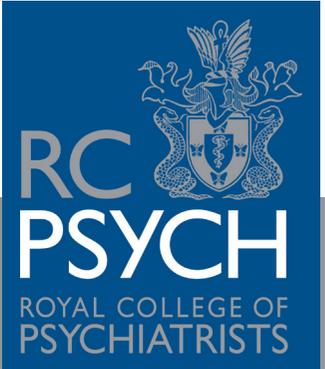


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Royal College of
General Practitioners

The management of patients with physical and psychological problems in primary care: a practical guide

Report of a joint working group of the
Royal College of General Practitioners
and the Royal College of Psychiatrists

January 2009

COLLEGE REPORT

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of the Royal College of General Practitioners
and the Royal College of Psychiatrists

College Report CR152
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Royal College of Psychiatrists
London

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Foreword

This joint report, written by members of the Royal College of Psychiatrists and the Royal College of General Practitioners, has arisen as a result of increasing recognition of the need to address patients' psychological welfare as well as their physical needs. Physical illness is stressful and often places great demands on patients and their families. A general practitioner (GP) is usually the first health professional to whom people turn when they develop symptoms. They are, therefore, ideally placed to elicit patients' concerns about their symptoms, as well as providing appropriate investigation and management.

It is well known that many people present to GPs with physical symptoms that often have an underlying psychological component. Careful and sensitive handling of such consultations can result in positive outcomes with the resolution of symptoms and the person feeling understood.

Liaison psychiatrists specialise in the interface between physical and psychological illness. They have expertise in the treatment of psychological symptoms that develop in the context of physical disease and also physical symptoms for which there does not appear to be an underlying organic explanation (so-called 'medically unexplained symptoms'). Most liaison psychiatry has traditionally been hospital-based, but as health services in England change, with more individuals receiving their treatment in primary care, liaison services can provide valuable support to GPs and Tier 2 services, in addition to acute hospital work.

This report is written as a practical guide for the management of individuals with physical and mental health concerns. It focuses upon the person, the practitioner and the process. It is jargon-free, yet full of useful professional guidance and advice. General practitioner registrars and trainee psychiatrists should all find it helpful.

Commissioning for physical health services and mental health services in England is currently a separate process. This means that individuals with comorbid physical and mental health needs often fall through a funding gap between physical and mental health commissioners. People with physical and mental health problems, whose mental health needs are not addressed, may consume large amounts of physical healthcare resources, both in the primary and secondary sector. As commissioning arrangements in England change, there is a real opportunity to provide needs-led integrated services for such people and we hope that this report will contribute to this.

Dinesh Bhugra, President
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Executive summary, recommendations and action points

This report between the Royal College of Psychiatrists and the Royal College of General Practitioners aims to highlight the importance of improving the management of individuals with both physical and psychological problems in primary care.

Depression and anxiety are common in physical illness, particularly in chronic or life-threatening illnesses. Yet, mental health services are separated from physical health services with separate commissioning processes, targets and service boundaries.

Several recent government reports have emphasised the need for individuals with physical illness to have access to both psychiatric and psychological services and to encourage staff working in mainstream services to develop their skills in identifying and managing psychological aspects of physical illness, common across all age groups, including the elderly, children and adolescents.

It still remains difficult, however, for most individuals with a combination of physical and psychological needs to access appropriate services that are integrated and relevant to their particular needs. Increasingly, individuals with chronic illness receive their treatment mostly in primary care. General practitioners (GPs) are ideally placed to provide a patient-centred approach, provided they have sufficient skills and are given appropriate resources. Recent government initiatives include the appointment of active case managers, changes to the GP contract that reward practices for screening individuals with diabetes and coronary heart disease for depression, and the Improving Access to Psychological Therapies (IAPT) programme, which aims to improve delivery of talking treatments to service users with mental health problems.

Multidisciplinary liaison psychiatry services, which have been traditionally hospital-based, can provide valuable community support and training for staff, including GPs, active case managers and other primary care professionals. Treatment can also be offered for individuals with severe and complex needs (if appropriate resources are available). Liaison psychiatry multidisciplinary services are able to offer both pharmacological and psychological interventions and can link across the primary/secondary care interface.

The development of future services is difficult to predict, but is likely to involve a greater variety of providers and a blurring of the boundaries between primary and secondary care. An example is the development of Tier 2 and Integrated Clinical Assessment and Treatment (ICAT) services, which offer a multidisciplinary approach to assessment and management of patients. Liaison psychiatry could be successfully integrated into such services.

RECOMMENDATIONS

- 1 Greater emphasis should be placed upon the assessment and management of individuals with a combination of psychological and physical problems during undergraduate training of all health professionals.
- 2 Medical students should be taught to incorporate brief psychological assessment into routine history-taking.
- 3 General practice (GP) registrars should have supervision and training in the assessment and management of individuals with medically unexplained symptoms as part of their core curriculum. This should focus on their consultation skills and basic therapeutic interventions as well as theoretical knowledge.
- 4 Training should be provided to enable all primary care staff to advise patients and carers on basic psychological self-help.
- 5 GPs should be able to know how to manage problems using psychological principles and should recognise the indications for prescribing psychotropic drugs in individuals with physical illness.
- 6 GP registrars should consider spending a period of time during their training attached to a liaison psychiatry firm for working- age or older adults. Such an attachment would provide a broader training experience that is more relevant to a GP registrar's needs than a general psychiatry placement.
- 7 Psychiatry trainees should be encouraged to use special interest sessions to gain experience of primary care to improve their understanding of the management of mental health problems in primary care.
- 8 GPs with a specialist interest in mental health may benefit from specific links with liaison psychiatry teams.
- 9 Good channels of communication should be established within the general hospital and with community services with regard to psychiatric as well as physical health.
- 10 Commissioning services should recognise the needs of individuals with a combination of physical and psychiatric problems and develop services accordingly.
- 11 Liaison psychiatry services can play an important role in supporting GPs and primary care services in the management of individuals with severe and complex physical and psychological needs.
- 12 Liaison psychiatry services for adults of working-age and older adults should span the primary/secondary care interface and should be funded accordingly, with support from acute hospital trusts and primary care. The development of an acute hospital tariff for liaison work within the general hospital should be encouraged to facilitate funding within the payment by results framework developed by the Department of Health.

ACTION POINTS

- 1 This report should be launched at a meeting of the Primary Care Mental Health Forum, the newly formed group supported by the two medical Royal Colleges.
- 2 The report should be sent to all undergraduate deans of medical schools in England.
- 3 The report should be presented to the training committees of both Colleges with suggestions that they follow the recommendations in future curriculum developments.
- 4 The report should be circulated to commissioners of both mental health and physical health services in all primary care trusts in England, including practice-based commissioning groups.
- 5 The report should be sent to the Department of Health, particularly the National Clinical Director for Primary Care and the National Director for Mental Health, for their consideration.

Introduction

CHAPTER SUMMARY

- The report addresses the particular problems experienced by individuals with both physical and psychological problems in primary care.
 - This is a practical guide that outlines the most common problems experienced by such individuals and advises how we, as clinicians, can provide the most appropriate help and treatment.
 - The report is divided into three parts: Person, Process and Practitioner.
 - A patient-centred approach to the doctor–patient relationship is given special consideration in the report.
 - The report recommends that liaison psychiatry services should be developed to span the primary/secondary care interface to provide more support for GPs in relation to the management of individuals with chronic and complex psychological and physical problems.
 - The jurisdiction of the report is confined to services in England.
-

Becoming physically ill is a stressful experience. Although most people manage to make an appropriate adjustment to their lives following the development of a physical illness, a significant number experience difficulties adapting to their illness or to the limitations it imposes upon them. Others develop symptoms that cannot be easily explained by medical examination or investigations and they can feel misunderstood or not helped by doctors. There is plenty of evidence that physical illness affects our thinking and feelings, just as personal and social stress can cause ill health. Several government reports in England and Wales have therefore emphasised the need for individuals with physical illness to have access to both psychiatry and psychological services (Department of Health, 2000, 2001*b*, 2004) and to encourage staff working in mainstream services to develop their skills in identifying and managing psychological aspects of illness common across all age groups.

In 2003 the Royal College of Physicians and the Royal College of Psychiatrists published a joint report on the psychological care of medical patients. The report was a practical guide intended for all hospital staff with the aim of improving the detection and management of psychological problems and issues in the general hospital. It did not cover the needs of children and adolescents or those with intellectual disability.

Subsequently, the Faculty of Old Age Psychiatry produced a report endorsed by the British Geriatric Society, the Royal College of Nursing and the Alzheimer's Society, calling for more attention to the specific psychological needs of older people admitted to general hospitals (Royal College of Psychiatrists, 2005).

The current report is the result of a joint working party between the Royal College of General Practitioners and the Royal College of Psychiatrists. The intention was to produce a practical guide to improve the detection and management of psychological issues and problems in the context of diagnosing and managing physical illness in the primary care setting. The report is highly focused on this particular area and does not cover other psychiatric or psychological problems in primary care. It includes the needs of older adults, children and adolescents. It does not specifically cover the particular needs of people with intellectual disability or make reference to the management of self-harm or substance misuse in primary care.

AIMS OF THE REPORT

This is essentially a practical guide for professionals working in primary care, specifically targeted at the needs of GP registrars. We think it will also be of interest and help to psychiatric registrars working in liaison psychiatry.

The aims of this report are to increase understanding of the needs of individuals with physical and psychological problems in primary care and to encourage all staff working in primary care to develop skills of good psychological management. Current service configuration encourages the splitting of patient problems into psychological and physical, with resulting separate service provision. This is not beneficial for some of our patients, or ourselves as doctors who are attempting to provide an integrated model of care.

We have divided the report into three sections: Person, Process and Practitioner. In all three, we present a 'patient-centred bio-psychosocial model' of care – we have tried to move away from a mind/body dichotomy and present an approach based on successful clinical practice and supported by a strong body of research.

PERSON

The first section of the report outlines common psychological problems experienced by individuals with chronic physical disease and provides advice on how these can be recognised. Special consideration is given to depression in the context of physical disease and to medically unexplained symptoms.

PROCESS

Section II is focused on the process of working with individuals to manage emotional problems in the context of physical disease. The longest chapter in this section is devoted to the doctor–patient relationship. We can all improve the way we interact with our patients, we can all learn from our mistakes and we can all learn to develop better skills in listening to and appreciating what our patients are trying to tell us. This fundamental aspect of patient care is often the one that we least attend to, because of other pressures on our time. However, if we are to improve our management of individuals with medically unexplained symptoms, we have to be able to understand their concerns and develop ways of helping them that encourage empowering

solutions. If we are to provide good care for individuals with chronic physical disease, we have to help them cope and adapt emotionally to the limitations imposed by their condition.

PRACTITIONER

The final section of the report discusses issues linked with training, referral to specialist care and the development and organisation of services. Until recently, most liaison psychiatry services were hospital-based and there was little direct work with GPs or primary care services. However, the increased throughput of service users in the general hospital, with shorter lengths of stay, means that the opportunity to identify psychological problems and provide help to patients is more challenging. We know that many individuals with emotional problems and physical disease do not receive the recognition and help that they require. If we are to improve their care, we need to develop better links between primary and secondary healthcare and to encourage service users to understand the causes of their symptoms and how they themselves can help to manage these. We also need to provide more support for GPs and other clinical staff to manage individuals with complex needs and chronic disability in a proactive and skilled way. We believe that liaison psychiatry services (for children and adolescents, adults of working age and older adults) that span the primary/secondary care interface should be developed.

Part I
Person

1. Mind and body: normal responsiveness and mechanisms

CHAPTER SUMMARY

- All illnesses have a psychological impact.
- Constitutional and developmental factors influence how symptoms are experienced.
- The degree of stress caused by an illness depends upon the individual's perception of the illness as well as its severity.
- Approximately one in four people who consult their GP are significantly psychologically distressed.
- We would encourage the adoption of a bio-psychosocial model of care for every patient, regardless of symptoms or diagnosis.

Doctors from a bio-scientific Western medical background are familiar with the concept that the mind can influence the body and vice versa, but our language, training and conceptualisation tend to make us think of these as linked but separate systems. Even the development of imaging techniques showing how emotions correlate with areas of activity in the brain does not alter the fundamental difference between the 'self' or 'person' and the infrastructure on which we depend: the brain is 'necessary but not sufficient' to account for what we are. Not all cultures conceive of this in the same way, but for the purposes of this report we shall write as if the mind were a system held within the body alongside others (e.g. cardiovascular), albeit expressing this as a 'continuum' of interdependent activities rather than a dualistic 'mind/body split'. We do not intend to address how consciousness arises from neural activity, but will address psychological issues such as identity and insight, where the way in which both patient and doctor construct the illness experience can be crucial to management of the patient's problems. Our purpose is to help you to ensure that your clinical practice is as effective as possible in the difficult areas of unexplained medical symptoms, functional disorders, somatisation and what is known as 'liaison psychiatry'.

WHAT IS 'NORMAL'?

It is worth identifying your own assumptions about this. Do you, for example, accept that 'research investigating the effects of personality on the development and progression of cancer and chronic inflammatory diseases supports the idea that psychosocial variables play a major role in disease

outcome' (Watkins, 1997)? Or that 'emotional expressiveness is a crucial life skill for psychological well-being' (Bass, 1990)? These are concepts that have not been taught in medical school until quite recently and whose implications for clinical management have not been fully absorbed into practice. Although this is still an emerging field, several important points are summarised in Box 1.

Box 1 KEY POINTS IN RELATION TO THE EXPERIENCE OF ILLNESS

- all illnesses have a psychological impact, because illness is a threat to self
 - any life stressor leads to physical consequences that can be prolonged
 - unexplained symptoms are common but their perceived significance and experienced severity varies between individuals even if the apparent causes are similar
 - an important factor that can influence how a person copes with an illness is how they perceive the illness
 - insight into and effective coping responses for ill health are useful adaptive mechanisms that can be learned
 - constitutional and developmental factors influence how we experience symptoms
-

The main reasons why people differ in relation to their perception of illness and how they cope with it are shown in Box 2.

Box 2 FACTORS THAT CONTRIBUTE TO AN INDIVIDUAL'S PSYCHOLOGICAL EXPERIENCE OF ILLNESS

- genetic/constitutional factors
 - home/child rearing practices
 - significant life events
 - developmental stage at which life events occur
 - beliefs about illness
 - cultural and societal environment
 - availability of significant others for support and confiding
 - socioeconomic factors
-

ATTACHMENT THEORY

Certain explanatory concepts are key to the ways in which we experience and express illness – one of them is 'attachment theory'. Children learn from their own behaviours and the responses of others. The early 'mother' – infant relationship acts as 'a homeostatic regulatory system that facilitates the emergence of a primitive mind from the bodily functions of the infant' (Mahler, 1982), from whom we move over time from external to internal regulation, with development of independence. A child's emotional and cognitive development requires him or her to internalise the 'other' psychologically and trust in their existence (and affection) while separated. Any event experienced as a loss or separation is thus always a threat to self-identity and may act as a significant stressor later in life.

Taylor and colleagues have proposed a model in which aberrant early care leads to abnormal attachment styles in parental relationships that persist into adulthood and encourage medical help-seeking (Taylor *et al*, 2000). This is one of many theories that attempt to explain psychological

processes that may underpin the development and persistence of medically unexplained symptoms.

LEARNING THEORY

Learning theory has had a major influence on developmental concepts and expression of illness. We learn from and model our behaviour on those around us, particularly our parents and key figures in our childhood. Patterns of behaviour become deeply ingrained without any real conscious awareness that this is happening. Attitudes towards expressing feelings and acknowledging emotions develop within family settings. Attitudes towards our bodies and illness are also shaped and influenced by our home environment.

Cognitive processes have been linked to the amplification of bodily experiences, which in turn may trigger further cognitive misattributions leading to a self-perpetuating cycle of illness concerns and emotional stress.

The linked concepts of self-esteem, coping and resilience are also important in relation to illness. Psychological resilience is 'the ability to adjust successfully to major life changes' (Luthar & Cicchetti, 2000) – a stable personality trait that minimises negative effects of stress and promotes adaptation. Coping mechanisms allow cognitive and emotional appraisal: rethinking the problem, reconsidering your reactions. Extroversion (emotional expressiveness, expression of feelings) is linked with fewer physical symptoms and better sense of well-being – it is said that the correlation between potential health problems and inhibition of behaviour and emotional expression is seen by the age of 2 years' old. Self-esteem is dependent on successful attachment and thus constructive psychological approaches in adult life are correlated with stable, caring relationships in childhood and weakened by disruptions in emotional security.

Caring parents, friendships developed as children and teenagers and close relationships as adults (whether at home, at work or in our social lives) all help to develop resilience against adversity. Positive relationships later in life can make up for earlier lacks or losses – if our early childhood experiences are adverse, much of the resulting damage can be overcome through nurturing relationships in adolescence and adult life (Rutter, 1987; Masten, 2001).

It is not just a question of whether or not we are born with a positive outlook on life, or whether we develop one as a result of what other people do for us. We can shape it ourselves, building up our range of positive emotions by concentrating on finding positive meanings in our daily events and circumstances or, as your grandmother used to say, 'by counting your blessings'. This can start up a benign cycle of change.

Positive emotions are important because they broaden our repertoire of thoughts and actions. Joy sparks the urge to play, interest sparks the urge to explore, contentment sparks the urge to savour and integrate, and love sparks a recurring cycle of each of these urges within safe, close relationships. Broadening our mind in these ways, whether through play, exploration, savouring or integrating, promotes discovery of new and creative actions, ideas and social networks, which in turn build up our personal resources and provide lasting reserves that can be drawn on if life gets difficult again (Fredrickson, 2001).

Finally, there is the set of concepts that show how our experiences are 'embodied' and how this links with somatisation defined as 'a tendency to

experience and communicate distress somatically' (Pilowsky, 1969). First, when stress is severe and prolonged, there can be much distress, however normal and appropriate the response to stress may be. Clearly, major life events such as bereavement are distressing to most people, but although we cannot control external factors and their consequences, there is clear evidence that how we respond biologically, cognitively, behaviourally and emotionally can alter the health outcomes of such events.

For example, an introverted person who has been very psychologically and materially dependent on their spouse may experience their sudden death as a catastrophic loss of their own identity and security. They cannot reconstruct their world in the absence of this person, cannot confide in alternative carers and do not use sport or distraction to manage their stress. This leads to prolonged overactivity in their autonomic sympathetic nervous system, mediated by the neuroendocrine pathways governing catecholamine and corticosteroid release, which produces symptoms such as palpitations, muscular tension and a complex but negative effect on the immune system via cytokine and neuropeptide transmissions. Another individual experiencing the same loss but whose world is socially richer and who has more resilient coping mechanisms will also grieve and suffer, but can draw on their own sense of independent self-esteem, will use expression of feelings to others to a greater extent and may also have more insight into how to 'self-manage' major stressors. The first is more likely to become one of the over 20% of spouses who develop a major illness or die within one year of the loss of a partner. Such a person may also experience frequent bodily symptoms, attend frequent appointments with the primary care team and find it difficult to attribute the symptoms to their bereavement rather than to a physical illness.

