow, a rat ... or any other animal*". It is not by exclusion but by positive features that we decided that it is an elephant. Similarly, we do not have to keep on checking all the illnesses known to us to say what the problem you have is. So we will not keep on checking. Doctors resort to inappropriate reassurance by saying that there is nothing wrong. This may give the patient the false impression that all of their troubles are in their mind. They may get angry. However after saying that there is nothing wrong they may still want to do an investigation⁶. This may lead the patient to think, 'if there is nothing wrong what is the doctor testing?', 'is there something the doctor has failed

to detect?' 'doctor may not be confident', or 'the doctor may not be telling the truth'.

To clarify this further 'I trust you but can I check your wallet' analogy can be used.

Phrasing: " I kept some money on the table just before you came here. But I cannot find it now. I am sure you did not take it. I trust you. However, before you leave, if I request you to show me your wallet you will not believe that I really trust you". This analogy explains the doctor's action, after saying that there is nothing wrong, doing an investigation destroys trust and this can add to the patient's distress, rather than help.

6. Encourage return to normal activities

Along with the reassurance seeking behaviour, there may be other dysfunctional behaviours such as reduction of the previous normal behaviour. Activity may be avoided due to fear of provoking symptoms. Sometimes it may be directly attributed to symptoms such as "lack of energy". These behaviours may lead to taking time off work, reduce domestic work, or even withdrawing from social encounters. This disability will again reinforce the fear and concern of potential serious illness. The disproportionate distress and disability experienced by the patient may result in the family becoming over-involved, relieving the patients of his usual day-to-day responsibilities. However, such actions will reinforce the patient's beliefs and dysfunctional behaviours rather than resolve them. So the patient must be encouraged to return to normal activities.

7. Carrying out specific CBT work

Elicit the patients cognitions (beliefs, assumptions etc) and work on changing the unhelpful/dysfunctional ones. This may be done by subtle

probing and enquiry, or more overtly by pointing to evidence to contrary. Let the patient see for himself that their suppositions and conjunctions may wrong. Similarly discuss dysfunctional behaviours, and work towards modifying them. For example encourage the patients not to avoid things such as activity.

Go through the symptoms with the patient in order to explain the relevance of the symptoms to known illnesses/diseases.

Third session

Objectives of the third session are;

1. Reinforce the messages given in the previous sessions,
2. More specific CBT work,
3. Discuss issues arising out of the diaries.

Bring in more generic CBT techniques using simple analogies given below.

'Driving a vehicle along a road where there is a huge cliff at the end'. Use this to explain the idea of thought stopping and challenging negative thoughts. Discuss the inevitable consequences if the vehicle continues along a road where there is a huge cliff at the end and what possible actions could be taken to prevent that. Inevitable result will be the vehicle falling into the precipice. Therefore, the rational action would be to apply breaks and stop the vehicle, take a turn and change the direction or to reverse.

This may help the patient to understand what would be the emotional consequence if unhelpful negative thoughts are allowed to proceed, and therefore what action should be taken to prevent it; i.e. the concept of 'thought stopping'(equal to applying breaks), challenging negative thoughts (reversing), distraction techniques (changing the direction).

Another simple analogy is *'knock on the door'*. Use this to explain 'distraction techniques' If possible create a situation where someone comes and knocks on your consultation room several times. You may even choose an example where your telephone rings several times while you try to engage the patient or a nurse repeatedly interrupting you during a consultation. Whatever the situation you choose, it will be clear that repeated interruptions will prevent progression of the consultation. Therefore, you will not reach the end of the conversation. Similarly, the ideas of the distraction techniques are to prevent progression of thoughts.

Use the *'rubber ball under the water'* analogy to discuss automatic negative thoughts. If a rubber ball is placed under the water it will come to the top automatically. An effort is needed to keep it under water. Automatic thoughts are also like that. These come up without any effort. You will need some active effort to stop these thoughts bothering you.

'Mum's cleaning slot' analogy explains the concept of activity rescheduling and how to use a 'worrying slots' to reschedule and control preoccupation with symptoms- 'learning to control thoughts instead allowing your thoughts to control you'.