RECOGNISING 'ABNORMALITY'

The practising clinician is likely to become involved only when symptoms are so troubling that the individual has decided to seek professional help and the background to who they are and how they deal with stress is relatively unclear. In the average GP surgery in the UK around one in four people consulting will be significantly psychologically distressed as defined by validated instrumental measures and systematic clinical assessment (Goldberg & Bridges, 1988). Further in the report we will discuss how to elicit and manage this in more detail, but this section gives some brief guidance on how to recognise and address the spectrum of normal and abnormal along the mind-body continuum. If illness is a threat to self-identity, then most individuals will be stressed by their symptoms and how they respond can influence the outcome either way. This is even more important if the clinician suspects that they are experiencing symptoms that are being exacerbated by their response to pain and distress. In general, significant stressors and illness episodes will be helped if the clinical team can address the following:

- advise about how to deal with stress productively – seeking personal support for practical and emotional needs, doing things they enjoy in the 'here and now', living as healthily as they can (diet, exercise, sleep)
- cognitive approaches – thinking about big issues for a limited period (rather than ruminating), practising positive thinking (what aspects

of today have gone well, what have they got on their side to fight the disease), addressing major concerns constructively (problem-solving, action-planning)

- emotional approaches – normalising the need to show feelings and express negativity, encouraging expression of feelings and confiding in trustworthy others, accepting feelings of grief and anger
- explanation and broadened attribution – giving clear explanations why and how symptoms may be arising, how these may be made worse or better by physical and psychological responses and showing how the mind and body interact
- recognising patients' emotional feelings about requiring help – understanding their needs and at the same time fear of the intervention of a 'team' of people to cope with a 'range' of symptoms; understanding patients' fears that the 'team may talk about them behind their back', or that the team don't care and don't talk about them (i.e. that they are not important).

There are particular challenges to using these approaches with children and adolescents, where the practitioner may need to adjust language and concepts more extensively than with adults and also share the conversation with the parent who usually shares the consultation with them. People with communication or cognitive barriers may also need linguistic adjustment to gain understanding and share decisions.

The following may be indicators of potential for psychopathology and a focus on bodily symptoms:

- lack of emotional expression or openness about feelings
- low self-esteem
- history of recurrent traumatic life events, especially in early years
- history of childhood or parental illness
- adverse life circumstances
- previous history of functional problems and unexplained symptoms
- health beliefs and explanations that are very disease-oriented or externally controlled ('it's the back, it's gone again, last time they said it was fibres that had scarred...') and that cannot easily be reconsidered with the clinician – a tenacity of insistence on the 'body' denotes a strong world view at this end of the spectrum
- dissatisfaction with attempts to share decision-making and to encourage self-help, which may appear to undermine the patient's perceived need for professional care and referral.

These generalisations must be weighed against the legitimate need of the individual for full assessment, accurate diagnosis and an acceptable vulnerability in a period of ill health. We would argue, however, that being alert to the aetiological factors and expressions of psychological factors during consultation are vital components for full diagnosis and effective management. The clinician's awareness of how the mind and body normally interact will be useful information for individuals when they are trying to understand their illness experience and how they can get better. These considerations also apply when parents act as 'advocates' or 'spokesmen' for their children who have symptoms.

BIO-PSYCHOSOCIAL MODELS OF CARE

BIOMEDICAL V. BIO-PSYCHOSOCIAL MODELS OF CARE

We would encourage the adoption of a bio-psychosocial model of care with every service user, regardless of symptoms or diagnosis. Most of our medical education has been and continues to be based on a biomedical model of care – the doctor acts like a motor mechanic who analyses defects in a car by applying knowledge of its structure and function and correcting them in the light of this understanding (Toon, 1994). This model fits well with certain types of illnesses that we see in family medicine, such as acute infections, but for some chronic conditions, such as low-back pain or medically unexplained symptoms, it is inadequate. Indeed, many other symptoms frequently seen in family medicine, such as headache and chronic abdominal pain, are also not readily amenable to diagnosis and treatment using this model. One study, for example, followed up 265 individuals presenting in general practice with new headaches – after 1 year only 27% had been given a diagnosis based on demonstrable physical changes such as migraine or sinusitis (McWhinney, 1997).

One limitation in using a biomedical model in general practice is the practical separation of mind and body. Consider the following clinical scenario:

CASE STUDY 1

David is 45 years of age and has not worked for 15 years following a brief episode of low back pain at work. His examination by his family physician at the time of injury was unremarkable and he was treated initially with advice and symptomatic medication. However, his symptoms recurred 2 weeks later on return to work (which involved heavy lifting) and he returned to his physician for further treatment and advice. The physician was unable to find any signs of pathology but undertook some routine blood tests and X-rays, the results of which confirmed the absence of pathology. The patient's symptoms persisted despite a continuing 'normal' physical examination and symptomatic treatment with anti-inflammatories and analgesics. He was, therefore, referred by his family physician to a consultant orthopaedic surgeon for advice.

In the absence of radiculopathy, the surgeon recommended a course of physiotherapy and exercises and referred him back to his family physician. The patient, however, has continued to attend regularly for sick certification and symptomatic treatment since that time. His visits are regular and he continues to complain of severe persistent low-back pain and stiffness, but there has been no real change in the past 14 years. He denies any depressive symptoms and refuses antidepressant medication.

Over the years, outlined in the case history above, the GP has conscientiously attended to the patient's physical symptoms and only occasionally strayed into psychological territory. The fears of the patient have been considered a distraction and the psychological and social aspects of the illness are minimised to be dealt with only when and if the 'real' (physical) problem has been dealt with.

Ries *et al* (1981) divided 'sickness' into disease (biomedical problem) and illness (psychosocial response of the patient). They described 'medical care abusers' as having extensive illness behaviour but with 'non-existent' disease. Such illness behaviour they thought was self-induced or had developed in response to the behaviour of their doctors (i.e. iatrogenic).

However, if as GPs we use such a biomedical model to diagnose, treat and manage individuals with psychological components to their physical illness, or those with medically unexplained symptoms, acute problems can become chronic and the patients' needs remain unmet (as illustrated by the example above). We ignore the psychosocial aspects of 'sickness' to both our and our patients' detriment.

It is important to move beyond this traditional biomedical model to a bio-psychosocial model of care in family medicine – a model that is able to encompass the psychosocial aspects of sickness. This will improve the quality of our care and the outcomes for our patients, although the evidence base for such 'patient-centred medicine' remains relatively small. However, at least eight prospective epidemiological studies have shown an association between mortality rates (from all causes) and social integration (Berkman, 1995). Psychosocial factors are clearly important in sickness and can either contribute to its causation or influence its severity and duration – they appear to modify patients' response to sickness by increasing or decreasing 'general resistant resources' (Antonovsky, 1979). For example, individuals who lack support, live alone or have not been married have a substantially increased risk of death after a myocardial infarction – socially isolated men in particular are twice as likely to die over a 3-year period after an infarct than non-isolated men.

In the case history outlined above (Case study 1) the doctor's initial response to the patient's back injury was an entirely appropriate initial biomedical response to an acute (short-term) episode. However, as the acute merged into the chronic (long-term), the limitations of the approach became increasingly apparent – treating the symptoms (pain, stiffness) in isolation without taking into account the context (psychological and social aspects), although depression was considered. However, the outcome of the doctor's best efforts resulted in a dysfunctional pattern of behaviour that was unhelpful to both doctor and patient. Using a bio-psychosocial model would have enabled the doctor and patient to examine all of the reasons for the patient's continuing disability and also provided the opportunity to involve other members of the primary healthcare team in his management.

The use of the bio-psychosocial model in relation to individuals with medically unexplained symptoms also avoids the pitfall of assuming that because the symptoms are unexplained they must have a purely psychosocial cause. This assumption can anger patients and potentially impair the doctor-patient relationship. Most symptoms that are currently medically unexplained are likely to arise from a combination of physiological and psychosocial processes, and the possibility of undiscovered physical disease should always be carefully considered.

USING A BIO-PSYCHOSOCIAL MODEL OF CARE

Disabling chronic symptoms are the result of interrelating physical, psychological and social or occupational factors. Both doctors' and patients' attitudes and beliefs play an important part in the development of such chronic disability and there are many examples of important conditions in general practice that require specifically a bio-psychosocial management approach. These include irritable bowel syndrome (IBS), bronchial asthma and diabetes.

Gaynes & Drossman (1999), in their review of the role of psychosocial factors in IBS, conclude that these are 'necessary for understanding the

clinical expression of IBS by virtue of their key roles in the development, precipitation and perpetuation' of the syndrome. Furthermore, they point out that addressing the psychosocial components, assessment and management leads to an improvement in clinical outcomes.

However, when we use the bio-psychosocial model in practice it does require a rigorous application of clinical method, referred to by some authors as 'patient-centred' medicine (Bensing, 2000). It is not just about resorting to empathy and compassion. Indeed, the use of the bio-psychosocial method in practice can easily be misunderstood – it is not that we deal with the biomedical, psychological and social problems of an individual, but rather that serious illness is at the same time a biomedical, psychological and social problem. No one, for example, can receive a diagnosis of cancer without an impact on their emotions and relationships – although dealing with a psychological component to the illness may not be considered by some of us as part of a GP's job. It is, however, an essential component of the management of our patient if it has a significant impact on their response to illness. This management too is more complex in 'triadic' situations, where a parent is attending with a less mature and articulate child or adolescent who is sick. (The complexities of triadic consultations are addressed in more detail in the chapter 'Using the doctor-patient relationship to the benefit of doctors and patients'.)

PATIENT-CENTRED MEDICINE

Patient-centred medicine has been described as a humanistic, bio-psychosocial model that combines the ethical values of the 'ideal physician' with psychotherapeutic theories on facilitating individuals' disclosure of real worries and the use of negotiation theories in decision-making (Bensing, 2000). Strong focus in patient-centred medicine is placed on patient participation in the making of clinical decisions. This means that both parties in clinical decision-making should take into account not only the patient's perspective, but also the incorporation of medical care when deciding on the patient's needs and preferences. There is, however, some uncertainty concerning the exact meaning of the term 'patient-centred' medicine and the best way of measuring the process and outcomes of using such a model. Stewart *et al* (1995), for example, identified six parts to a patient-centred model of care:

- exploring the disease (illness) experience
- understanding the whole person
- finding common ground regarding management
- incorporating prevention and health promotion
- enhancing the doctor-patient relationship
- 'being realistic' about personal limitations and issues such as the availability of time and resources.

Patient-centredness, therefore, is a broader (less well-defined) concept of doctor-patient interactions than the bio-psychosocial model *per se*, although it is clearly a pragmatic and clinically useful approach to the consultation.

By contrast, it is more difficult to be clear exactly what holistic medicine is, as it combines two concepts (Toon, 1986). The first derives from the recognition of the limitations of using the biomedical model in practice and the potential for the integration of complementary treatments into orthodox management (integrated medicine). The second concept is that holistic medicine is 'whole person medicine', whereby we treat illness as part of a person's life. There is some overlap here with the theories of Balint (1986) and with the bio-psychosocial model of care.

CONCLUSION

To practise family medicine using a bio-psychosocial model requires more from us than the technical/rational skills we require to utilise the biomedical model. To use this model and become 'healers' we must attend to our patient's experience and assist their own healing powers. It is important for us to recognise and acknowledge their illness experience, to understand the meaning the illness has for them, to be present for them in their times of need and to give them hope. Empathy is a core value in family practice and compassion is not a luxury but a fundamental requirement underlying our use of a bio-psychosocial model of care. Although numerous definitions of family medicine have been proposed that encompass a biomedical, psychological and social approach to patients and their problems, there is, of course, 'nothing new under the sun'. Doctor Caleb Parry, an eminent UK physician in the 18th century, wrote that:

'it is more important to know what sort of patient has the disease than what kind of disease the patient has.'

2. Concepts and definitions

CHAPTER SUMMARY

- Diagnostic criteria provide consistency and reliability in relation to diagnosis, treatment and management.
 - They force doctors into grouping patients as either those who do, or do not, have a disorder.
 - Diagnostic criteria are less relevant in the primary care setting.
 - The most common psychiatric conditions that occur in the context of physical disorder are anxiety and depressive disorders.
 - 'Medically unexplained symptoms' is the preferred term to refer to distressing physical symptoms or complaints for which it has not been possible to establish underlying pathology.
 - The pathogenesis of such symptoms is poorly understood, although psychological factors may play a role in the development and persistence of such states.
 - Illness behaviour refers to ways in which people perceive, appraise and respond to illness.
-

As doctors, we are taught to conceive of illness in terms of a medical model. Diseases are usually diagnosed by the identification of characteristic symptom profiles that can be confirmed by medical examination and pathophysiological testing. The classification of psychiatric disorder has been modelled on this format, in which different psychiatric disorders are defined by the presence of particular symptom clusters. Diagnostic criteria are useful, both for research and for clinical purposes, as they help to provide consistency and reliability, in relation to diagnosis, treatment and prognosis. There are also, however, major problems with this kind of approach, particularly in the primary care setting.

Diagnostic criteria force us into classifying individuals into those who 'have' or 'do not have' disorders, whereas in reality psychological symptoms lie on a continuum from the very mild to very severe. Individuals who do not quite meet the criteria for a particular condition may still be very distressed and require help from their GP. Diagnostic criteria also force doctors into a dualistic approach towards individuals, as the diagnostic systems themselves are split into physical or psychiatric disorders. This is in direct contrast to a patient-centred medicine approach (see pp. 22–23) in which the development of symptoms (whether psychological or physical) is understood in the context of a bio-psychosocial model.

Doctors should work within both paradigms simultaneously, provided the strengths and weaknesses of the different approaches are acknowledged. Recognising problems and making a clinical diagnosis are not mutually exclusive but necessarily compatible, as the latter can be helpful to treatment and prognosis. In general, in a primary care setting psychiatric diagnostic

criteria are not as relevant or helpful as in secondary care. However, even in secondary care, traditional medical concepts of psychiatric disorder have been frequently challenged.

DEPRESSIVE AND ANXIETY DISORDERS

The most common psychiatric conditions that occur in the context of physical disorder are anxiety and depressive disorders. The main ones, according to the International Classification of Diseases ICD-10 (World Health Organization, 1992), are listed in Table 1, together with the relevant diagnostic criteria. The American Classification System DSM-IV (American Psychiatric Association, 1994) is very similar to ICD-10, but adopts slightly different criteria for each condition. A special edition for family practitioners is available (American Psychiatric Association, 1995). In clinical practice, practitioners should use these diagnostic systems only as a guide to inform decision-making regarding treatment and it is unwise to interpret them literally. This is particularly important in the context of physical disease. For example, a relatively mild eating disorder, which would not meet criteria for bulimia nervosa, may have devastating consequences for someone with diabetes mellitus and should warrant active management with appropriate referral for help. This is particularly important in childhood and adolescence when it may be more difficult for the doctor to elicit and identify the symptoms and harder for the patient to describe their experiences. It is also common during this life stage for adjustments to change and reactions to emotional distress from any source to be experienced with physical symptoms.

Depression is discussed in more detail in Chapter 4. Recognising depression in the physically ill is sometimes difficult, but very important as it is associated with an increased risk of suicide (Høyer *et al*, 2000), increased disability (Pohjasvaara *et al*, 2001) and poor quality of life (Katon, 2003; Robinson-Smith *et al*, 2000). In primary care, individuals with major depression are significantly more likely to have comorbid major physical illnesses such as diabetes in comparison with those who are not depressed, and there appears to be a particularly strong association between pulmonary disease, depression and suicidal ideation (Goodwin *et al*, 2003). You should consider the possibility of a depressive disorder when:

- the individual has suicidal ideas
- lowering of mood is persistent and pervasive
- there is no evidence of adjustment to the illness
- physical function is much poorer than expected
- recovery from illness is much slower than expected
- the family are concerned about the patient's mood.

Anxiety disorders are also common in individuals with physical illness, particularly generalised anxiety disorder and panic disorder (Table 1). However, 'normal worry' is also common and important, as it provides a vital function in motivating people to solve problems. Anxiety disorders are characterised by excessive or problematic worrying, as a consequence of which individuals become distressed or dysfunctional; excessive worrying is disabling, counterproductive and uncontrollable. Anxiety disorders are

Table 1 The main features of the different anxiety disorders¹

Panic disorder	Recurrent and unexpected panic attacks, with or without anxiety in between attacks
Agoraphobia	Fear or anxiety about being in public places or enclosed situations from which escape may be difficult
Generalised anxiety disorder	Excessive anxiety and worry
Specific phobia	Marked and persistent fear of specific objects or situations
Social phobia	Marked and persistent fear of social situations in which embarrassment may occur

1. ICD-10, World Health Organization, 1992.

common throughout the lifespan; in early childhood they are particularly associated with physical symptoms, with concerns about separation and normal developmental fears, for example of darkness or thunder.

Consider an anxiety state in a person who has a physical illness if:

- their degree of worry is very severe
- the worry dominates their life
- the worry is not confined to the illness alone
- the person cannot be reassured
- there are frequent presentations to emergency services for falls or atypical chest pain, or faints without evidence of underlying pathology
- the person experiences flashbacks, vivid dreams or nightmares
- there is avoidance of specific activities that provoke anxiety (for children, this will probably be school and peer group activities).

Individuals with a prior history of psychiatric illness or with a psychiatric illness at the time an organic illness develops, or a particularly severe response to an illness or injury, should be monitored by their GP, as they are at risk of developing persistent problems; this applies to all age groups.

MEDICALLY UNEXPLAINED SYMPTOMS

Medical nosology has failed to develop adequate nomenclature for describing many unpleasant or distressing states experienced by individuals for which an underlying cause has not been identified. These states are very common and in fact most individuals who present to their GP with such symptoms are unlikely to receive a clear diagnosis consistent with a recognised medical illness. A variety of terms have been used in the past to describe such states, including 'psychosomatic' illness, 'psychogenic' illness and 'hysteria'. All of these terms imply that the underlying cause of the symptomatology is psychological, based upon the false premise that if an organic condition cannot be diagnosed then the symptoms must be produced by emotional factors. Such conceptualisation of these conditions falls into the trap of mind/

body dualism in which the mind and body are seen as independent agencies. It also assumes that the absence of demonstrable pathology always excludes its presence.

At present, the preferred term used to describe such states is 'medically unexplained symptoms'. This is not entirely satisfactory, as the experience of any physical or emotional state in the body is obviously mediated by an underlying physiological process, so the term 'medically unexplained' is in a sense a misnomer. It is, however, an attempt to avoid terms such as 'psychosomatic' or 'psychogenic', which imply that the symptoms have a psychological cause. The use of the term also means that the relative contribution and interaction of physiological, psychological and behavioural factors in any particular condition or symptom presentation should be considered.

We believe that psychiatric classification systems are distinctly unhelpful in relation to medically unexplained symptoms and virtually irrelevant in relation to primary care, as only individuals at the very extreme end of the spectrum of these states will meet diagnostic criteria. The relevant section in ICD-10 is termed the 'somatoform disorders' (Table 2 presents a precis of formal clinical descriptions of these disorders in ICD-10). These diagnoses are reserved for individuals with very severe and long-standing problems in which psychological issues appear to play a prominent role in the persistence of illness. As DSM and ICD are revised, future editions are likely to have major changes in relation to this section.

Table 2 Main features of ICD-10 somatoform disorders: summary

Diagnosis	Main features include
Dissociative (conversion) disorders F44	Symptoms or deficits affecting voluntary motor or sensory function that suggest a neurological or other medical condition, but cannot be explained by organic causes. The symptom is not intentionally produced or feigned. There are convincing associations in time between the onset of symptoms of the disorder and stressful events. Symptoms include: amnesia, fugue, stupor, motor disorders, convulsions, memory loss. Presentations in childhood are more common than in adults and are more likely to be accompanied with 'blindness', 'deafness', funny turns, collapses, pseudo-seizures, losing the ability to move a limb and unusual sensory experiences.
Somatisation disorder F45.0	Many physical complaints, lasting for at least 2 years. Preoccupation with symptoms causes persistent distress and leads the individual to seek repeated (three or more) consultations. Symptoms are disproportionate to underlying organic disease. The symptoms are not intentionally produced or feigned. There must be a total of six or more physical symptoms from at least two different bodily systems.
Hypochondriacal disorder F45.2	Either a persistent belief of the presence of serious physical illness or a preoccupation with a presumed physical deformity or disfigurement (body dysmorphic disorder). The beliefs cause significant distress or impairment and the duration of disturbance is at least 6 months. The belief is not better accounted for by other psychiatric conditions. There is persistent refusal to accept medical reassurance that there is no physical cause for the symptoms.
Somatic autonomic dysfunction F45.3	Symptoms of autonomic arousal that are attributed to the individual to a physical disorder of one or more of the following systems or organs: cardiovascular, gastrointestinal, respiratory and genitourinary. Two or more autonomic symptoms must be present (palpitations, dry mouth, sweating, flushing, epigastric discomfort). One or more of the following must be present: chest pains, dyspnoea, tiredness, aerophagy, frequent bowel movements, increased frequency of micturition, bloatedness. There is no evidence of a disturbance of structure or function in the organs or systems about which the individual is concerned.