In this example you can discuss a mother with several children. They generally untidy the house by placing toys all over the house. If mother try to tidy it every minute the kids mess it she will not have time to do anything else. So she deals with the problem by having tidying up sessions, may be once a day, twice a week or whatever appropriate to her. She schedules her tidying activity. Similarly one can work with 'bothering thoughts' by working on

them in an allocated slot of time rather than being preoccupied with, continuously .

'First day in school and the difficulty with the alphabet' analogy helps to explain why learning the CBT techniques initially requires effort, but becomes easier with continued practise.

Ask the patient whether he wrote an essay on the first day in school. There may be two answers. One is a direct 'no' or 'cannot remember'. If the answer was the first then it is straight forward to proceed. If not, ask whether anyone will be able to write an essay on the first day in school. Not only an essay but even a few letters in the alphabet was difficult. Then clarify whether writing the alphabet remains difficult to this day. The answer in most literate people will be 'we can do it now'. Then discuss how they gained these skills, through learning and practice. "It will be the same with CBT techniques. They can be learnt even if you feel it is difficult now".

The *'child and chocolate analogy'* explains the concept of exposure and response prevention.

When a child cries, parents may give a piece of chocolate to stop the child crying. When we know it works next time we may even offer chocolate before the child start to cry. We learn that the crying can be stopped by giving chocolate so we continue to do it. Our behaviour gets reinforced. The child learns that if he cries he will get chocolate. Although by giving chocolate a parent can stop a child crying on that occasion, what actually happens is that in the long run we encourage the child to cry if he wants chocolate or anything else because he learns that by crying he will get rewards. By not giving the chocolate the child may cry, but eventually will

stop of his own accord as he learns that crying will not ensure a piece of chocolate.

Optional sessions

Fourth session

Objectives of the fourth session are;

- 1. Questions and answers,
- 2. Reinforcement of the treatment provided during the previous sessions,
- 3. Discuss the diary and carry out more CBT work to consolidate what has been achieved so far.

Fifth Session

Objectives of the fifth session are;

- 1. Reinforcement of the treatment provided during the previous sessions,
- 2. Discuss the diaries and carry out further CBT work.

Final session

Objectives of the final session are;

- 1. Recapitulate what has been done over the previous sessions,
- 2. Explain the strategy for future management as these sessions have now come to an end,
- 3. Warn the patient that symptoms may arise again in the future and this should not unduly alarm the patient or be interpreted as treatment failure,
- 4. If a consultation with a doctor is required then this should be with the present doctor if possible or another doctor known well to the patient who can then liaise with the present doctor. Go through the patient’s formulation .

Formulation should be in simple language.

This patient was seen with the following complaints.

.....
.....
.....

He was assessed by me, and based on the most recent knowledge of “medically unexplained multiple symptoms and repeated consultations”; she/he was treated using a new strategy based on cognitive behaviour therapy.

We recommend the following course of action if she/he comes to you for treatment:

Avoid reinvestigating this patient any further for the same complaints noted, unless there is clinical evidence to suggest a new or life threatening condition. It is best to refrain from administering symptomatic treatment.

If required, the therapist indicated below may be contacted.

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Chapter 13

Model Diaries and Patients Handout

The following 2 diaries are recommended for use during treatment. The first one is to be used by the patient to note his symptoms, thoughts, feelings and behaviours. The second is also given to the patient but to be completed only if the patient visits any other doctor.

Model Diaries

Model Diary for Patient

Date	
What sort of difficulties did you experience in your body (symptoms)	I had a headache. I felt like a electric current traveling along my right arm. I heard a rumbling noise coming from my tummy. Backache I had from the morning got worse.
What sort of thoughts crossed your mind when you had these difficulties	I felt that there will be no end to this misery. What is going to happen to me. I am so unlucky, there is not a single day I can feel happy. What is this? Although the doctors say there is nothing wrong then why all these pains. What is the point of a life like this? Should I see a different doctor? My mother also had a very similar illness and suffered for many years before she died. If I die who is going to look after my youngest daughter. How can she live without me? I feel totally lost
What did you do or not do	I tried to ignore it as the doctor said. But it was impossible. Then I gave up cleaning the room and sat down for a while. Then I cried as I had nothing else to do. Took two paracetemols. I thought of going to the doctor, but later changed my mind.
Anything else you want to write	

Model Diary for Doctor

Reason for the visit or complaints/symptoms discussed by the patient.	
Significant positive or negative clinical findings detected by the doctor.	
Investigations ordered or done by the doctor.	
Details of treatment, if provided.	