Table 2 Main features of ICD–10 somatoform disorders: summary *continued*

Persistent somatoform pain disorder F45.4	Persistent severe and distressing pain for at least 6 months, which cannot be explained by evidence of a physiological process or physical disorder.
Neurasthenia F48.0	Persistent tiredness and exhaustion which is accompanied by at least one of the following symptoms: muscular aches, dizziness, headaches, sleep disturbance, inability to relax, irritability. Symptoms present for at least 3 months.

In primary care it is much more common for patients to present with individual symptoms, such as headache or abdominal pain, which have been present for a relatively short period of time. In some instances, these symptoms may be stress-related and the patients themselves may recognise this. In general, the greater the number of symptoms the individual complains of, the greater the likelihood of associated psychological distress (Kroenke & Price, 1993). In a large international study of primary care patients with depression, between 45% and 95% of patients did not report any psychological symptoms at all; instead, they presented with somatic complaints (Simon *et al*, 1999). It is important, therefore, to check for depression in any individuals with medically unexplained symptoms while remaining alert to the possibility of a physical ailment.

MEDICALLY UNEXPLAINED SYMPTOM CLUSTERS

Conditions such as fibromyalgia and irritable bowel syndrome are very common in the primary care setting. At present, the pathogenesis of such states is poorly understood, although psychological factors may play a role in their development and persistence (this is discussed in more detail in Chapter 5). The term 'functional somatic syndromes' is used to refer to medically unexplained symptom clusters. Different functional syndromes have been described according to the different bodily systems and medical specialties – common examples are listed in Box 3.

Box 3 COMMON FUNCTIONAL SOMATIC SYNDROMES

- irritable bowel syndrome
 - functional dyspepsia
 - atypical chest pain
 - hyperventilation
 - irritable bladder
 - fibromyalgia
 - repetitive strain injury
 - chronic back pain
 - chronic pelvic pain
 - multiple chemical sensitivity syndrome
 - atypical facial pain
-

There is much symptomatic overlap between the different 'conditions' and their existence as discrete entities remains to be established. However, in primary care and the community, there is much less overlap between

symptom clusters than in secondary care (Whitehead *et al*, 2002). The relationship of these conditions to psychiatric illness and psychological distress is complex. Psychiatric illness (such as depression and anxiety) is more common in functional somatic states than in individuals with comparable organic conditions, but this is largely a phenomenon of secondary care. Individuals with functional somatic syndromes in the general population do not appear to have elevated levels of psychological distress and the presence of psychiatric disorder appears to be more closely associated with the treatment setting rather than the conditions themselves. In earlier childhood, headaches, tummy aches, and limb and back pains predominate. The importance of childhood and adolescent presentations is that they often persist or presage the later appearance of anxiety or depression.

Medically unexplained symptom clusters are common in children and adolescents – although it is only in adolescence that the problems listed in Box 3 start to emerge clearly. Even then, the symptom clusters tend to be focused on a range of pains in the joints and limbs, on bowel complaints or on tiredness.

ILLNESS BEHAVIOUR

Illness behaviour refers to the ways in which people perceive, appraise and respond to illness (Mechanic, 1986). There is a wide range of normality, but the term 'abnormal illness behaviour' refers to a behavioural response to a condition that appears out of proportion to the underlying problem. The use of this concept is obviously fraught with difficulty, as there are no agreed standards in relation to how people should behave in response to illness. It can be a particularly difficult concept to apply in relation to individuals who have a different cultural background from the GP.

However, behaviour in response to symptoms or illness does vary remarkably between people and some behaviour can be counterproductive or lead to a worsening of the condition. Behaviour is usually secondary to beliefs about illness, so for example fears about exercise following a myocardial infarction can lead to avoidance of a graded exercise programme, with consequent weight gain and an increased risk of further ischaemic episodes.

The way individuals perceive and respond to illness is shaped by a variety of factors, including social and cultural norms, genetics and familial experiences. Children of mothers with medically unexplained symptoms are more likely to be taken to the GP for minor ailments than children of mothers who do not have these conditions, and they have more time off school because of sickness (Craig *et al*, 2002). Children of parents with somatoform disorders also report greater 'illness worries' than children of parents with organic disease (Marshall *et al*, 2007).

Childhood adversity is associated with increased healthcare use (Walker *et al*, 1999) and prospective work has found that childhood experience of illness is associated with adult illness behaviour (Hotopf *et al*, 1999).

FACTITIOUS DISORDER

It is common for most of us at some time in our lives to exaggerate or even make up physical symptoms. We may be looking for sympathy from loved ones, or we may be trying to avoid some unpleasant duty or social function (children from an early age learn that they can avoid school by making up

symptoms). Usually these 'minor deceptions' are short-lived and do not result in any major harm to either ourselves or others.

In rare instances, however, some people intentionally produce or feign symptoms of illness or disability in a persistent and maladaptive fashion. This can include self-infliction of wounds, false reports of serious illness and abuse of medication (e.g. warfarin) to produce a physical disorder. There are many individual case reports that describe the ingenious ways people can fabricate illness and sometimes fool doctors into unnecessary surgery or treatment. In some cases the outcome can be fatal. The term 'factitious disorder' (F68.1) is used to describe such states, when there is no obvious external motivating reason. This allows cases of fraud, where people feign illness in order to extort money, to be excluded from psychiatric nosology.

We know relatively little about factitious disorders, as individuals are often very reluctant to engage in any kind of treatment or help. Childhood neglect and abuse are common and it is assumed that people with factitious disorder are in some way trying to obtain care and support for themselves, albeit in a maladaptive and potentially dangerous manner. Little is known about the long-term outcomes, as few individuals remain in contact with health services.

Factitious disorders are unusual in early and middle childhood but emerge in adolescence in similar patterns to those seen in adults. While abuse and neglect should be considered as aetiological factors, they are far from universal. Other common presenting backgrounds are difficult family relationships, temperamental or personality traits and difficulty relating to a school or peer group. Indirectly, attention is drawn to these through the factitious symptoms. Often these sources of distress are initially angrily denied and parents may strenuously support the young person's 'physical' explanations. However, if the family can be engaged with child and adolescent mental health services (CAMHS), they may support the adolescent remaining in treatment for long enough to achieve change.

A further very rare situation is where parents (usually mothers) fabricate or induce illness in their children. These may be verbal fabrications only or extend to fabrication of 'signs', such as objects supposedly passed by the child or fake temperature charts. Direct induction of illness by poisoning or suffocation is the most dangerous form. Usually such fabrications begin very early in the child's life and are accompanied by difficulties in the mother herself, for example in experiencing medically unexplained symptoms, anxiety and depression, developing problems in the relationship with the child/children, basic parenting difficulties including feeding and managing the child's behaviour. It may be difficult initially to distinguish these situations from those where mothers are anxious, coping poorly and seeking reassurance through frequent surgery attendance. A pattern of persistent introduction of new symptoms and seeking intrusive investigations and treatments is usually the key to distinguishing those families where worrying fabrications might be taking place and where there are significant child protection concerns. Close working with all the relevant agencies (social services, paediatrics, voluntary sector) is needed in these circumstances to ensure the welfare of the children.

CONCLUSION

We believe that traditional psychiatric diagnostic classification systems are often unhelpful in the primary care setting, as they force us to label

individuals and exclude from treatments those who do not quite meet criteria for a certain condition. In individuals with physical disorder, even mild psychological states can have a profound influence on their ability to manage a chronic and/or disabling disease. Depression is also common in individuals with chronic disease and it is sometimes difficult to recognise and identify. We recommend that GPs ask their patients routinely about their mood, particularly those with serious or chronic illness. Many individuals in primary care present with physical symptoms for which it is difficult to establish an underlying cause. It is important that we adopt a balanced perspective and consider physical, psychological and social factors and their interaction. We should try to avoid falling into a mind/body split and be receptive to our patients' concerns about their symptoms.

FURTHER READING

- Ayers, S., Baum, A., McManus, C., *et al* (eds) (2007) *Cambridge Handbook of Psychology, Health and Medicine* (2nd edn). Cambridge University Press.
- Dowrick, C. (2004) *'Disputed Diagnoses' from Beyond Depression*. Oxford University Press.
- Guthrie, E. & Creed, F. (1996) *Seminars in Liaison Psychiatry*. Gaskell.
- House, A., Mayou, R. & Mallinson, C. (1995) *Psychiatric Aspects of Physical Disease*. Royal College of Physicians & Royal College of Psychiatrists.
- Lloyd, G. & Guthrie, E. (2007) *The Handbook of Liaison Psychiatry*. Cambridge University Press.

USEFUL WEBSITES

- www.cancerbacup.org.uk/info/depress/depress-15.htm (website for people with cancer who also have depression)
- www.nimh.nih.gov/publicat/index.cfm#disinfo (authoritative information regarding specific psychiatric disorders)
- www.rcpsych.ac.uk (website of the Royal College of Psychiatrists; provides advice for patients and professionals)

3. Psychological response to physical illness

CHAPTER SUMMARY

- The degree of stress caused by an illness is related more closely to the individual's perception of the illness than the illness itself.
 - GPs have a key role in helping people to cope with physical illness and facilitating a natural psychological adjustment.
 - Problems with anxiety and depression occurring in conjunction with other illnesses are commonly missed, which results in unnecessary suffering and increased physical disability.
-

Physical illness of any kind is a major stressor. People vary in how they cope and respond to illness, but most, given time, adapt and develop ways to manage their condition. As doctors, we are ideally placed to help facilitate this process or identify problems when they occur.

Most people require time to adjust to the development of a major physical illness. There is often initial fear and shock surrounding the diagnosis, followed by a period when information needs to be assimilated, an understanding of the illness acquired and its likely impact evaluated. This is a dynamic process, with rapidly changing feelings and thoughts. People gradually develop ways to cope with illness and the limitations it imposes upon them. There are different responses to illness and people may require different periods of time to adjust to their condition or changes in their life circumstances that occur as a consequence of their disorder.

HOW CAN GPs HELP?

One of a GPs' most important roles is to facilitate an individual's natural adjustment to illness. This involves:

- listening to what the person says about the illness
- picking up cues (really hearing what is said and also conveyed by body language)
- eliciting concerns
- responding to those concerns appropriately
- acknowledging distress

- providing information when appropriate
- providing emotional support to the individual and family.

For most of us, the most difficult part of this process can be listening to what the person is actually saying. General practitioners and patients often appear to have different agendas when discussing physical problems, almost as if two separate conversations were occurring at the same time. There may be a variety of reasons for this, including:

- pressures on doctors to manage consultations within 5–10 minutes
- discomfort about talking with patients about distressing feelings
- assumptions that people with similar conditions will respond in the same way
- unwittingly attributing our own fears about illness to the patient
- not understanding responses to illness that arise in the context of cultural or religious beliefs.

Many people who are distressed or worried about their illness will offer several cues about their emotional state during a medical consultation. If doctors can recognise these and acknowledge them, the person's concerns about illness can be explored. We can also use gently probing questions to identify illness worries when they are not volunteered.

The psychological care of individuals with physical illness should be based on an understanding that emotional responses and coping strategies are a normal part of illness. Patients may have different beliefs and want different types and amounts of information at different times. They may find it difficult to take in or assimilate information, even if it has been given to them on several different occasions. It is therefore important to monitor the impact of previous experience and to identify the need for new information.

People obtain and receive information from many different sources, including secondary care, the media, the internet, relatives, patient organisations, etc. This can be difficult to assimilate and is often contradictory. As doctors, we are often best placed to help them make sense of what they have been told or have discovered about their condition.

STRESS ASSOCIATED WITH ILLNESS

An important factor that determines how someone will cope with an illness is how they perceive it (Leventhal *et al*, 1992; Scharloo *et al*, 1998). The more threatening an illness is perceived to be, the greater the stress and the greater the difficulty in managing or coping with it. Responses can range from severe anxiety and panic to bland indifference and a denial of any difficulties. There is no clear separation between 'normal' and 'abnormal' psychological reactions to illness. Very high rates of initial anxiety or psychological distress are associated with longer-term difficulties with adjustment and an increased risk of subsequent depressive or anxiety states. A response of denial, while helping to prevent extreme emotional distress in the short term, may have undesirable consequences, such as delays in seeking healthcare and non-adherence to recommended treatment.

Certain conditions are associated with high degrees of distress. Life-threatening conditions (such as cancer) or conditions affecting the brain are

difficult to cope with. However, the prevalence of psychological distress may vary widely between individuals with the same disease, depending upon its severity, nature and course. People with recently diagnosed cancer have relatively low rates of psychological distress or psychiatric disorder (Sharpe *et al*, 2004), but those with more advanced disease have much higher rates (Breitbart *et al*, 1995).

Chronic conditions such as diabetes or chronic renal failure may require a series of psychological adjustments as different problems or complications are manifested. Points of transition (between different forms of treatment, or between young people's and adult services) are particularly important.

Most people with chronic illness receive a regular review of their physical condition by either their GP or hospital consultant. Psychological status is often neglected despite the fact that all patients with chronic illness should receive a regular review of their physical, psychological, social and spiritual needs (McIllmurray *et al*, 2001). This may take place in the context of a care plan review and include all members of the multidisciplinary team who are involved with the patient and their carers in primary and secondary care. The assessment should include:

- discussion of physical, emotional, spiritual, practical and social concerns
- evaluation of any carers' needs.

FAMILY, FRIENDS AND THE WIDER CONTEXT

Interpersonal factors and the support provided by the family and other carers have an important influence on the degree of emotional distress and disability experienced by the patient (Singer & Lord, 1984; MacMahon & Lip, 2002). Relatives or friends who may increase or decrease patients' worries often influence their views of illness. This is notably the case for children and adolescents and is an important reason why doctors need to find out both the young person's fears and worries and those of their parents.

A large amount of information about illness is now available from the internet and other media. Making sense of it all, however, is difficult and may require help. Patient organisations can be extremely helpful in providing information and support, and helping people understand their illness better. It is often useful to give patients contact details of relevant organisations.

ADHERENCE TO TREATMENT

Adherence refers to the extent to which individuals engage with services and follow medically recommended behaviours. This includes:

- keeping appointments
- taking prescribed medication
- following recommended lifestyle changes.

Many factors can influence treatment adherence and patients may adhere to one treatment but not to another. They can decline to take medication because they do not understand its importance or the rationale underlying its treatment effects (e.g. failure to complete a course of antibiotics), or they may simply forget. For others, costs may be problematic.

Those who are just above the poverty line and who do not qualify for benefits may find it difficult to pay prescription charges.

Other people may intentionally choose not to take medical advice. They may have specific concerns about medication or its side-effects, or beliefs about their illness that affect their decision (e.g. whether they view their illness as chronic, acute, amenable to cure or amelioration). In adolescence, treatment non-adherence rates may be significant in chronic health conditions. Involving the young person directly from the outset in discussions about their illness and its management may help to prevent the treatment becoming the arena where battles for independence are fought.

There is little evidence at present that there are any specific measures that can improve adherence, and patients' views regarding their illness should be respected. We should, however, provide patients with good-quality information about their illness, which will help them make an informed choice regarding treatment, including the option of no treatment.

Verbal advice should be clear, easy to understand and easily memorable. It should be backed up with written communication. In general, doctors should:

- address potential reasons for non-adherence (access barriers, beliefs and expectations)
- ensure patients' views and values have impact on decisions
- establish a collaborative relationship with patients
- customise treatment in the light of the above factors
- enlist family support and involve other healthcare professionals, with the patient's consent.

STRESS ASSOCIATED WITH INVESTIGATIONS AND HOSPITALISATION

Many investigations for physical disease are unpleasant and embarrassing. Doctors may not think twice about ordering a barium enema or colonoscopy, yet for the patient, unused to such procedures, these are daunting and uncomfortable experiences.

Hospitalisation is associated with specific stressors over and above those caused by illness. Privacy, independence and social support are reduced and people are placed in a strange, unusual and sometimes threatening environment. The loss of personal support structures, which people develop to cope with illness when they are hospitalised, can cause distress. This can be particularly so for older people with some degree of cognitive impairment, who may function well in their home environment but become more disorientated in hospital. Others at risk may be those whose carers are overanxious or overprotective.

Loss of chemical dependence can also be a problem. All hospitals place stringent limits on smoking and ban alcohol. If individuals have used nicotine or alcohol to control anxiety, they may become additionally stressed if these drugs are suddenly withdrawn or limited. It is still not unusual for individuals to go into alcohol withdrawal following admission to the general hospital. This is the reason why smoking and alcohol intake are often included in referral letters to hospital teams.

Much has been done to reduce the unpleasantness of hospital admission for young people: ward environments are much more informal and parental presence throughout the day is routine. Psychological preparation

for planned surgery should be standard and better attention is now being paid to children's pain relief. Ward support and safety is also a priority for the elderly and those in a confused or distressed state – this is a priority of national patient safety policies.

COMMON COPING STRATEGIES

Most people have a repertoire of coping strategies that they can employ depending on the particular circumstances (Weinman, 1987). Helpful strategies are ones that facilitate adjustment, whereas less helpful ones may impede long-term adjustment (although they are useful in the short term) or alienate others (Box 4). The greater the stressor or the threat, the harder it becomes to utilise adaptive coping strategies and the greater reliance on less helpful ways of coping.

BOX 4 COMMON COPING STRATEGIES

- helpful
 - sharing concerns and feelings about illness and its consequences on self and others
 - expressing anger or distressing feelings in an appropriate way
 - acknowledging loss
 - giving up unrealistic hopes of recovery (without giving up hope)
 - seeking information
 - seeking practical support and social support
 - learning new skills
 - actively participating in treatment
 - maintaining interests or activities or developing new ones, if previous ones are compromised by illness
 - helping others.
- less helpful
 - hoping and praying the condition will disappear spontaneously
 - blaming others (without a legitimate reason)
 - obsessively focusing on minute details of the disorder
 - denial (if it prevents someone seeking appropriate treatment)
 - giving up

TERMINAL ILLNESS

Psychological problems, including psychiatric illness and neuropsychiatric problems, are common in terminal illness. Depression, and particularly anxiety disorders, are often unrecognised as they are considered 'normal' responses to terminal illness. However, the alleviation of psychological symptoms may make an important contribution to the overall experience of dying and death for patients and their families (Hotopf *et al*, 2002). A recent systematic review of the role of psychological treatments in palliative care concluded that there is insufficient evidence to support a specific treatment intervention and that more studies are required (Ly *et al*, 2002).

Most palliative care research has been carried out in secondary settings and the prevalence of depression in one recent primary care-based study involving patients with advanced cancer was lower (4.1%) than expected

and screening tools also performed differently (Reeve *et al*, 2007). There is a need for the development of a primary care palliative care evidence base to underpin appropriate medical care.

DECIDING TO DIE

A small number of people with chronic and disabling illness decide that they do not wish to live and may discuss with their GP the withdrawal of active treatment. The GP is likely to know the person and his/her family well and is often in a better position than a hospital doctor to counsel them about such an issue. Thoughts about dying may fluctuate widely over a few days in those who are severely ill, so it is important to establish that the ideas are relatively stable. The reasons for the person's wish to die should be elicited, as there may be practical steps that can be taken (e.g. better pain management) that will improve their overall quality of life and reduce the desire to end it.