Patient's information leaflet

About your illness in brief

Let me tell you at the very beginning that your complaints and concerns are understood as genuine. These symptoms are not in your mind and you are not telling lies. Any symptom, irrespective of its cause, can make people worry. Therefore I understand why you are distressed. We wouldn't say there is nothing wrong. There is something wrong. But most importantly, I can assure you that these symptoms will not mean you will be disabled permanently or going to die. We will help you find out what it is and guide you to do what is best. The aims of the treatment are to:

- i. Reduce symptoms,
- ii. Reduce distress,
- iii. Reduce disability
- iv. Reduce/limit inappropriate use of medical services and use of medication.
- v. help you to get back to your routine

Dos and Don'ts

It is very important for you to actively take part in the treatment. I can only help you do it but I cannot do it for you. Likewise, you cannot do it all by yourself and that is why you are here today, seeking help to overcome the difficult situation you are now in. This is a partnership in which I can teach you what to do, how to do it and what things you should not do. This will enable you to deal with your symptoms yourself instead of depending too much on medical help, which has not done a great deal for you.

Things you should do

You should agree to work with one professional care giver and to engage one non-professional care

giver; your spouse or a family member. You should make regular notes in the diary given to you about the symptoms, associated thoughts and related behaviors. You should come for all sessions offered and agreed.

What you shouldn't do

You should not go to many different doctors as you used to do. We will refer you to appropriate health professional if such need arise. You should refrain from talking to many different people about your symptoms as that will only increase your preoccupation with symptoms. They may also make contradictory suggestion that may make you more worried. Going to many different doctors, receiving contradictory and ambiguous advice, repeating unnecessary investigations and talking to different people about your symptoms will only increase your attention towards your body. That will make you feel more and more symptoms. That is why we tell you not to do any of these things. During the treatment sessions I will discuss with you how best to help. Our concern is not solely with the symptoms but also with you as a person. For that we will examine you and look at all the investigations carried out so far. If it is essential only we will do any new investigations. Let me also reassure you again that you are not 'mad', that these symptoms are not in your mind. It is very important for you to actively take part in the treatment process. We will help you overcome the difficult situation you are now in.

Chapter 14

A Guide for Trainers

Pre-training evaluation

The trainee should be asked to carry out an “initial consultation” with a role-played patient. This should be coupled with a management session during which the trainee is expected to spell out his management plan. During the second session the role-played patient should provide some important cues specified below. This is done with a view to demonstrating the number of cues missed by the trainee. Videotape recordings can also be used to assess the trainee later.

Cues

1. A list of somatic complaints.
2. Duration to highlight chronic nature of the problem.
3. Mention the number of visits to numerous care providers.
4. Details of negative investigations.
5. Attributing symptoms to the possibility of cancer.
6. Demonstrating indirectly the underlying fear of death.
7. Mention the impact of symptoms on daily living.
8. Repeated reassurance-seeking behaviour; requesting a referral/investigation/prescription.

Post-training evaluation

This evaluation too should follow the same steps as in pre-training evaluation. The trainee should

be asked to carry out an “initial consultation” with a role-played patient.

This should be coupled with a management session during which the doctor will spell out his management plan and also be expected to demonstrate the key micro-skills required for the management. After this the role-played patient should provide the same cues to demonstrate to the trainee those that were missed.

Evaluation of micro-skills during assessment

These items should be rated as “yes” or “no”

1. Elicit the presenting complaints and follow it up with a closed question (‘are there any other problems or complaint’s’) to ensure whether the patient has any other complaints or problems he did not volunteer?
2. Establish the duration of the problems.
3. Inquire about the help seeking behaviour (places and people visited for treatment/help).
4. Inquire about investigations carried out.
5. Find out about the opinion expressed by therapists consulted.
6. Ask for the patient’s own view/opinion on his/her problem.
7. Elicit other associated concerns or fears.
8. Establish the impact of the illness on the day to day life of the patient; social functioning and on employment.
9. Explore the patient’s expectation.