From a medico-legal perspective, there are some central issues:

- Does the person have capacity to make an informed judgement in relation to the withdrawal of treatment?
- Is there any evidence that the person has a depressive disorder or other psychiatric condition that may impair judgement?
- Is there any evidence that the person may be being subject to undue pressure from others (consider risks of domestic or elder abuse, emotional vulnerability, etc.).

All doctors should be able to assess the patient's capacity to make informed decisions, which rests on four criteria:

- Can the person comprehend the nature of his/her illness and the likely consequences of withdrawing treatment?
- Can they retain this information?
- Do they believe the information that has been given is correct?
- Can they weigh in the balance the consequences of either continuing or discontinuing treatment?

If these criteria are met, then the person has the capacity to make an informed judgement about stopping treatment. However, depression is common in individuals with chronic or severe illness and low mood can impair rational decision-making, particularly the ability to weigh in the balance the consequences of ending treatment. Thoughts of wishing to die, feeling a burden on relatives or thoughts of hopelessness are all common symptoms of depression and the best predictor of 'wanting to die' in individuals with terminal illness is the degree of their depression or anxiety (Chochinov *et al*, 1997). The suspected presence of psychiatric disorder should prompt urgent referral to a liaison psychiatrist, as treatment of depression may result in a reversal of the patient's decision to stop treatment.

Depression should be considered when:

- the patient has a previous history of depression or other psychiatric disorder
- there is a strong family history of psychiatric illness

- there is no evidence of a shared decision-making process within the family
- family and close others think the patient is depressed
- there are other symptoms suggestive of depression (see next chapter)
- the decision is sudden, without evidence of planning.

If the person is depressed, usually he/she can be persuaded to start treatment for depression and to continue with medical care. In rare circumstances, mental health legislation may need to be used to admit the person to hospital for psychiatric treatment and a court order obtained to continue with medical treatment against the person's wishes. In reality, this is unlikely to happen, as it is virtually impossible to impose physical treatment upon a person if he/she does not want it. There is a danger in these circumstances that doctors can be 'too paternalistic'. However, there is also the risk that depression is missed and the person may die when a potentially treatable condition could have been reversed.

If we are satisfied the person has capacity to make informed decisions, doctors should record this clearly in the notes and discuss with the patient and his/her family the most appropriate methods of treatment withdrawal.

EMOTIONAL NEEDS OF CARERS

Psychological distress and depression are common in people caring for those with chronic illness, such as cancer (Krishnasamy *et al*, 2001; Braun *et al*, 2007) or stroke (Sinnakaruppan & Williams, 2001). Demands upon the family and other carers can be onerous. In some conditions, female carers of men are more likely to become depressed than male carers of women (Perlesz *et al*, 2000). This may reflect the increased rates of depression in the general population that are seen in women in comparison with men. Male carers, however, often receive more support from other female carers within the family than female carers, for whom caring is viewed as a more natural role.

The UK government has been directing health and social care agencies to take account of carers' needs (Department of Health, 1999). This has included:

- encouraging more support services for carers
- involving carers more in decision-making about service provision
- increasing availability of short-term respite care.

CONCLUSION

People react differently to illness and their reactions to illness or disability may change over the passage of time. One of the most important roles of the GP is to help patients and their families adjust to illness, which can be a painful and difficult process. Less experienced staff should seek advice and supervision from others who have had greater experience of the complexity and diversity of people's responses to illness. GPs are usually better

placed than hospital doctors to identify depression and help those who are struggling to cope with their illness.

FURTHER READING

- Ayers, S., Baum, A., McManus, C., *et al* (eds) (2007) *Cambridge Handbook of Psychology, Health and Medicine* (2nd edn). Cambridge University Press.
- Guthrie, E. & Creed, F. (1996) *Seminars in Liaison Psychiatry*. Gaskell.
- House, A., Mayou, R. & Mallinson, C. (1995) *Psychiatric Aspects of Physical Disease*. Royal College of Physicians & Royal College of Psychiatrists.
- Lloyd, G. & Guthrie, E. (2007) *The Handbook of Liaison Psychiatry*. Cambridge University Press.

USEFUL WEBSITES

- www.cancerbacup.org.uk/info/depress/depress-15.htm
- www.nimh.nih.gov/publicat/index.cfm#disinfo
- www.rcgp.org.uk (information on GP practices and links to primary care mental health)
- www.rcpsych.ac.uk

4. Depression

CHAPTER SUMMARY

- 'Depression' refers to a wide range of mental health problems characterised by low mood.
 - There is enormous variation in the presentation, course and outcome of depressive disorders.
 - The efficacy of antidepressants for individuals with mild to moderate depressive disorders in primary care is unclear.
 - Physical illness may have depressive components with a clear physiological and psychological basis.
 - Depression may increase the risk of developing physical illness or adversely affect its outcome.
 - Doctors are in general less likely to diagnose depression when patients present with physical symptoms.
 - Medically unexplained symptoms frequently coexist with mood or anxiety disorder.
-

Depression is the most common mental health problem that doctors diagnose in primary care.

The term 'depression' refers to a wide range of mental health problems characterised by low mood, loss of interest and enjoyment in ordinary things and experiences, and a range of associated emotional, cognitive, physical and behavioural symptoms (National Institute for Health and Clinical Excellence, 2004). There is enormous variation in the presentation, course and outcome of depressive disorders, which is reflected in the breadth of theoretical explanations for their aetiology. It is not always easy to distinguish between mood changes in depression and those that occur 'normally'. The reliability of diagnostic categories has been improved by introducing standardised criteria such as those used in DSM-IV (American Psychiatric Association, 1994) and ICD-10 (World Health Organization, 1992) (Table 3).

However, doctors also need to be aware that there is disagreement over whether depression as a diagnosis in primary care has either validity (asking the question: is it real?) or utility (asking the question: is it helpful?).

The validity of the diagnosis is based on a set of assumptions that are the subject of debate within psychiatry, in particular the extent to which depression and anxiety may or may not be different conditions. Depression overlaps with a wide range of common physical diagnoses and with medically unexplained symptoms. From the patient's perspective it cannot readily be dissociated from social difficulties, nor is it always helpful in clinical practice. Using the diagnosis of depression as a basis for improvement in detection and management in primary care has produced mixed, often disappointing results. The commonly held assumption that antidepressant medication is an effective treatment option for major depression needs to be reviewed in

the light of growing evidence of a strong placebo response (Dowrick, 2004a) and the recent National Institute for Health and Clinical Excellence (NICE) guidelines for the management of mild to moderate depression (2004). NICE guidelines on depression in children are shortly to be published.

Table 3 Summary of depressive symptoms in DSM-IV and ICD-10

Symptom of depression	DSM-IV	ICD-10
Depressed mood	+	+
Markedly diminished interest or pleasure in activities	+	+
Loss of energy or fatigue	+	+
Loss of confidence or self-esteem	-	+
Unreasonable self-reproach or guilt	+	+
Recurrent thoughts of death or suicide or any suicidal behaviour	+	+
Diminished ability to think or concentrate, indecisiveness	+	+
Psychomotor agitation or retardation	+	+
Insomnia or hypersomnia	+	+
Change in appetite	+	+

There is growing evidence that depression in pre-adolescents is both similar to and different from that in adolescents, which has more continuities with the disorder in adults. Antidepressants are of no clear benefit in pre-adolescents and psychological and family approaches should be used. In adolescents, symptoms of depression are similar to those in adults, although they may require more clinical skill to elicit and the language used may need some modification. It is essential to talk to the adolescent alone as parents are often unaware of their children's suicidal thoughts and plans (as well as other disapproved of thoughts and actions) and their presence may discourage the young person from revealing them.

Bearing these caveats in mind, we can reasonably distinguish several different ways in which physical illness and depression may interact (Box 5).

Box 5 POSSIBLE INTERACTIONS BETWEEN DEPRESSION AND PHYSICAL ILLNESS

- physical illness may have:
 - psychologically depressive components
 - psychologically depressive consequences
- depression may:
 - be a risk factor for physical illness
 - amplify the symptoms of physical illness
 - adversely affect the course of physical illness
- people who have depression may present with (sometimes unexplained) physical symptoms

DEPRESSIVE EFFECTS OF PHYSICAL ILLNESS

Physical illness may have depressive components with a clear physiological basis. Depression is a major and sometimes life-threatening complication of neurological disorders such as Parkinson's disease and endocrine

disorders such as Cushing's syndrome, Addison's disease, hypothyroidism and hyperprolactinaemic amenorrhoea (Fava *et al*, 1987). It may also be a physiological component of post-viral fatigue.

Physical illness may also have psychologically depressive consequences, if it is seen by the individual as being either a life event or a life difficulty (Harris, 2002). The prevalence of major depression is high in people with chronic medical conditions with associated increases in the use of health services, lost productivity and functional disability (Egede, 2007).

LIFE EVENTS AND LIFE DIFFICULTIES

A life event is a change in the external environment or in personal physical health that occurs sufficiently rapidly to be approximately dated: a heart attack, a stroke or injuries sustained from a road traffic accident come into this category. Myocardial infarction, for example, is followed by an episode of major depressive disorder in up to 20% of people and by depressive symptoms in many more (Lesperance *et al*, 2002; Martens *et al*, 2008).

Life difficulties are problems lasting for at least 4 weeks, for example relationship difficulties, stressful living conditions or chronic physical ill health. In chronic medical conditions, the extent of depression is likely to be related to the severity of the problem. For instance, in a study of people with diabetes the severity of depression over follow-up was related to the presence of neuropathy at entry and to incomplete remission during the initial treatment trial (Lustman *et al*, 1997). An example of a person who may be at high risk of depression is presented below (Case study 2). (Later on (pp. 91–92) we will consider how her problems might develop over time and what we could do to help her in primary care.)

CASE STUDY 2

Sarah has two major long-standing life difficulties – she has a physical disability and is looking after her autistic son. She has problems with work as a result of these and receives little support either from her partner or from her informal social network. She is quiet and reflective and tends not to confide in other people, assuming that she should work her problems out for herself. She was born with a problem in her lower spine, resulting in partial paralysis of both legs and some problems with urinary continence. During the past year or so she has found walking increasingly troublesome. She sometimes falls when getting up from a chair, often trips over and is anxious when crossing the road. This is embarrassing for her and is also beginning to interfere with her work. She had an operation to release her Achilles tendons a few years ago and will probably need a hip replacement at some stage in the future.

She has a 14-year-old daughter, with whom she gets on very well. She also has a 10-year-old son who has been diagnosed as autistic and often has severe behavioural problems. She describes herself as happily married. However, she has to carry the major responsibility for looking after her son. This often gets her down. She finds herself getting frustrated and angry with him or else with neighbours and schoolteachers when they don't appear to understand the problems he causes. Sometimes she thinks she can't cope with caring for him any more. He does go for regular respite care, but she has also enquired through social services about long-term residential or fostering arrangements. This line of thought makes her feel very guilty.

PHYSICAL EFFECTS OF DEPRESSION

Depression may increase the risk of developing a physical illness and about half of those who have depression report pain (Katona *et al*, 2005). This can be seen in relation to two common primary care problems, low back pain and coronary artery disease.

The presence of depressive symptoms predicts the onset of back pain. In a survey of British general practice service users who were currently free of back problems, the likelihood of developing a new episode of low back pain during the next 12 months was higher among those who currently had symptoms of anxiety and depression (Croft *et al*, 1995).

People who meet criteria for depressive disorders are more likely to develop angina or myocardial infarction than people who do not. In a study of British civil servants, those with an elevated score on the General Health Questionnaire were more likely to develop coronary heart disease during the next 5 years, irrespective of socioeconomic status and other psychosocial factors (Stansfeld *et al*, 2002). A 'dose-response' effect has been reported, in which a greater exposure to depression leads to a higher incidence of coronary events. A study in Amsterdam found that people with depressive symptoms and people with a diagnosis of major depression were respectively 1.6 and 3.8 times more likely to die from heart disease than people with no depressive symptoms (Penninx *et al*, 2001).

Depression may aggravate the symptoms of physical illness and the way they are perceived by the patient. In people with urinary incontinence, for example, depression is associated with increased symptom perception and functional impairment (Melville *et al*, 2002). In diabetes, severity of diabetic symptoms is more strongly associated with depressed mood than with glycosylated haemoglobin levels (Ciechanowski *et al*, 2003). In coronary disease, depressive symptoms are more strongly associated with symptom burden and physical limitation than two traditional measures of cardiac function, ejection fraction and ischaemia (Ruo *et al*, 2003).

Depression may also adversely affect the course and outcome of physical illness. For example, depression is one of the main factors associated with persistence of back pain and its development into a chronic, long-term condition. While the severity of pain may influence consulting behaviour at the acute stage, those who continue to consult for more than 3 months are much more likely to have depressive symptoms (Waxman *et al*, 1999). The presence of depressive symptoms is also associated with a poor coronary prognosis, in terms of increased likelihood of future experience of angina, recurrence of myocardial infarction and death from cardiac disease (Lesperance & Frasura-Smith, 2000).

DIAGNOSTIC DIFFICULTIES

General practitioners vary a great deal in their likelihood of making a diagnosis of depression. This is partly related to the way they approach mental health as a clinical problem – GPs are more likely to make a diagnosis when they feel comfortable about treating depression (Dowrick *et al*, 2000a). Diagnostic variation is also related to a number of 'patient factors' such as gender (GPs are more likely to diagnose depression with women than with men), age (less likely with children or adolescents), ethnicity (less likely with individuals from Black and ethnic minority communities) and the presence of life events and difficulties (less likely when the GP thinks symptoms can be explained by the person's life experience).

Of particular relevance here is the fact that GPs are, in general, less likely to make a diagnosis of depression when people present with physical symptoms. Two aspects of this are particularly worth noting.

The first is that the extent to which individuals present with physical symptoms depends not just on patient or doctor factors but also on the type of healthcare system that is in operation. The World Health Organization International Study of Psychological Problems in General Healthcare (Sartorius *et al*, 1993) examined the relationship between somatic symptoms and depression. They found that 69% of 1146 individuals with depression reported only somatic symptoms. However, this proportion varied markedly from 45% to 95% across the 15 primary care centres involved in the study. A somatic presentation was significantly more likely at centres where patients lacked an ongoing relationship with a primary care physician, compared with those primary care centres where most patients had a personal physician (Simon *et al*, 1999). In the UK, where we have a primary care system based on continuity of care, individuals are less likely to present with depression in the form of physical symptoms. However, this may be changing with the introduction of new routes for people to access primary care, such as walk-in centres or NHS Direct.

The second aspect is medically unexplained symptoms. Many people present in primary care with a variety of physical symptoms that are difficult clearly to diagnose (Case study 3).

CASE STUDY 3

Frank has a combination of symptoms and presentations that GPs find difficult to explain. The story his GP tells will be familiar to most family doctors:

'Frank has come to consult with me about his stomach pain. He says he finds it hard to pin down exactly where it is. It starts with his tummy button but spreads all over one side. It has been off-and-on for about 18 months. It lasts around a day at a time, sometimes longer. He finds it hard to get to sleep because he has to try to lie in a way that eases the pain. When it flares up he feels very low, thinking "Oh no, this is starting again". When it is not happening he feels anxious that it might start again.

He has found himself noticing other problems lately, although he is not sure whether I will want to hear about them as well as his stomach pain. He had a migraine the other day. He used to get them a lot but has been free of them for a few years. He has also had bad acne for about 3 months. Whatever he does, the spots will not go away. He has a mole on his arm which might have grown a little over the past few months. At night he has throbbing in his leg sometimes. He is worried what it all might be.

He has tried to work out what it is, but it doesn't seem to link to diet. He has talked to people about it. A previous doctor suggested he had bruised his ribs. Another doctor had suggested gallstones. In the past 2 years he has had blood tests and scans of his gall bladder and liver but these were all normal. Friends have suggested it could be his appendix and his grandmother thinks it is probably his "nerves". He had flu last year and is wondering whether he might have a lingering virus. He also wonders if stress might be involved. His wife had an affair 3 years ago but they have moved house since then and are trying to put those problems behind them. But the pain is horrible, so it can't just be stress.'

People like Frank from Case study 3, with symptoms for which doctors can find no satisfactory diagnostic formulation (Peveler *et al*, 1997), provide us with considerable conceptual and therapeutic challenges. A common strategy has been to explain such symptom presentations in terms of somatisation, the assumption being that they actually express underlying

depression or anxiety. Medically unexplained symptoms frequently coexist with mood or anxiety disorder – this relationship may be cross-sectional, when all these symptoms appear together at the same time, or longitudinal, when one set of symptoms is followed closely in time by another (Fink *et al*, 1999; Piccinelli *et al*, 1999).

If we consider depression to be a principal problem in people with medically unexplained symptoms, it may be useful to employ reattribution techniques (pp. 83–84). However, doctors also need to be careful not to over-diagnose depression. In UK general practice, particularly since the advent of once-daily antidepressant medication, there is a growing tendency to use a diagnosis of depression as an apparently handy means of finding one's way out of consultations that doctors find difficult to resolve (Dowrick, 2004b).

CONCLUSION

The ways in which doctors and patients communicate with each other are very important in determining how patients present their problems, in particular the balance between physical and psychological issues. We go on to explore this further in Chapter 6.

5. Medically unexplained symptoms in primary care

CHAPTER SUMMARY

- People with medically unexplained symptoms make disproportionately heavy demands on health services.
 - Doctors' explanations of symptoms are often in conflict with patients' own perceptions.
 - Explanations from doctors aimed at empowering patients can result in the patient and doctor working collaboratively to manage the problem and may potentially reduce healthcare contacts.
 - Most individuals with medically unexplained symptoms in primary care provide opportunities for GPs to address psychological needs.
 - Medically unexplained symptoms in a parent make an important contribution to the risk of developing similar symptoms in a child.
 - Sexual and physical abuse in childhood and childhood neglect are linked to a greater risk of both psychological and physical problems as an adult.
 - The overall prognosis for the majority of individuals with medically unexplained symptoms is very good.
-

Somatic symptoms unexplained by an identifiable disease form a substantial proportion of general practice work. An estimated 20% of new inceptions of illness in primary care – and as many as one-third of all medical out-patients – have symptoms inadequately explained by relevant organic disease. Individuals with medically unexplained symptoms receive large amounts of symptomatic investigation and treatment (Barsky & Borus, 1999). They are more likely to be female and less likely to be married or living with a partner (Feder *et al*, 2001) than those without medically unexplained symptoms. An increasing number of medically unexplained symptoms occurring over a person's lifetime correlate linearly with the number of depression and anxiety disorders experienced (Katon & Walker, 1998).

The existing terminology is unsatisfactory as most terms that are used in relation to these kinds of problems rapidly develop a stigma. The term 'somatisation' is widely used to describe the psychological process in which psychological distress is transformed into somatic symptoms. There is little evidence, however, that this process actually occurs, although psychological factors undoubtedly play a role in the development and maintenance of many physical complaints. In this report, the term 'medically unexplained symptoms' is preferred as this nomenclature does not imply any sense of psychological causation.

Medically unexplained syndromes such as irritable bowel syndrome, chronic pelvic pain and fibromyalgia are characterised by clusters of symptoms that suggest a shared underlying malfunction of a particular bodily system (e.g. gastrointestinal, reproductive, neuromuscular). Studies show syndromes often overlap – for instance, 70% of individuals with debilitating fatigue lasting more than 6 months also have diffuse muscle pain (fibromyalgia or chronic widespread pain). Similar overlaps occur between irritable bowel syndrome, atypical non-cardiac chest pain and gynaecological syndromes. In primary care there is little evidence to support the existence of discrete somatic syndromes (Stanley *et al*, 2002). Apparent differences between syndromes are usually the result of artificial distinctions made on the basis of presenting complaint, physician interest and service configuration. Symptom-based classifications often reflect access to care, which may result in a 'narrow focus' and multiple referrals to different specialists.

COMMUNICATION AND SOMATIC SYMPTOMS

The way symptoms are presented to doctors is shaped by the social context in which the symptom is experienced (intolerable job, marital discord) and presented (primary care, psychiatrist), the patient's beliefs and expectations and the physician's diagnostic language.

People form explanatory models of the likely causation of their symptoms based upon current and outdated biomedical ideas and social constructions (Stimson, 1974; Shorter, 1995). For example, if a well-known football manager suffers a heart attack, a large amount of press coverage will be devoted to the role of stress in ischaemic heart disease. In reality, however, although psychological factors have been implicated in heart disease, other factors such as obesity, smoking and a family history of heart disease are more relevant. People develop models of illness that involve weighing up and scrutinising doctors' opinions along with many other sources of information.

Recent work from Liverpool suggests that individuals with medically unexplained symptoms perceive the GPs' explanations as being at odds with their own thinking (Salmon *et al*, 1999). Analysis of over 400 taped consultations between doctors and patients revealed that most doctors' explanations are experienced as a rejection of patients' suffering. Some consultations were categorised as 'colluding' and a minority of explanations were experienced as empowering (Table 4).

Table 4 Doctors' explanation for symptoms

Rejection	<ul style="list-style-type: none"> deny the reality of the patients' symptoms imply the problem is imaginary or related to a psychological problem, which is perceived as stigmatising
Collusion	<ul style="list-style-type: none"> acquiesce to explanation offered by the patient
Empowerment	<ul style="list-style-type: none"> provide a tangible mechanism of causation remove any sense of blame from the patient strengthen the doctor-patient relationship to work together to resolve the problem

Adapted from Salmon *et al* (1999).

Explanations that were perceived as rejecting resulted in conflict and patients were unlikely to trust doctors with future or continuing symptoms. Collusive explanations were less likely to result in conflict but led patients to question doctors' competence or perceive them as being very passive or having little interest in patients' problems. Empowering explanations had the effect of removing blame and enabled patients to develop mind-body models, which in turn led to their greater involvement in their own treatment.

When individuals with unexplained symptoms describe their symptoms, the most striking feature of their account is their conviction that their symptoms are real and so 'must be caused by something' (Peters *et al*, 1998). To a large extent, people understand their symptoms using metaphors. For example, a plumbing metaphor underlies ideas of blockage and pressure in the body, whereas beliefs that the body lacks energy or a part of it is worn out suggest a metaphor of the body as a machine. Tangible, physical explanations are consistent with people's essentially physical conception of the body and its function. Even psychological conditions such as depression can be conceptualised as being caused by an alteration in neuronal function in the brain. Such explanations may be considered by some doctors as 'very medical' but they remove any sense of blame and provide a metaphor for understanding a complex bio-psychosocial disorder. They also strengthen the doctor-patient alliance and provide a platform from which other, perhaps more psychosocial, issues can be explored in safety.

Most people with medically unexplained symptoms in primary care provide opportunities for doctors to address their psychological needs (Salmon *et al*, 2004). During consultations about their symptoms, people may describe social or emotional difficulties using terms such as 'stress'. They may also express concern about their symptoms, make suggestions that disease may be absent or make tentative references to serious disease, indicating fears or concerns about this. In general, however, doctors do not engage with these cues, so the opportunities for exploring psychosocial issues are often lost. The longer the consultation, the more likely doctors are to prescribe medication as opposed to exploring psychosocial issues (Salmon *et al*, 2007). If doctors could truly learn to listen to their patients, identify their anxieties and concerns in a way that does not undermine or invalidate their physical symptoms, find some common ground and develop explanations that avoid collusion, they might be of more help to them (Salmon, 2007).

GPs' ATTITUDES

Most GPs believe that people with medically unexplained symptoms should be managed in primary care. A survey of 284 randomly selected GPs in the south of England suggested that GPs felt they had an important role in being able to provide reassurance and counselling for such people and to act as 'gatekeepers' to prevent inappropriate (i.e. unnecessary) investigations (Reid *et al*, 2001). A majority of GPs also felt that such people had emotional problems and that there were few effective treatments available. Thus, GPs consider the management of people with medically unexplained symptoms to be an important part of their workload, but there is a perception that effective management strategies are lacking. This is one area where liaison psychiatrists, child and adolescent liaison psychiatrists and other health professionals including clinical and health psychologists, may be able to offer more help and support for doctors and patients.

CONCEPTUAL ISSUES

For most illnesses there is a very poor correlation between symptoms and observed pathological changes, such as peptic ulcer, upper respiratory tract symptoms and back pain. Differences in sensitivity to painful stimuli are biologically and psychosocially conditioned, and personality traits and values also affect the perception and reporting of physical symptoms.

Furthermore, it is normal to experience emotions in the body and for bodily symptoms to be accompanied by emotional distress. Thus emotions are simultaneously experienced in the emotional and somatic processing areas of the brain. This new understanding of the emotions is discordant with the distinctions between somatic and psychological symptoms in modern medicine. However, the bio-psychosocial model addresses the central challenge of reconciling the patient's and the doctor's perspectives and incorporates recent research in psychology and neurobiology. Although patients may use different models to explain illness, it is clear that a conceptual understanding of symptoms is important and determines to a large extent how people react and behave in relation to their symptoms.

So what role, if any, do psychological factors play in the development of medically unexplained symptoms?

In recent years, there has been a growth of research that encompasses both biological and psychosocial aspects of medically unexplained symptoms. These include early life experiences that may shape future responses to stress, in addition to current events that may precipitate the development of symptoms.

MEDICALLY UNEXPLAINED SYMPTOMS IN CHILDREN

Medically unexplained symptoms in a parent make an important contribution to the risk of developing similar symptoms as a child (Levy *et al*, 2000; Craig *et al*, 2002). For example, children whose parents have irritable bowel syndrome make 25% more healthcare visits per year than children whose parents do not have this syndrome (Levy *et al*, 2000). Although genetic factors may make a small contribution, the evidence suggests that most of this behaviour is best understood by social learning (Levy *et al*, 2001).

Children with recurrent abdominal pain have higher levels of anxiety and depression than healthy children and high levels of depression predict persistent physical symptoms over a 5-year period (Walker & Heflinger, 1998).

Psychological factors are also more predictive of the development of back pain in adolescents than mechanical factors (Jones *et al*, 2003). Children with high levels of somatic symptoms also show lower academic competence generally, are at particular risk of avoiding school in response to abdominal pain and have more worry about illness (Eminson *et al*, 1996). Children with recurrent abdominal pain without an obvious organic cause are at significant and continuing risk of adverse functioning and school absence than children without pain (Ramchandani *et al*, 2007). Children with more aches and pains, tiredness and fatigue are more likely than their peers to develop anxiety and depression (Campo *et al*, 2004). This may become an established pattern that persists into adulthood.

Sexual and physical abuse in childhood and childhood neglect are linked to a greater risk of both psychological and physical problems as an

adult. Children who experience such problems may also have difficulty with schooling and come from families who are unable to provide support and consistent care.

MEDICALLY UNEXPLAINED SYMPTOMS IN ADULTS

In adults, environmental stressors such as divorce or bereavement can precipitate both psychological reactions and the development of painful somatic syndromes. The development of a particular physical complaint may be the result of complex interactions between physiological systems and social/psychological processes. For example, the development of irritable bowel syndrome following a gut infection appears to be dependent upon both the inflammatory process and the psychological status of the individual at the time the gut infection occurred.

Continuing chronic life stress (e.g. a very unhappy or abusive marriage, a terminal illness in a partner) prolongs medically unexplained symptoms. In one study, patients with medically unexplained symptoms and chronic life stress were extremely unlikely to improve over a 2-year period, and nearly all improvement observed in the study occurred in those who were free of chronic stress or in whom the chronic stress resolved, although even in this group not all patients improved (Bennett *et al*, 1998).

FREQUENT ATTENDANCE IN PRIMARY CARE

Some people consult doctors much more frequently than others. This may be sporadic and due to a specific issue (e.g. pregnancy) or continuous because of a chronic physical illness. Others may never see their GP at all. As we are all more likely to develop physical problems as we get older, the highest consultation rates in primary care are among the elderly. Consultation rates may also be practice-specific, due to the varied patient populations that different practices serve and the individual practice of GPs (Neal *et al*, 1998). To avoid bias in defining frequent attendance, one study of frequent attendees in primary care (in the UK and Spain) stratified mean consultation rates in a series of GP practices for age and gender and defined frequent attendance as an annual rate of consultation at least twice as high as the practice gender- and age-related mean (Dowrick *et al*, 2000b). Controls were defined as patients who had consulted at or below the practice gender- and age-related mean (Table 5). When this was done, different cut-offs for each gender and age range were established, with the highest thresholds for frequent attendance occurring in middle-aged women and elderly men in the UK and elderly men and women in Spain.

Table 5 Mean annual attendance rates used to determine frequent attendee and control groups (Liverpool, UK, and Granada, Spain)

	Mean (s.d.)	Frequent attendee cut-off	Mean (s.d.)	Frequent attendee cut-off
Women, age				
16-34	4.5 (2.7)	9	2.8 (3.0)	6
35-54	4.8 (3.4)	10	5.7 (5.0)	11
>54	3.8 (3.5)	8	8.3 (6.1)	17

Table 5 Mean annual attendance rates used to determine frequent attendee and control groups (Liverpool, UK, and Granada, Spain) continued

Men, age				
16–34	2.0 (2.4)	4	2.7 (3.0)	5
35–54	3.8 (4.1)	8	4.2 (4.9)	8
>54	4.8 (3.6)	10	6.7 (5.6)	13

Another way of understanding consultation in primary care is to identify different factors that may contribute to consultation frequency. A recent longitudinal cohort study identified factors that independently predicted primary care consultation over a 5-year period (Kapur *et al*, 2004). Data were obtained for 738 patients who accounted for 12 182 consultations. Box 6 shows the factors that were independently associated with consultations over 5 years. Psychological distress was more strongly associated with consultation in women than men, whereas cognitive factors (negative attitudes) were more strongly associated with the consultation rate in men than women (Kapur *et al*, 2005). These variables together accounted for a difference of ten consultations per year between groups. Other researchers have also found that psychological distress increases the risk of future frequent attendance among adults consulting family practice in the daytime about illness (Vedsted *et al*, 2001) and that depressive symptoms were the major predictor of frequent attendance in primary care populations in the UK and Spain (Dowrick *et al*, 2000b). Parental anxiety, depression and physical symptoms are important factors affecting consultation rates for children.

BOX 6 FACTORS INDEPENDENTLY ASSOCIATED WITH CONSULTATION IN PRIMARY CARE

- negative attitudes towards illness
- presence of physical and psychiatric disorder
- health anxiety
- changes in psychological distress
- reported physical symptoms
- age
- gender

Adapted from Kapur *et al* (2004).

The importance of medically unexplained symptoms among older primary care attendees is unclear. Frequent attendees over the age of 65 years have higher rates of depression, physical illness, medically unexplained symptoms and lower perceived social support than those elderly who attend less frequently (Sheehan *et al*, 2003). This suggests that in addition to physical illness, psychological distress and social isolation may influence consultation in this age group, of which we should be aware. However, elderly patients with medically unexplained symptoms may not be more likely to have depression than those with clear organic disease (Sheehan *et al*, 2004).

PROGNOSIS

In approximately 70% of individuals medically unexplained symptoms spontaneously remit within a few months of presentation and others will adapt and find ways to cope with their symptoms. However, nearly one-third

of such problems become chronic (Craig *et al*, 1993) and are associated with poor quality of life and high consultation rates.

The following factors may contribute to the poor prognosis:

- history of somatic symptoms of 2 years or more
- history of childhood physical or sexual abuse
- history of psychiatric disorder
- ongoing severe psychosocial stressors.

CONCLUSION

Individuals with medically unexplained symptoms are numerous in primary care and receive large amounts of symptomatic investigation and treatment. Their problems are often complex and may involve a mix of physical, physiological, psychological and social dimensions. They often feel undermined or misunderstood by doctors, as they often have different agendas. The challenge for GPs is to be able to find ways to engage with and empower patients without undermining their beliefs in the reality of their symptoms, to allow a discourse about other relevant factors to take place.

FURTHER READING

Eminson, D. M. (2001a) Somatising in children and adolescents, part 1: clinical presentations and aetiological factors. *Advances in Psychiatric Treatment*, **7**, 266–274.

Eminson, D. M. (2001b) Somatising in children and adolescents, part 2: management and outcomes. *Advances in Psychiatric Treatment*, **7**, 388–398.

Part II
Process

6. Using the doctor–patient relationship to the benefit of doctors and patients

CHAPTER SUMMARY

- A professional relationship with patients is a crucial element in the management of the psychiatric and psychological aspects of physical ill health in general practice and primary care.
- Patient-centredness means that best patient outcomes can be achieved in an environment that encourages care based on partnership and information-sharing.
- Doctors need to have knowledge of the relevant cultural and religious beliefs and practices of patients in order to communicate effectively, make correct diagnoses and negotiate appropriate management plans with patients.

'If you ask questions, you will get answers and nothing else.'

Balint, 1986

Many people who consult doctors in primary care have powerful feelings they wish to express. However, as a result of the way doctors have been trained to focus primarily on the biomedical or physical symptom agenda, patients may only express their distress indirectly (McWhinney, 1997). Feelings of shame or guilt may be particularly difficult to express directly. Most GPs are familiar with the phenomenon of the 'admission ticket' (whereby patients present with a relatively trivial physical symptom and with emotional cues to respond to), the 'hand on the door' comment ('While I am here...'), the question during physical examination ('Should it hurt when I make love?') and the hints of underlying distress ('My mother died of cancer'). Such indirect communication can protect both patient and doctor from embarrassment or rejection. A trusting relationship between ourselves and our patients sustained over time can improve such communication and enable both of us to agree a common agenda for the consultation. Of course, how a patient presents their distress to us also depends on how they perceive us and whether we are able to pick up the emotional cues. If we work predominantly within a biomedical or physical agenda, then patients may only offer physical symptoms to us. A patient-centred doctor, however, with whom the patient has a good relationship, is more likely to be offered symptoms of psychological distress directly.

There is some evidence of a relationship between a style of consulting that may be described as patient-centred and better outcomes for the patient (Mead & Bower, 2002). If we are able to provide such a patient-centred

approach in a positive way, patients are likely to be more satisfied with their consultations, feel more enabled, have a reduced burden of symptoms and lower rates of referral (Little *et al*, 2001).

THE DOCTOR–PATIENT RELATIONSHIP

Doctors' professional relationship with patients is crucial in the management of the psychiatric and psychological aspects of physical ill health in general practice and primary care. This relationship may bring significant benefits for both doctors and patients. It is of particular value when a person has more serious physical problems as well as psychological problems and when both doctor and patient report that their relationship is more important than a simple convenience of consultation (Kearley *et al*, 2001). Having a personal GP may help create and sustain a therapeutic doctor–patient relationship.

A recent international survey of more than 3500 service users and their doctors showed that service users put relationships with their doctors as second only to that with their families (Magee, quoted in Pincock, 2003).

The doctor–patient relationship is a complex area and a large number of different approaches have been used to try and understand its role in caring for patients. Various models have been described to account for doctors' and patients' behaviour in consultation, ranging from the psychoanalytical approach (e.g. Balint, 1986), through the bio-psychosocial model (e.g. Engel, 1979), to a purely task-orientated approach (e.g. Stott & Davis, 1979). At the heart of all these approaches is the idea of 'patient-centredness', which proposes that best treatment outcomes can be achieved in an environment that encourages partnership in care and information-sharing. The studies of such approaches suggest that not only concordance with medication but also clinical outcomes improve as a result, irrespective of the patient's condition (e.g. Bass *et al*, 1986). However, for a doctor–patient relationship to be therapeutically effective it needs to be sustained and developed (Leopold *et al*, 1996). The features of a sustained doctor–patient relationship are summarised in Table 6 and the measurable outcomes of such a relationship in Table 7 (Rosser & Shafir, 1998).

Table 6 Important features of a sustained doctor–patient relationship

Whole person focus	The GP attends to all health-related problems either directly or through collaboration regardless of the nature, origin or organ system involved.
Physician knowledge of the patient	The GP knows the person, their family, their community, their context. They are aware of and have respect for individual values and personal preference.
Caring and empathy	The family and GP demonstrate interest, concern, compassion, sympathy, empathy, attentiveness, sensitivity and consideration.
Patient trust of the physician	The patient believes that the physician's words are credible and reliable. The physician will always act in the patient's best interests and provide support and assurance.
Appropriately adapted care	The family and GP tailor treatment to the patient's goals and expectations as well as patient beliefs, values and life circumstances.
Patient participation and shared decision-making	The GP encourages patient participation in all aspects of care, treatment and referral. To the degree the patient wishes or desires they are involved in all decision-making.

Adapted from Leopold *et al* (1996).

Table 7 Measurable outcomes of a sustained doctor–patient relationship

Patient outcomes	Short-term: <ul style="list-style-type: none"> • satisfaction • knowledge • reduced level of anxiety • intent to adhere to advice. Intermediate: <ul style="list-style-type: none"> • behavioural change • adherence to programme • self-efficacy. Long-term: <ul style="list-style-type: none"> • improved physiological, functional and behavioural health status • symptom resolution • disease prevention • reduced anxiety level • improved quality of life.
Doctor outcomes	Improved: <ul style="list-style-type: none"> • satisfaction • accuracy of diagnosis • appropriateness of treatment • patient loyalty. Reduced malpractice claims.
Health system outcomes	<ul style="list-style-type: none"> • reduced visitation, costs, malpractice claims • continuity of care.

There are some simple techniques that can help the development of the doctor–patient relationship with children: including them as much as possible, explaining their current symptoms, the examination process and the findings in language they can understand, checking their understanding directly at all stages, and using verbal and non-verbal language.

MODELS OF CONSULTATION

Consultations provide the opportunities for both service users and physicians to develop and sustain a professional relationship. During the past 30 years a large number of consultation models and approaches have been developed to help doctors engage more effectively with the needs of service users. These consultation models may be broadly classified into the psychoanalytic approaches, skills-based (including communication skills) approaches and those primarily concerned with the completion of tasks during the consultation. Some approaches incorporate different components from the different models, which result in overlapping boundaries between them. However, all require particular skills that can be used to increase the effectiveness of both present and future consultations.

For example, by using a specific skills approach within the context of a trusting doctor–patient relationship, doctors can help patients make the connection between psychological distress and their physical symptoms. Such an approach needs to combine knowledge and understanding of the normal responsiveness and mechanisms of the mind and body (see Chapter 1) with the specific skills necessary for the reattribution of symptoms (Mathers & Gask, 1995). Some individuals, however, may be resistant to this idea of a link between their psychological symptoms and their bodily sensations – their attention may be focused ‘exclusively and inappropriately on the somatic aspects of a complex problem’ (McDaniel *et al*, 1990). This

can result in unnecessary investigations, treatments and referrals as well as the unnecessary use of healthcare resources.

The essential components of a doctor–patient relationship that have been demonstrated to lead to improved health outcomes are summarised in Table 8. One important benefit of an ‘effective’ relationship with service users is the achievement of ‘common ground’ in understanding the implications of a particular intervention, which in turn results in better concordance of the patient with their treatment. It may be helpful to think of these encounters between doctor and patient as a ‘meeting of experts’ with a common goal (Department of Health, 2001*b*). Doctors have the medical expertise necessary to address a particular health issue and patients have the expertise from experience of the disease and its effect on their life. This knowledge and experience held by patients is often an ‘untapped resource’ that can be used to improve their quality of care and, ultimately, life.