Evaluation of management skills

During this each trainee will be rated on the following specific skills required for management.

• Recapitulation

Recapitulate the problem and present a summary using the explanatory model.

Rating: not attempted/ attempted but not satisfactory/ attempted and satisfactory/excellent

• Understanding the patient

Appreciate the distress as genuine and not imagined and empathise with the distress (not sympathy)

Rating: not attempted/ attempted but not satisfactory/ attempted and satisfactory/excellent

Orientation on the treatment package

• Explaining the aims of the treatment:

To reduce distress

To reduce symptoms

To reduce disability

To reduce/limit inappropriate use of medical services

Rating: not attempted/ attempted but not satisfactory/ attempted and satisfactory/excellent

• Explaining the methods and duration of treatment

This is a “talking treatment”

Number of sessions; 3 mandatory and 3 optional

Rating: not attempted/ attempted but not satisfactory/ attempted and satisfactory/excellent

• Making a contract

To work with one professional carer,

To engage one non-professional carer,

To maintain a diary.

Rating: not attempted/ attempted but not satisfactory/ attempted and satisfactory/excellent

• Maintaining a Diary

This will be used as an appropriate way of expressing distress. This will also provide a basis to monitor symptoms, cognitions, distress and behaviour, and as a basis for therapeutic work by the treating doctor.

Rating: Not attempted/ attempted but not satisfactory/ attempted and satisfactory/excellent

• Explain and provide appropriate reassurance

Rating: not attempted/ attempted but not satisfactory/ attempted and satisfactory/excellent

• Link between physical and psychological symptoms

Rating: not attempted/ attempted but not satisfactory/ attempted and satisfactory/excellent

• Why no more blood tests or laboratory tests should be conducted

Rating: not attempted/ attempted but not satisfactory/ attempted and satisfactory/excellent

• Explain the link between distress and disability

Rating: not attempted/ attempted but not satisfactory/ attempted and satisfactory/excellent

• Discuss the iatrogenic contribution

Rating: not attempted/ attempted but not satisfactory/ attempted and satisfactory/excellent

Specific CBT work

• Cognitive skills

Identify negative automatic thoughts

Deal with negative automatic thoughts

Explore evidence

Consider alternatives

Thought stopping

A global rating for cognitive skills based on the appropriateness of each element

Rating: not attempted/ attempted but not satisfactory/ attempted and satisfactory/excellent

• Behavioural skills

Distraction

Activity monitoring and rescheduling

Goal setting

Exposure and response prevention

A global rating for behavioural skills based on the appropriateness of each element

Rating: not attempted/ attempted but not satisfactory/ attempted and satisfactory/excellent.

Assessment for the number of missed cues provided by the role-played resource person

Cues provided by the role-player.

1. A list of somatic complaints
2. Duration to highlight chronicity
3. Reiterate the number of visits to numerous care providers
4. Amount of negative investigations
5. Attributing symptoms to the possibility of cancer
6. Demonstrating indirectly the underlying fear of death
7. Impact of symptoms on daily living
8. Repeated reassurance-seeking behaviour-request for a referral
9. Repeated reassurance-seeking behaviour request for investigations
10. Request for a prescription

Self-evaluation

Self-evaluation : Part One

Please mark answers on a separate sheet so that the questions can be completed again after the training. Evaluation allows the reader to evaluate their knowledge briefly through some Multiple choice questions, and short answer questions.