Table 8 Components of an effective doctor–patient relationship that lead to improved outcomes of consultation

Physician’s role in facilitating discussion	<ul style="list-style-type: none"> • Patient actively listened to, their views acknowledged and respected • Patient encouraged to ask questions • Patient successful in obtaining desired information • Patient provided with information packages and programmes • Physician provides clear information and emotional support • Physician willingness to share decision-making with the patient • Both physician and patient agree about the nature of the problem and the need for follow-up
Measured effects on patient outcomes	<ul style="list-style-type: none"> • Reduced anxiety, reduced role limitation, reduced physical limitation • Improved functional and physiological status • Improvement in pain control, function and mood, and reduced anxiety • Reduced psychological distress, improved symptom resolution • Reduced patient anxiety • Acceleration of problem and symptom resolution

Adapted from Stewart *et al* (1995).

Concordance is a fundamental concept that underpins the psychiatric and psychological aspects of physical ill health. It is defined as an agreement about treatment between doctors and patients, reached after a negotiation that respects the wishes and beliefs of the patient in determining whether, when and how a particular intervention should be used. Interventions in this particular area of physical ill health are enhanced in primary care by such a patient-centred approach within the context of a therapeutic doctor–patient relationship. Therapeutic doctor–patient relationships are also likely to provide increased job satisfaction for doctors and promote the better use of limited healthcare resources (investigations, prescriptions and referrals).

TRIADIC CONSULTATIONS

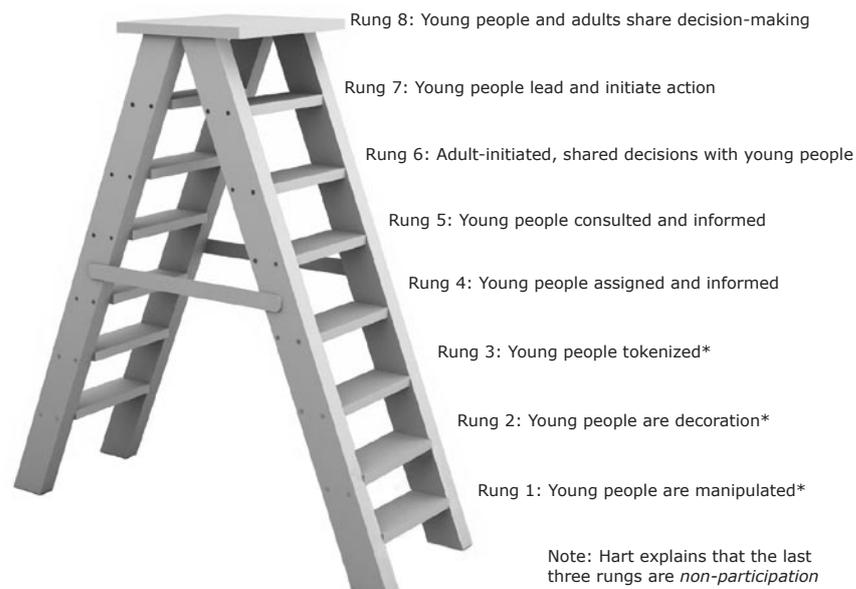
There has been little study of the complex area of ‘triadic’ consultations – when two people are consulting a doctor, one more articulate and powerful than the other who is a patient. This occurs, for example, when parents attend with children or adolescents and when frail old people attend with

a mature son or daughter. The two elements, handling a consultation with disparate levels of power and perhaps understanding between the consultees and a requirement to maintain rapport, gather information and gain agreement from and with both parties, add considerably to the skills required and often to the time necessary.

Video consultations of doctors in triadic consultations with children and their parents show that whereas the children are usually greeted pleasantly and examined respectfully, they are often ignored in the history-taking, formulation and explanation. There is rarely an effort to maximise their contribution or to explain plans and findings in a language they can understand (Meeuwesen *et al*, 1991). Often GPs offer both children and adolescents a quasi-social involvement ('Did you see the match last night?') rather than involving them fully as participants in the health issues being discussed. Almost never does a GP ask to talk to a young person alone if they have attended with a parent.

It seems at present that we are losing many opportunities to encourage the development of a relationship between a child and their doctor. It is not surprising that adolescents express dissatisfaction with their doctors (Jacobson *et al*, 1996) and also seek access to healthcare services on their own, without their parents'/carers' help. The development of the doctor–patient relationship when the patient is a child should involve a gradual increase in the involvement of the child, starting from very early on. Roger Hart's ladder of young people's participation (1992) identifies eight rungs on the ladder, with shared decision-making being the 'top rung' (Fig. 1). Achieving this level of participation must start from simpler beginnings when children are less mature, but these earlier stages are necessary to achieve full participation. Whatever framework is used, it is natural that the child's contribution to different aspects of consultations will vary depending on the urgency and severity of the physical condition, its chronicity and the complexity of the decisions required to manage it. The doctor's inclusion of the child in gaining examination consent, in describing findings and in explaining plans should begin in early childhood.

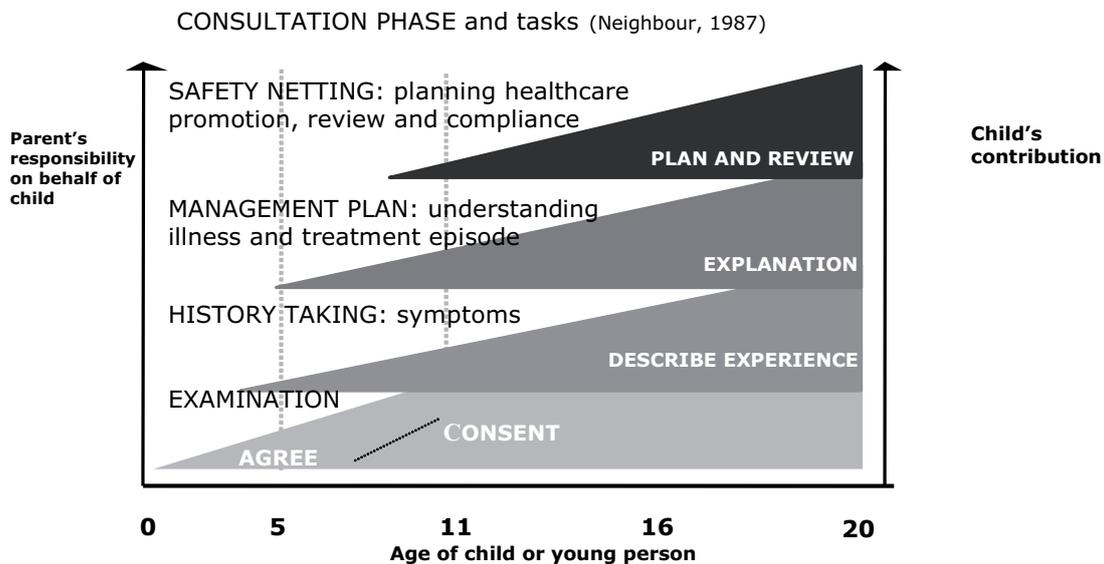
Fig. 1 Roger Hart's ladder of young people's participation



Source: Adapted from Hart, R. A., 'Children's Participation from Tokenism to Citizenship', *Innocenti Essays No. 4*, UNICEF International Child Development Centre, Florence, 1992.

Another way to approach this, in the primary care context, is presented in Fig. 2. This summarises the sharing of tasks and responsibility between parents (guardians) and their dependants as it changes over about 20 years (Eminson *et al*, 2002). This diagram uses as its framework Neighbour's consultation model (1987) with its four phases of history-taking, examination, management plan and 'safety netting'. It suggests children's contributions to each phase can be integrated with parents' contributions from early childhood. The first key point is that the sharing of decision-making and a well-developed doctor-patient relationship will need to be preceded by a period in which the child's contribution to the consultation builds up from simpler beginnings. The second key point is that most children and parents are unlikely to institute this change to greater and earlier involvement of children in their healthcare consultations – the responsibility here rests with doctors.

Fig. 2 Relative contribution of parents and children to consultations for children at different ages



Adapted from Eminson *et al* (2002).

ACCENTUATING THE PHYSICAL

In a survey of GP opinion on Merseyside some years ago, it was apparent that the bio-psychosocial model has little substance beyond the descriptive – in everyday general practice it is viewed mainly as necessary rhetoric (Dowrick *et al*, 1996). In reality, GPs prefer to work to what is more accurately characterised as a 'bio(psycho)' model of healthcare. Doctors' main concern is to identify – or rule out – the presence of serious physical illness. We tend to see acute physical problems as most appropriate for us to deal with, followed by chronic physical and psychological conditions, but we generally consider social problems to be inappropriate for medical attention and can become irritated if we are presented with too many of them.

Patients are inclined to agree. In a survey of primary care attendees in Wales, almost all responders said they would go to the doctor with chest pain and 71% would do so with symptoms of breathlessness. However, there was

a widespread reluctance to disclose evidence of emotional problems to GPs: only 47% said they would disclose suicidal thoughts and fewer than one in ten were prepared to discuss tiredness, irritability or lack of self-confidence with their doctor (Prior *et al*, 2003).

This emphasis on the physical is all very well in its place, but it can lead to problems.

First, doctors may perceive pressure from patients to meet medical needs when such pressure is not necessarily present (Ring *et al*, 2004). This outweighs patients' own preferences in determining management decisions re examination, prescribing, investigation and referral (Little *et al*, 2004).

Second, in consultations where patients present a mixture of physical and psychosocial problems there is a serious risk that their psychological and social cues may be ignored. The patients describe social or emotional difficulties as problems of stress or mood and present opportunities for psychological discussion through explicit questions and statements of concern about their symptoms. However, GPs generally do not engage with these cues (Salmon *et al*, 2004), as the following exchange illustrates:

Patient: 'Yes, it's a terrible feeling inside, I feel rotten inside for some reason, I don't know why.'

Doctor: 'Well let's see you in a fortnight and see if you've shaken it.'

There are several reasons why this failure may be unfortunate. Acknowledging psychosocial cues is an important dimension of patient-centred care. It is associated with shorter – not longer – consultation time (Levinson *et al*, 2000). Also, clinical improvement in distressed individuals is related to the therapeutic alliance with the GP (Cape, 2000), which is conspicuously absent in cases where people have both physical and psychosocial problems.

NORMALISATION

General practitioners commonly offer reassurance to patients about physical problems that cannot be explained medically and which doctors believe are unlikely to benefit from healthcare. Doctors tell patients that their problems are within the normal range of experience and are likely to resolve spontaneously.

However, when attempts at normalisation are not linked to an adequate explanation grounded in the patient's concerns, they may be counterproductive. When normalisation consists simply of rudimentary reassurance or is based solely on the authority of a negative test result (exchange below) we can see how the patient may express uncertainty and worry, elaborate or extend symptoms and provide external authority (here – the parent) to attest to the reality of suffering:

Patient: 'So I've just come for my results for the scan and blood test.'

Doctor: 'Right, right... the blood tests are perhaps easier because I think they are normal.'

Patient: 'That's strange...'

Doctor: 'A little bit of a rise in your ESR but it's not, you know, it's not significant ESR.'

Patient: 'I've been getting more problems.'

Doctor: 'Like what?'

Patient: 'Pain in my fingers, goes from my knuckles to the tips of my fingers and then my knee and my wrist and my elbows... it's exactly what my mother had...'

The result, paradoxically, is that in these sorts of consultations doctors are more – not less – likely to find themselves issuing a somatic prescription, ordering some further investigations or organising a referral to secondary care (Dowrick *et al*, 2004).

THE NEEDS OF DOCTORS

The interaction between doctors and patients may be adversely affected by doctors' own needs and problems (Case study 4). These can lead to complex consultation patterns if doctors do not acknowledge and deal with them.

CASE STUDY 4

The O'Shea family were renowned for the frequency with which they consulted their doctors. As Fig. 3 shows, there was a sharp increase in frequency in the late 1970s, reaching a peak of 14 mean consultations per person per year in 1988 before dropping down towards normal.

The most powerful explanation for this change was the loss of significant people, both among the O'Shea family and the primary care team. Mr O'Shea's mother had been the family's first port of call for all advice, medical or otherwise. She died unexpectedly in 1979. Ten years later, at Christmas, Mr O'Shea himself died of a massive heart attack, in difficult circumstances. The doctors were also going through a complicated period of transition. The husband and wife founding partners retired in the early-1980s. The woman partner in particular had acted as a grandmother figure both for the family and for the practice and was sorely missed. There was also some rivalry and tension between the remaining partners, perhaps jockeying for position in the resulting power vacuum, which resulted in two of the newer partners deciding to leave.

Neither the family nor the doctors had talked about these traumatic events very much among themselves (let alone to each other). Both were experiencing a considerable amount of unacknowledged grief. This may well have been the key factor in explaining why the O'Sheas consulted so often: that they were seeking support and comfort from doctors who were too distressed to provide either (Dowrick, 1992).

Fig. 3 The O'Shea family: mean individual annual consultation rates, 1967–1995



'UNSTICKING' THE DOCTOR–PATIENT RELATIONSHIP

All relationships, particularly between patients with a psychological aspect of a physical illness and their doctors, can get 'stuck' when either one or both parties become entrenched in their positions and each consultation becomes a 'ritual dance', for example:

Doctor: 'Your stomach ache is because of all the stress you are under.'

Patient: 'I don't think so, doctor. I'm sure there must be something seriously wrong for it to carry on for so long', etc.

Box 7 summarises some of the strategies and skills that doctors can use to 'unstick' their relationships with patients and minimise unnecessary investigations, treatments and referrals of those with a psychological component to their physical illness. This approach can also minimise the unnecessary use of healthcare resources, although appropriate investigation of bodily symptoms that are causing concern to the patient and/or doctor may be an essential component of any management plan agreed with the patient.

Box 7 STRATEGIES AND SKILLS TO AVOID UNNECESSARY INTERVENTIONS

- assessment
 - listening
 - summarising
 - clarifying current problems
 - drawing up problem list
 - confronting conflicting statements
 - using knowledge from past consultations
- formulation
 - information
 - advice
 - negotiation
- management
 - goal-setting
 - ventilation of feelings
 - problem-solving
 - testing out capacity to change
 - providing supportive feedback

After Mathers & Gask (1995).

A brief step-by-step problem-solving strategy with questions that doctors can ask themselves and/or their colleagues may also be used to 'unstick' the doctor–patient relationship (Box 8). It will help doctors to understand the 'stuck' relationship with the patient and formulate a plan of action for the next consultation, particularly if undertaken with colleagues.

Box 8 STEP-BY-STEP PROBLEM-SOLVING STRATEGY FOR 'STUCK' DOCTOR-PATIENT RELATIONSHIPS

- 1 What am I finding difficult about helping this person?
 - 2 What do I want to achieve?
 - 3 What are the key sources of support that I have access to?
 - 4 Can I make use of them? If not, why not?
 - 5 What sources of relevant training do I have access to?
 - 6 Can I make use of them? If not, why not?
 - 7 Are the expectations that I have of myself in the care of this person realistic or unrealistic?
 - 8 Are the expectations that I have of the patient realistic or unrealistic in this case?
 - 9 Am I guilty of undervaluing what I have achieved so far?
 - 10 What is my plan of action now?
-

Balint (1986) worked with groups of GPs over many years to investigate the doctor-patient relationship. He was able to identify the importance of transference and counter-transference within the relationship. Such unconscious processes can result in doctors setting limits to the content of a consultation so as to avoid discomfort in particular areas of enquiry – some doctors, for example, may find discussing sexual difficulties particularly uncomfortable if they also have similar problems. An understanding of these psychoanalytic processes can help doctors intervene in such 'ritual dances' with patients and 'unstick' their relationships. Balint also emphasised the role of the doctor as the 'treatment' or 'drug' itself and the potential therapeutic power within the relationship where doctors 'prescribe' themselves to patients.

For interested readers, Balint groups provide an opportunity for doctors to grapple with these issues (www.balint.co.uk).

TRANSCULTURAL DOCTOR-PATIENT RELATIONSHIP AND INTERACTIONS

Many members of Black and ethnic minority groups face considerable difficulty communicating with their doctors. Communication is often hindered by the conflicting concepts of illness and disease of the doctor and the patient (Cheng, 1989). Such communication barriers may have a substantial impact on the use of and satisfaction with healthcare services and adherence to treatment. Individuals with a language barrier or a limited proficiency in spoken English report lower satisfaction with their consultations – something that holds true even for individuals from ethnic minority groups with good English language skills (Brach & Fraser, 2002).

One way of improving the doctor-patient relationship in these circumstances is for doctors to appreciate not only different beliefs about illness and health, but also the value that individuals may place on the use of complementary medicine, including traditional therapies and spiritual healing (Batts, 2002). In Western medicine, for example, the concept of an individual determining his or her own health is generally accepted. People from other ethnic backgrounds, however, may perceive their illness and health as a matter of 'fate'. Such beliefs and fears will need to be explored in the consultation in a caring and empathic way. Certain topics may be taboo within a particular culture, particularly if the doctor is of the opposite gender. Describing a problem to the doctor in these circumstances may be very difficult for the patient and when combined with their cultural expectations may inhibit them from sharing their important concerns.

Some members of ethnic groups attribute great power to the doctor in the doctor–patient relationship and may, therefore, avoid asking questions. A patient-centred approach may be particularly challenging to individuals from such cultures. A potential patient response may be:

Doctor: ‘What do you think is causing these symptoms?’

Patient: ‘You are the doctor. That’s the reason I come to see you. You tell me what is causing my problem.’

It is important in these circumstances to recognise that the person may have no concept of a negotiation around their diagnosis, and doctors should be confident in responding, for example, with ‘Yes, I’ve an idea what the problem is but I would like to find out what you think to see if we agree’. Continuity of care is probably one of the most important components in managing such individuals to establish a good level of trust and rapport.

Styles of communication vary and extend beyond these cultural and language differences. All types of communication – verbal, non-verbal and written – are important components of the doctor–patient relationship. Where language is a barrier, the role of non-verbal communication becomes more important. Open-ended questions should be used to explore psychosocial issues and doctors need to be aware that they may receive monosyllabic answers because of the person’s limited vocabulary, which limits their expression in the English language, particularly when an interpreter is not present. Doctors who do make attempts to learn about and understand the cultural backgrounds of their particular communities of patients are best equipped to engage in effective, culturally competent communication. It can, for example, be very useful to learn important phrases, both social and medical, in the most prevalent language for the practice setting. Some research studies have demonstrated that speaking even a few words or phrases in the patient’s own language can be interpreted as a desire to connect, lowering communication barriers and inviting trust (Green-Hernandez *et al*, 2004).

Other communication challenges include the use of medical terminology, lay terms, varying literacy levels, speed of speech, pitch and amplitude of tone, culturally inappropriate words or phrases, dialects, use and misuse of interpreters, and gender-specific terminology.

Understanding the patient’s family issues, family structure, who is the head of the family and the decision-maker, and observing signs of conflict, promotes more culturally competent care. Management should be tailored on an individual basis and one should not make generalisations that ethnic minorities behave in a specific way. Encouraging the person to discuss their concerns and beliefs about complementary medical practices helps to gain a better understanding of their perspectives and determine how alternative therapy, relaxation or yoga and increased enjoyable physical activity can be used as part of the management plan.

Other areas that need to be addressed to improve the doctor–patient relationship with culturally diverse individuals include: knowing how they are to be addressed, their history and background, home environment, the language or dialect that is spoken, the impact of religion on their daily routines and care decisions, their moral beliefs and their influence on care decisions and disclosure to physicians, food habits, availability of community services, acculturation, the duration they have resided in the adopted country, and the degree to which each individual family member has adopted the local culture.

CULTURAL COMPETENCE (CONGRUENCE)

Our cultural competence in consultations extends beyond the use of language to include the full 'set of congruent behaviours and attitudes among professionals which enables those professionals to work effectively in cross-cultural situations' (Price *et al*, 2007). The implementation of a cultural diversity programme in the undergraduate medical curriculum has been shown to increase positive attitudes towards other cultures as well as increased knowledge (Dogra, 2001), but there is little research to show whether these attributes translate into specific clinical skills or better outcomes. Educational interventions can help doctors in training to develop specific cultural competence skills. These skills include the use of interpreter services and community health workers, the use of ethnically or linguistically concordant clinicians and staff, culturally competent education and training, culturally competent health education, involvement of the family and community members in discussions to fully understand the dynamics of a patient's symptoms, coordinating care with traditional healers and religious figures, and using culturally appropriate health promotion techniques (Dein, 1997; Kundhal & Kundhal, 2003).

Becoming culturally competent can change both doctor and patient behaviour by improving their communication, increasing trust, improving ethnically specific knowledge of epidemiology and treatment efficacy, and expanding the patients' options within their environment. These behavioural changes can lead to more appropriate utilisation of services and improved outcomes (better health status, functioning, satisfaction and cost-effectiveness) for the ethnic minority group. Assessing the essential components of cultural competence is summarised in Box 9.

Box 9 ASSESSMENT OF DOCTOR'S CULTURAL COMPETENCE AND TREATMENT OUTCOME

- use and availability of interpreter and link worker services
- awareness that staff and interpreter of the same gender may be preferred
- availability of written translated educational material for prevalent ethnic minority groups in practice
- accessibility and use of concordant clinicians/staff
- recognising cultural issues and interacting with patients from other cultures in culturally sensitive ways
- receiving education/training on the different cultural norms and religious beliefs of the main ethnic groups consulting the practice
- asking service users and their family members (with users' consent) to share their cultural views on the cause of the problem, past coping patterns, healthcare-seeking behaviours and treatment expectations
- showing respect for the service user
- ability to explain in simple and easily understood terms
- showing an understanding of the issues of racism and stigma in relation to the mental health of ethnic minority groups
- acknowledging personal biases and preventing these from interfering with the delivery of quality care.
- ability to avoid conflict when strong differences in beliefs emerge
- ability to provide information about western concepts of mental illness and its treatments
- incorporating cultural preferences, health beliefs, behaviours and traditional practices into the management plan
- accessing culturally appropriate resources to deliver care, such as the availability of intercultural therapy to provide psychotherapy to ethnic minority groups

Adapted from Brach & Fraser, 2002; Kramer *et al*, 2002; Green-Hernandez *et al*, 2004.

CONCLUSION

Whatever the doctor's level of experience and degree of 'seniority', they can improve the way they communicate and respond to service users. The quality of the doctor–patient relationship affects not only how doctors respond to patients, but also how patients respond to doctors. Better understanding will result in a more fruitful dialogue and, hopefully, doctors and patients speaking 'the same language'. Managing people from ethnic minority groups who have psychological aspects to their physical ill health is a relatively common and difficult task for doctors because of language and cultural barriers. Having a continuing patient-centred doctor–patient relationship is a key component of any management plan. Doctors are not only expected to appreciate and have some knowledge of their patients' culture, including their beliefs and practices, but also to be culturally competent in handling psychosocial issues from a diverse range of ethnic groups. Cultural competence has the potential to change both clinician and patient behaviour in ways that result in the provision of more appropriate and cost-effective services.

7. Assessment and shared decision-making: managing mind and body

CHAPTER SUMMARY

- For the service user to share in the decisions that are made about their care they need to work in effective partnership with doctors.
 - Such partnerships are based not only on good communication and an established doctor–patient relationship but also timely access to appropriate information for both the doctor and the patient, as well as a willingness on both sides to negotiate on equal terms.
-

The previous chapter has given advice about how to approach both psychological and physical aspects of the consultation in a way that is patient-centred and should maximise dialogue. This chapter focuses on aspects of assessment that should allow a specific diagnosis of psychological problems and the presence of significant somatisation.

PSYCHOLOGICAL ASPECTS OF ASSESSMENT

Doctors should share their conclusions from the assessment with the individual and their family (if appropriate) in a way that is honest about psychological aspects of the illness but not stigmatising. It is inevitable that this is not easy. When the person lacks insight into mind–body interactions or is psychologically resistant to such possibilities, the doctor will need to use all their communication skills of staged explanation and negotiation to reach a mutually satisfactory treatment plan. Setting aside adequate time to make a full assessment is therefore crucial and all that has been said about how to explore such issues must be taken into account.

Assuming that the doctor has established a rapport with the patient and heard their full narrative, cueing, clarifying and summarising appropriately, they should then be able to set an agenda for the next part of the consultation. They may not need to do a full mental state examination, but in view of the aetiological and correlating factors they will need to:

- screen for depression (ask about mood, sleep pattern, pleasure in life and activities, concentration, guilt and self-dislike, and if appropriate libido, appetite and self-care)
- screen for anxiety (ask about mood, sleep pattern, tendency to worry, self-confidence, any physical symptoms)

- for adolescents it is crucial these anxiety and depression screens include a thorough and continual enquiry of the young person – there is evidence that parents are often unaware of the extent and severity of psychological symptoms in their children, especially suicidal thoughts
- take a focused family and social history – key others, life events, family health (especially major parental or childhood illnesses and relationship disruptions)
- screen for use of drugs and alcohol, any self-harm
- check for any significant previous or coexisting health problems and the person's perceptions of those experiences – this may give significant insights into how they handle illness and expose their health beliefs and also give the doctor clues as to areas of previous misunderstanding or dissatisfaction with healthcare that could be potential stumbling blocks in current treatment.

When the person has presented multi-system symptoms and already holds a firm view that their problems have a physical cause against medical evidence, the doctor may also need to screen for full somatoform disorder and distorted thinking. Enlisting the help of a more experienced psychiatrist for further assessment may also be worth considering. Exploring the views of parents about their children's symptoms, their explanations and attitudes is important because these are central to appropriate reassurance.

In view of the nature of such a focused history, it can be useful for the doctor to explain why they are probing into these areas and again it helps to keep the mind–body agenda open. The doctor may comment, for example:

'Thanks for telling me all about what's been going on. I now need to know a bit more about how this is affecting you and also to ask you a bit more about yourself and your life, if that's OK. Some of the questions may be a bit personal, but that's because we know that things that happen in people's lives can make them ill.'

After explaining this to the patient, a full examination and appropriate arrangements for investigation are necessary. Patients are unlikely to believe doctors when they say they know their abdominal pain is psychological when they have not laid a hand on them (nor will the medico-legal team). Touch is also a useful source of information – tension, lack of responsiveness and hypersensitivity may all be revealed by the physical examination.

Explaining possible diagnoses and plans for management is the point at which doctors have to commit themselves and it is important to address first the patient's own ideas, concerns and expectations, and then expand them by including doctor's own views. The principles of breaking bad news may be useful if the doctor's view is going to differ radically from the patient's – staged explanation, stopping to check understanding, giving the patient a chance to respond (Box 10).

Box 10 A TYPICAL CONVERSATION WITH A PATIENT EXPLAINING WHAT MIGHT BE THE DIAGNOSIS AND TREATMENT:

'OK, let's talk about where we have got to now... I remember you said at the start that you thought you might have heart trouble... well, we still need to do one or two tests to rule that out, but I'm already pretty confident that the pain isn't coming from your heart... I say that because what you've told me about when it happens and how it affects you just isn't typical

of angina... and examining you was absolutely fine. You also told me how well you look after yourself, so that makes it less likely too... Does that make sense so far?

'OK, what else could it be? In my view, the most likely cause is a muscle spasm in the ribcage lying over your heart [*give reasons why*]... That can cause a bad pain, but it doesn't mean it's serious... and I was wondering if you might be prone to this because of your job, as you said, lifting all day and doing long hours as well...'

The patient may raise further concerns and queries and the discussion will need to continue after any tests are back, by which time the more somatically inclined individuals may have lost their grasp of the doctor's interpretation and may need to rethink the diagnosis.

SHARED DECISION-MAKING

Involving patients in joint decision-making is becoming an increasingly important task of daily consultations (Smith *et al*, 1998), but although such patient-centred models of consultations are widely advocated, their use in practice is fairly limited (Law & Britten, 1995; Barry *et al*, 2000). If doctors do not provide a positive, patient-centred approach, patients will be less satisfied, less empowered, may have a greater symptom burden and hence consume more health resources (Little *et al*, 2001). This is likely to be particularly the case in those individuals who have psychological and psychiatric aspects to their physical illnesses.

Many GPs use their personal knowledge of the patient to make decisions in the consultations – for example, patients' coping abilities, their social supports and stresses, social circumstances and doctors' own feelings about the patients (Jones & Morrell, 1995). A very early review of decision-making in general practice identified ten factors that influence doctors' decisions (Box 11).

BOX 11 FACTORS INFLUENCING THE DOCTOR'S DECISION-MAKING

- nature of the clinical problem (e.g. seriousness)
- patient (e.g. their expectations)
- impact of family (e.g. specific requests)
- impact of other people (e.g. advice from others)
- doctor's skills/experience/personality (e.g. tolerance of uncertainty)
- results of investigations (e.g. significance)
- resource considerations (e.g. referral waiting times)
- time factors (e.g. workload)
- ethical and legal issues (e.g. practising 'defensive medicine' by carrying out unnecessary investigations for fear of being sued)
- management strategy (e.g. risks/benefits of different treatments)

Adapted from McWhinney (1997).

Shared decision-making is, therefore, a very complicated process. Patient-centredness, for example, is closely linked to the idea of shared decision-making, which is not the same as sharing information. To share in the decisions that are made about their care, patients need to work in

effective partnership with doctors. Such partnerships are based not only on good communication and an established doctor–patient relationship, but also on timely access to appropriate information by patient and doctor as well as a shared willingness to negotiate on an equal basis. One of the problems about this, however, is that the interactions doctors have with patients are sometimes characterised by unconscious paternalism as well as informed choice. Paternalistic doctors take all the responsibility for making clinical decisions, whereas patients making informed choices need to have sufficient information for the doctor to withdraw from the decision-making process. Shared decision-making lies somewhere in between.

One recently validated questionnaire evaluates the clinician’s ability to share decision-making using the following criteria (Elwyn *et al*, 2003):

- ‘identifying a problem which requires a decision-making process’
- stressing that there is more than one way to deal with the identified problem (‘equipoise’)
- assessing the patient’s preferred approach to receiving information to assist decision-making (e.g. discussion, reading printed material, assessing graphical data, using videotapes or other media)
- listing options that can include the choice of ‘no action’
- explaining the pros and cons of each option to the patient
- exploring the patient’s expectations/ideas about how the problem(s) is/are to be managed
- exploring the patient’s concerns/fears about how the problem(s) is/are to be managed
- checking that the patient has understood the information
- offering the patient explicit opportunities to ask questions
- eliciting the patient’s preferred level of involvement in decision-making
- indicating the need for a decision-making (or deferring) stage
- indicating the need to review the decision (or deferment).

This is a valuable gold standard against which doctors can be assessed. However, in functional disorders and medically unexplained symptoms it is important to limit the options to those that are justified, as a free choice given to a person who is convinced of the need to be referred to secondary care is clearly going to result in another hospital attendance. Despite that, giving appropriate choices may be a useful strategy to keeping the person engaged and at the same time giving doctors some scope to set out goals that might be useful:

‘I can understand why you think you should have some tests and an X-ray, so what I suggest is that we do that before we make any decision about referral and then meet to see the results. I wonder, if until we get those results, you could keep a diary for me of when the pain is worst and what you do when it happens.’

One of the most difficult situations for a doctor arises when their views of how to proceed are not shared by the patient and/or their carers, or parents in the case of young people. This may also be the case with

colleagues, where the management plan may be altered by another member of the doctor's team. In such a case, stepping back and reiterating why you have reached a certain conclusion, taking others' views into consideration and in the end standing by your own integrity in a respectful and non-blaming way may be the only way forward. As most management plans are multi-factorial, a valuable compromise may be to involve others who can begin to work on an area that has been agreed, while outstanding differences of opinion are allowed to go to a further investigation or discussion. (The next chapter will consider relevant therapeutic options for individuals with medically unexplained symptoms.)

DO PATIENTS THEMSELVES WISH TO BE INVOLVED IN SHARED DECISION-MAKING?

Patients vary in their desire for involvement in decision-making in consultations (McKinstrey, 2000). This variation depends in part on the presenting problem, the person's age, social class, smoking status, their own health literacy and also on the clinician's skills, knowledge of their patient and adequate time being made to allow effective shared decision-making.

Vignettes below (Boxes 12 & 13) illustrate the differences between a shared approach and a directed approach to clinical decision-making in primary care. Patients' preferences for shared or directed decision-making depend on the problem presented – for those with psychological or psychiatric components to their physical illness the directed approach is not associated with benefit, but for those with uncomplicated physical problems this approach is of more use.

BOX 12 SHARED AND DIRECTED APPROACHES TO DECISION-MAKING (I)

The patient is a 30-year-old woman. She has come to see her doctor after a bout of bronchitis to get a certificate to go back to work. She is fully recovered now and is expecting a brief consultation. Her doctor is concerned that she is continuing to smoke despite having had three bouts of bronchitis in the past year. He decides to use the consultation to talk about her smoking.

1 Shared approach

Doctor: 'Are you still smoking?'

Patient: 'I'm afraid so, doctor.'

Doctor: 'This last infection didn't put you off then. Do you think the smoking is connected to these chest infections you've had?'

Patient: 'I dare say. I wouldn't mind stopping, but it's not easy to give up.'

Doctor: 'I know it's very difficult. Quite a lot of my patients say that. Have you ever tried to give up?'

Patient: 'Yes, a few years ago I gave up for 4 months.'

Doctor: 'Well, that was good. What made you start again?'

Patient: 'It was stupid, really. I was at a wedding, had a few drinks, and thought one drag wouldn't hurt, and that was it.'

Doctor: 'Was it hard to stop?'

Patient: 'That was the odd thing, then I didn't really find it that hard.'

Doctor: 'I heard recently that it takes an average of three tries to stop smoking. It's worth trying again, because the smoking definitely appears to be catching up with you. Do you think you will give it another go?'

Patient: 'Well, maybe.'

Doctor: 'The other thing that might be worth considering is cutting down. There's good evidence to show that the fewer cigarettes you smoke the less the risk. Would that be easier?'

Patient: 'No. If I was going to stop I would stop completely.'

Doctor: 'I have some information here which you might find useful. It tells you about some of the aids we have to help us stop smoking, such as nicotine patches and gum, along with other common-sense stuff. If I can do anything to help you with this, or can give you advice, please let me know.'

Patient: 'Thanks doctor, I'll think about it.' [smiling]

2 Directed approach

Doctor: 'Well, you seem to have shaken off another of these infections, but that's the third time this year. It can't go on like this. You really have to stop smoking.'

Patient: 'It's not easy, doctor!'

Doctor: 'I know it's difficult, all my smoking patients tell me this, but if you keep trying you will be successful. I read somewhere that on average people have to try three times before they eventually stop smoking. I'm sure someone like you can do that.'

[brief gap]

'Even if you can't stop, you should cut down. The less you smoke the less the risk. If I can be of any help to you I will. So give it a go. I have some information here which you might find useful. It tells you about some of the aids we have to stop smoking, such as nicotine patches and gum, along with other common-sense stuff. If I can do anything to help you with this or can give you advice, please let me know.'

Patient: 'Thanks doctor, I'll think about it.'

Doctor: 'Don't think about it, do it!'

Patient: 'OK.' [smiling]

After McKinstrey (2000).

In the example presented in Box 12, although similar ground is covered with a shared approach as with a directed approach, the doctor is able actually to provide more detailed information with a shared approach and the interview is less like a lecture, with more discussion of the topic area. In the next example (Box 13), the shared approach enables both patient and doctor to express their doubts and ambivalence regarding the outcome of treatment. With the directed approach the focus is on the treatment working, which may result in the patient feeling even more let down and disappointed if it does not work.

Box 13 SHARED AND DIRECTED APPROACHES TO DECISION-MAKING (II)

The patient is a 32-year-old man who has quite severe rheumatoid arthritis. He has tried a variety of treatments, which have not been very successful. He is in constant pain but has chosen to keep on working as long as he can. He is married and has two children, aged 10 and 14. He is currently receiving gold injections for his arthritis. They have not helped. He is disappointed as he had been told this treatment is usually successful and he had started with high hopes. He has found the injections and blood tests a real nuisance and he wants to stop the treatment. His doctor has phoned the specialist, who has recommended a higher dose of the drug. His doctor can think of no other course of action at the moment.

1 Shared approach

Doctor: 'Well, how are things?'

Patient: 'Not great.'

Doctor: 'Has there been any improvement since we last spoke?'

Patient: 'I'd love to say yes, but there hasn't.'

Doctor: 'What do you feel about the treatment then?'

Patient: 'I think I've given it a good trial. It hasn't worked. I'd like to stop.'

Doctor: 'I spoke to a specialist, she's very keen to try a higher dose.'

Patient: [*Look of exasperation and disbelief*] 'You're not serious!'

Doctor: 'I know, I don't blame you, that would probably be my reaction.'

Patient: 'Do you really... I want you to be honest... think it will work?'

Doctor: 'Honestly... I don't know for certain. It might. I have seen a higher dose work before. I think if it were me, and I know it is very hard to know how you are feeling at the moment, I would probably give it a go, but I would be going in with my eyes open, not expecting too much.'

Patient: 'I'm just fed up with being disappointed.'

Doctor: 'I know.'

Patient: 'OK, let's do it, what have we got to lose.'

2 Directed approach

Doctor: 'Well, how are things?'

Patient: 'Not great.'

Doctor: 'Well, we'll have to do something about that then. I know you've been disappointed by the gold so far, so I've been on to the specialist. She says that much better results are obtained from higher doses. She recommends that we double the dose. I think that that's what we should do.'

Patient: [*Look of exasperation and disbelief*] 'You can't be serious!'

Doctor: 'I know you're fed up, but I really hope this will make a difference.'

Patient: 'It's just that I've heard this before.'

Doctor: 'Believe me, we've got very few other options. I think this represents our best hope.'

Patient: So I have to keep going with these darn injections and blood tests. I wish to goodness I thought they would work.

Doctor: Dr Johnson is an expert in this. She wouldn't recommend it if she didn't think it would work. I think you should try it.

Patient: Well, I don't suppose I have a choice. Let's do it.

After McKinstrey (2000).

It is essential to have the patient's goodwill for any therapeutic intervention to be effective and so keeping to the tenets of shared decision-making wherever possible forms an important basis for an effective treatment.

CONCLUSION

Shared decision-making should be the rule, not the exception, in healthcare. Doctors need to involve patients in all aspects of their care, recognising that they may want different levels of involvement, depending upon their temperament, current circumstances and the nature of the problem.

8. Management and treatment of psychological problems associated with physical illness

CHAPTER SUMMARY

- One of the most important roles of the GP is to help patients use their own resources to manage illness or a change in circumstances brought about by illness.
 - Too active a role (e.g. using tranquillisers to alleviate distress) may hinder rather than help the process of adjustment.
 - There is relatively little evidence regarding the pharmacological treatment of depression in physical illness.
 - Antidepressants may help to improve health-related quality of life in individuals with a broad range of medically unexplained symptoms.
 - Psychological treatments that appear to be effective in secondary care may not necessarily be as helpful in the primary care setting.
 - Most psychological interventions in primary care (including counselling and cognitive therapy) have equivalent effects and are better than usual GP care in the short term.
-

The management and treatment of psychological problems and issues are predominantly undertaken in primary care. As secondary mental health services focus more and more on severe mental illness, primary care mental health teams and GPs are faced not only with service users with mild or acute psychological issues, but also those with long-standing problems and chronic difficulties. In particular, individuals with both physical and mental health problems often fall between acute general hospital services and secondary mental healthcare, with both expecting the other to provide ongoing treatment and support. Primary care services are best placed to provide a comprehensive and integrated service for individuals with both physical and mental health problems, providing there is sufficient skill base among the staff and resources to manage these kinds of problems.