Multiple Choice Questions

Please answer “True” or “False” (T and F is sufficient). Leave blank if you do not know

1. The following terms are also used to describe medically unexplained symptoms
 - (a) Medical symptoms unexplained by organic disease
 - (b) Functional somatic symptoms
 - (c) Somatisation
 - (d) Functional overlay
 - (e) Neurogenic shock

2. The following symptoms by their nature will not fall in to the category of medically unexplained symptoms
 - (a) Chest pain
 - (b) Numbness
 - (c) Headache
 - (d) Backache
 - (e) Visible and palpable swelling on the buttocks

3. The following statements are true for patients with medically unexplained symptoms
 - (a) They are overusers of health care facilities
 - (b) They are more likely to give up their employment than patients without medically unexplained symptoms
 - (c) They are usually disabled by their symptoms
 - (d) They are satisfied with numerous investigations carried out on them and the treatments they received
 - (e) They may have associated minor physical illnessess

4. Patients with medically unexplained symptoms will achieve long term benefits by
 - (a) Discussing their symptoms, fears and concerns with as many family members as possible
 - (b) Repeatedly investigating when they become distressed about their symptoms
 - (c) Referral them to a specialist to exclude all possible physical illnesses
 - (d) Relieving them of their household responsibilities
 - (e) Providing them with symptomatic medication

5. The explanatory model of illness for a patient will include
 - (a) Perceived causes
 - (b) Preference for help seeking
 - (c) Beliefs concerning the nature of the presenting complaint
 - (d) Beliefs about the consequences,
 - (e) Beliefs about the severity and its effects on body

6. The following statements are true of cognitive behavioural therapy
 - (a) The behaviour of the patient is central to the emotional, thinking and physiological changes of the body
 - (b) Identifying the patient's own beliefs and assumptions is useful for treatment
 - (c) Diary-keeping is an important part of the treatment
 - (d) Challenging automatic thoughts is dangerous
 - (e) It has no use for patients with depression

7. In cognitive behavioural therapy
 - (a) The number of sessions should be unlimited and decided by the patient
 - (b) The therapist will have to take the sole responsibility for implementing the treatment
 - (c) Educating the patient is not a component of the therapy
 - (d) Response prevention is a part of the therapy
 - (e) Restructuring dysfunctional cognitions will help to modify dysfunctional behaviours

8. The following thinking patterns are actively encouraged for therapeutic benefit during cognitive behavioural therapy
 - (a) Arbitrary inference
 - (b) Maximisation
 - (c) Selective abstraction
 - (d) Catastrophic thinking
 - (e) Personalisation

9. The following are true for management of medically unexplained symptoms
- (a) Anti depressants have no role
 - (b) A comprehensive history and physical examination may not be necessary
 - (c) Assessment to elicit the patient's explanatory model alone can be therapeutic
 - (d) A Structured Care including regular planned visits with adequate time for consultation and retaining the patient itself may be therapeutic in primary care
 - (e) Patients should be referred to a psychiatrist if CBT is indicated
10. Underlying causes of medically unexplained symptoms include
- (a) Depression
 - (b) Anxiety
 - (c) Hypochondriasis
 - (d) Somatoform disorder
 - (e) Minor physiological changes in the body

Self - evaluation : Part Two

Short Answer Questions

A 29 years old man comes to you and complains that he had been suffering from chest pain from time to time during the last 8 months. He has already been to 3 general doctors, and one physician but is not satisfied with the treatment he has received so far. They have done blood tests, an X ray, and ECG and have said that there is nothing wrong with him.

- List 3 important questions you will ask from the patient about his complaint.
=>
=>
=>

- List 4 other important steps in the management of this patient
=>
=>
=>
=>

- Do you believe convincing the patient that “there is nothing wrong” is an important step in the management of this patient? (Circle only one correct answer)

Yes/No/Don't know

- Give reasons for your answer
.....
.....

He had been admitted twice and the doctors have ruled out any possibility of heart disease.

The patient is once again requesting admission or referral to a cardiologist.

- What will you do?

- Give reasons for your answer.

.....
.....

His wife reports him having difficulty in sleeping, loss of appetite, lack of interest, and not being happy. He has taken many days off work and attempts to avoid any form of exertion.

- How do you explain the above symptoms

.....
.....
.....

His 55 year old father died suddenly following a heart attack two years ago, after returning home from work. His wife feels that all his problems started a few months after the death of the father.

- What could be the link between his father's death, his symptoms and repeated consultations?

.....

- How would you manage this patient? Mention 5 important steps in the management.

⇒
⇒
⇒
⇒
⇒

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