PREVENTION

Informing and preparing patients for any planned medical or surgical procedure can help to reduce unnecessary worry or anxiety caused by ignorance or unrealistic fears as well as helping to make an informed choice about the treatment. Some people may want more autonomy and a greater say in their treatment than others who may prefer to receive more guidance.

We know relatively little about what people actually want from doctors. Recent research suggests that for certain conditions (e.g. breast cancer) individuals may want doctors to play a more active, authoritative role in decision-making than has previously been assumed (Wright *et al*, 2004). These findings tell us how important it is to treat each person as an individual and to discuss with them how much he/she wants to be involved in active decision-making about his/her illness. Other important considerations include:

- simple advice and problem-solving
 - specialist nurses (e.g. diabetic nurses, midwives, Macmillan nurses) may be particularly helpful in relation to certain conditions
 - helping individuals with practical problems (e.g. access to benefits) may enable them to cope better emotionally with their illness
- illness and disability affect whole families, not just individuals
 - relatives and carers require support in their own right and often will be closely involved in the day-to-day management of the patient's condition
 - families should always, if possible, be included in discussions about management (provided the patient agrees)
 - families can unwittingly hinder improvement by being overprotective
 - relatives may need permission or encouragement to withdraw and allow the patient more independence
- in a medical model of care it is easy to forget the spiritual and cultural dimensions of life, but many religious organisations offer support and help at times of adversity and other forms of cultural support may be available.

PHARMACOLOGICAL TREATMENT OF DEPRESSION

There is a considerable debate in the literature regarding the relative merits of antidepressants for the treatment of depression. There has been concern about the design methods of many trials and the tendency to report only positive studies. It is clear that antidepressants have been over-prescribed in the primary care setting and individuals with mild or atypical symptoms of depression are unlikely to benefit from drug treatment. There has also been concern about the placebo response to antidepressant medication, which may account for some of the improvement witnessed in clinical settings (Charney *et al*, 2002; Kirsch *et al*, 2002; Kupfer & Frank, 2002; Walsh *et al*, 2002). The NICE guidelines for the management of depression recommend the use of antidepressant treatment for severe depression, but suggest the evidence is less strong for mild or moderate depression (NICE, 2004).

There is relatively little evidence regarding the pharmacological treatment of depression in physical illness. One Cochrane review that considered 18 randomised controlled trials (some with very small numbers of participants) (Gill & Hatcher, 2000) concluded that:

- antidepressants brought about greater reduction in depression than either placebo or no treatment in individuals with a wide range of illnesses
- number needed to treat to produce one recovery from depression was four

- antidepressants were reasonably acceptable to patients, but a higher drop-out rate was observed for tricyclic antidepressants.

A large study ($n=371$) of the treatment of major depression (using a selective serotonin reuptake inhibitor (SSRI) antidepressant) in individuals with acute myocardial infarction or unstable angina suggested that there was a minimal advantage for the antidepressant over placebo drug in relation to both cardiac outcome and improvement in depression for most participants. However, participants with a previous history of depression or with severe depression responded more favourably to the antidepressant than the placebo treatment in relation to mood (response rates were 72% v. 51% for those with a previous history of depression and 78% v. 45% for those with severe depression). The antidepressant itself was well tolerated, with relatively few side-effects (Glassman et al, 2002).

For adolescents, the evidence for antidepressants is relatively weak and only fluoxetine is recommended for those under 16 years of age. This advice must be balanced against the need to identify depression in this age group, where risks of recurrence are high. Psychological interventions, such as cognitive-behavioural therapy, should be offered with antidepressants in this age group.

As with most conditions, the treatment of depression in the context of physical illness requires doctors to balance potential benefits against any possible harm. There is relatively little work that has evaluated the safety of antidepressants for the treatment of depression in individual physical conditions. You should always seek advice from an appropriate health professional if you are concerned about potential side-effects or drug interactions. This is particularly important in children and adolescents in relation to the risks of suicidal thoughts or actuation.

From the evidence available, it appears that many individuals with major depression in the context of physical illness will improve spontaneously, without pharmacological treatment (Keitner *et al*, 1991). On the other hand, depression is often missed in people with a physical illness as it may be regarded as a normal, understandable response. It is important to recognise and treat depression in such people as it may result in a poorer recovery and is a risk factor for suicide.

Doctors should consider treatment with antidepressant medication if:

- the depression is severe
- the person has suicidal ideas
- the depression is persistent
- there is a strong family history of depression
- the person has a previous history of severe depression.

Many people are wary of taking psychotropic medication and for that reason the doctor will need to carefully discuss any proposed treatment with their patient. They will need to provide the following information (Table 9):

- a rationale for using pharmacological treatment
- how antidepressants work
- how to take the drug
- potential side-effects and drug interactions
- likely duration of treatment

Table 9 Explaining antidepressants to patients

Rationale	'Physical illness is debilitating and often gets people down. When people become very down this is accompanied by changes in biochemical factors in the brain. These changes can sometimes occur as a direct consequence of a disease.'
How antidepressants work	'Antidepressant drugs restore the balance of chemistry within the brain and lift mood, making it more possible to cope with illness.' If the condition is painful, it is also helpful to add that antidepressants can also have a beneficial effect on pain.
Potential side-effects	Inform the patient of the most common side-effects of the drug(s). Also check for any drug interactions.
Likely duration of treatment with antidepressants	If the drug treatment is helpful, it would be advisable to stay on it for 6 to 9 months.
How long before the drug takes effect	It may take 2–4 weeks for any benefits to become apparent.
How to stop	'If you want to stop taking the drug, you should do this gradually. Some people who stop suddenly (e.g. those who were taking an SSRI) become very anxious or jittery. Come and see me so I can advise you about this. At the end of the 6–9 months, I will slowly reduce the amount you are on before stopping it. Most people do not miss the drug or crave it once it is out of their system.'

- how long the drug will take to have effect
- how to stop the drug.

Once a decision on treatment has been agreed, the choice of drug will depend to a large extent on known side-effects and potential interactions with other drugs. Often the first choice for the treatment of depression is an SSRI drug. There are important pharmacokinetic differences between the SSRIs, particularly in their ability to inhibit hepatic cytochrome P450 isoenzymes responsible for the metabolism of many drugs. *In vitro* studies suggest that citalopram, escitalopram and sertraline are the least likely to inhibit these isoenzymes and are therefore least likely to cause interactions with other drugs. The choice of drug should be matched to the person's needs as far as possible, depending upon the effect and tolerability of previous treatment with an SSRI, whether sedation is required and the risks of interactions. For those less than 16 years' old only fluoxetine is currently recommended.

Four antidepressants have been introduced since the SSRIs: venlafaxine and duloxetine are serotonin and noradrenaline reuptake inhibitors (SNRIs), mirtazapine is a presynaptic alpha 2 antagonist and reboxetine is a selective inhibitor of noradrenaline reuptake. All four have very low rates of drug interactions and are potentially attractive options for individuals with combined medical and psychiatric illness. Sexual dysfunction, common with the SSRIs, is rarer with mirtazapine and reboxetine. None

of these drugs, however, has been evaluated extensively in medically ill populations (i.e. patients with physical illness and depression) and at present they should be used as second-line drugs.

PHARMACOLOGICAL TREATMENTS FOR MEDICALLY UNEXPLAINED SYMPTOMS

Antidepressants lead to an improvement in health-related quality of life in people with a broad range of medically unexplained symptoms (Jackson *et al*, 2000; Jailwala *et al*, 2000; O'Malley *et al*, 2000). It is not known whether this can be explained by reduction of depression or by a direct analgesic effect and whether the effect is better for SSRIs or tricyclic antidepressants. There are no similar meta-analyses regarding the use of antidepressants in other specific medically unexplained syndromes.

Randomised controlled trials suggest that antidepressants can be useful in the treatment of individuals with medically unexplained symptoms regardless of whether depression is present. Before starting antidepressants it is important to explain to the person that the drug is not being used primarily to treat depression but to help 'damp down' their awareness of physical sensations.

Treatment should start with a low dose of the drug, to be increased gradually (usually at weekly intervals) according to response. For instance, amitriptyline could be increased in weekly increments from 10mg to a dose that the person can tolerate (e.g. up to 25mg).

Benefit is usually seen within 1 to 7 days of starting treatment – before any antidepressant effect would be expected to occur. Patients should be told about the importance of taking the medication regularly.

PSYCHOLOGICAL TREATMENTS FOR MEDICALLY UNEXPLAINED SYMPTOMS

A range of different psychological treatment approaches is currently available on the NHS in primary care settings. The relative availability of each treatment will vary according to local circumstances and organisation of services. The psychological treatments most commonly available in the NHS are cognitive-behavioural therapy, counselling, psychodynamic or interpersonal therapies and problem-solving therapies. The expansion of psychological therapies has become a government priority, which should make psychological treatment more easily accessible in primary care (Department of Health, 2008).

In secondary care, psychological treatments (including cognitive-behavioural therapy, psychodynamic interpersonal therapy and hypnosis) have been shown to be helpful in the management and treatment of certain types of medically unexplained symptoms (Kroenke & Swindell, 2000). Cognitive-behavioural therapy is also a recognised treatment for anxiety disorders and depression, and interpersonal and psychodynamic interpersonal therapies are effective treatments for depression.

There are very few studies, however, that have evaluated these therapies for the treatment of psychological problems/depression associated with physical illness. For cancer, a meta-analytic review of psychological

treatment interventions did not show convincing evidence of efficacy (Sheard & Maguire, 1999), but comparison between studies is difficult because of a variety of factors, including variability in recruitment of groups of participants (some included those who did not have depression), kinds of cancer and stages of illness. A well-conducted study of cognitive-behavioural therapy in women undergoing treatment for breast cancer found there was a very high drop-out rate from treatment as women felt physically too ill to proceed with the psychological therapy (Moorey *et al*, 1998).

Psychological therapies are routinely overlooked in older people, although there is no evidence that they do not respond to psychological treatment and many can benefit (Hepple, 2004).

EFFICACY AND EFFECTIVENESS OF PSYCHOLOGICAL TREATMENTS IN PRIMARY CARE

Treatment that appears to be effective in secondary care may not necessarily be as helpful in the primary care setting. Patient groups are more heterogeneous and spontaneous recovery may be more common in primary than secondary care. Cognitive-behavioural therapy appears to have equivalent effects to counselling for the treatment of depression in primary care (Ward *et al*, 2000) and brief problem-solving therapy may also be helpful (Mynors-Wallis *et al*, 1995, 1997, 2000). Patient choice regarding treatment appears to be important, and therapies that are less focused on symptom reduction and more on solving problems seem more acceptable (Dowrick *et al*, 2000c).

The evidence for the efficacy or effectiveness of any of the above treatments for anxiety or depression in primary care is very limited (Barkham & Hardy, 2001) and there is no evidence base for the treatment of depression in the context of physical illness. A recent systematic review concerning psychological treatments for medically unexplained symptoms found that the effect was clearer in trials performed in secondary rather than primary care (Raine *et al*, 2002). The evidence base for primary care was very weak. Treatment studies in primary care with children and adolescents with medically unexplained symptoms are virtually non-existent and there are very few studies concerning the treatment of children and adolescents with mental health problems in primary care (Bower *et al*, 2001).

GP INTERVENTIONS

Good-quality feedback from secondary to primary care regarding problem identification and recommendations about treatment can be helpful for individuals with medically unexplained symptoms (Dickinson *et al*, 2003). This recent study has found that a care recommendation letter with advice about treatment for individuals with medically unexplained symptoms had a positive effect on their quality of life for a 12-month period when compared with controls.

Training GPs to manage individuals with medically unexplained symptoms in a more effective way and to identify relevant emotional factors has also shown promising results (see reattribution techniques, pp. 83–84). Specific treatment packages that involve the whole of the primary care team have been developed (Smith *et al*, 2003).

ALTERNATIVE THERAPIES

There are relatively few evaluations of alternative therapies for individuals with medically unexplained symptoms. For example, in primary care acupuncture may be helpful for chronic headache (Vickers *et al*, 2004) and in secondary care hypnosis has been shown to be helpful for irritable bowel syndrome (Gonsalkorale & Whorwell, 2005).

DEVELOPING A RATIONAL APPROACH TO TREATMENT

There is an insufficient evidence base to recommend on a routine basis pharmacological or psychological treatments to individuals with medically unexplained symptoms or psychological difficulties in the context of physical disorder. However, as clinicians, we have to develop a rational approach to managing and helping people in distress.

For those with mild symptoms of recent onset the most helpful and sensible approach may be explanation, reassurance and education. This may alleviate anxiety and increase the person's chances of spontaneous recovery from depression (they are high at approximately 70%; Oxman *et al*, 2001). Emphasis should be placed on helping the individual adjust to their illness.

For people with moderate or more persistent symptoms, doctors should be more proactive and consider brief problem-solving strategies. If unsuccessful, referral for psychological treatment or counselling may be warranted. Doctors should also consider antidepressants, particularly if the person has a prior history of depression or a family history of depression. Their medication should be carefully reviewed to identify any pharmacological agents that could cause depression.

If the person has severe symptoms of depression with suicidal ideation they should be urgently referred to psychiatric services. Advice or referral to liaison psychiatry services is appropriate for people with persistent symptoms of depression that have failed to respond to first-line treatments or for those with complex psychosocial problems.

MEDICALLY UNEXPLAINED SYMPTOMS

In medically unexplained symptoms it is important for doctors to elicit concerns and make sure that they understand the problem from the patient's perspective. A combined physical and psychological assessment will be necessary.

Many people with medically unexplained symptoms are uncertain what their symptoms are caused by. They will not necessarily expect doctors to do anything about their symptoms, but rather hope that their problems will be acknowledged and explained reasonably (Ring *et al*, 2004). Most people are aware of the importance the social and emotional factors play in how they are feeling, and often doctors need only to listen to them, discuss their social and emotional issues and offer an explanation for their problems that fits within their beliefs and concerns (Dowrick *et al*, 2004). At this stage it is probably better to avoid organising special investigations, somatic treatment or referral, unless clinically indicated.

REATTRIBUTION TRAINING FOR GPs

GPs view medically unexplained symptoms as their second most important training need in mental health (Kerwick *et al*, 1997). In practical terms, there is increasing evidence that certain types of reattribution training or broadening attribution may be helpful with this group of service users. Reattribution training can be delivered to GPs over the course of two or three afternoons as a combination of lectures, role-plays, video with feedback and group discussion. The training aims to enable doctors to recognise and manage four crucial stages in the consultation process:

- 1 Feeling understood – the GP elicits a history of the physical symptoms, the person's beliefs about them and associated psychosocial and lifestyle factors, and makes a brief focused physical examination.
- 2 Broadening the agenda beyond the presenting physical symptoms – the doctor feeds back the results of the examination and any recent investigations and explains the lack of serious underlying pathology. They explicitly acknowledge the reality of the person's physical symptoms and assess their acceptance of the fact that psychosocial or lifestyle factors may be linked to these symptoms.
- 3 Making the link – the doctor links the physical symptoms to an underlying psychosocial or lifestyle explanation, using physiological and/or temporal links compatible with the person's symptom beliefs.
- 4 Negotiation over further management – there are various components to this stage, including eliciting the person's views about treatment, promoting problem-solving and coping strategies, the appropriate use of muscle relaxation, the appropriate treatment for depression, and agreeing specific plans for follow-up.

Morriss *et al* (1999) have conducted a 'before and after' study of reattribution training *v.* treatment as usual, as taught to eight GPs, who then treated 215 individuals with medically unexplained symptoms. In terms of patient outcomes, they found that the training significantly improved function and reduced mental disorder among the majority of individuals who did not have fixed beliefs that their symptoms had a physical cause. The improvement was apparent at 1 month and greatest at 3 months. Among individuals who did have a fixed belief that their symptoms had a physical cause, the training significantly reduced the prevalence of major depression by half at 1 month. In terms of health costs, the researchers found that reattribution training decreased the costs of health contacts outside the primary healthcare team by 23%, with very little change in primary care costs. Overall health costs were reduced by 15% over 3 months. This reduction in health contacts with outside agencies is particularly important. The ICD-10 category of 'symptoms and signs of ill-defined conditions' is the largest category of NHS hospital out-patient expenditure at over £200 million per year. Many of these service users could be better managed clinically and more cost-effectively in primary care, with an estimated saving from reattribution training of up to £30 million per year. Further work (Morriss & Gask, 2002) has also shown benefits for service users but with less obvious effects on GP behaviour in terms of prescribing costs and investigations.

A recent cluster randomised controlled trial of reattribution training for GPs to help manage individuals with medically unexplained symptoms has reported positive outcome in doctor–patient communication, without improving patient outcome (Morriss *et al*, 2007). It is possible that even those with relatively mild symptoms may require more intensive approaches than that offered by the reattribution model alone.

MODERATELY SEVERE AND SEVERE MEDICALLY UNEXPLAINED SYMPTOMS

For individuals with moderately severe symptoms (less than 2 years' duration) referral for specific psychological treatment should be considered. Antidepressant treatment may also be helpful for certain forms of medically unexplained symptoms and in reducing pain. Graded exercise programmes, pain programmes and physiotherapy-based rehabilitation programmes may also be of help. Child and adolescent mental health services should be involved early by paediatricians or GPs (certainly after 6 months or even less) when symptoms lead to continuous school or peer group activities non-attendance and hamper the development of age-appropriate independence.

Individuals with severe symptoms who are severely disabled will probably need to be managed jointly between primary and secondary care. The involvement of a liaison psychiatrist for people of working-age or older adults may be helpful. Emphasis should be placed on management rather than cure.

WORKING WITH INDIVIDUALS FROM ETHNIC MINORITIES WHO HAVE PSYCHOLOGICAL COMPONENTS TO THEIR PHYSICAL ILLNESS

Managing service users from ethnic minorities who have psychological components to their physical illness, a somatisation disorder or medically unexplained symptoms is a particularly challenging task given the possible linguistic barrier, cultural differences and different communication styles, and a very complex transcultural doctor–patient relationship.

Race and ethnicity have often been used synonymously, but this can lead to confusion. Race implies genetic homogeneity and racial distinctions are often made on the basis of appearance, particularly skin colour. Ethnicity, however, is self-described on the basis of shared origins, culture, religion and language. Culture may be defined as the network of shared ideas, meanings and rules that people use to perceive and interpret the world (Livingston & Sembhi, 2003). It determines what is seen as normal and abnormal within a given society. Culture is that complex whole that includes knowledge, beliefs, communications, actions, values, arts, morals, laws and customs and relates to psychological illness in several ways, particularly in its mode of presentation and response to treatment (Dein, 1997). In healthcare services we increasingly encounter individuals whose values and beliefs differ from our own (Rait *et al*, 1996) and our ideas of distress and symptoms are not necessarily appropriate for people from other ethnic groups. In addition, it is clearly difficult to translate emotions into English from another language,

even if the person has good language skills or an interpreter is present. Different cultures have different beliefs about health, illness or the use of medical services and treatments, and all symptom presentations are culturally mediated. For example, certain illnesses may be stigmatised within different cultures and individuals may, therefore, present with symptoms acceptable within their own cultures rather than those that may conform to a Western model of disease (Katon *et al*, 1984; Kundhal & Kundhal, 2003).

As doctors, we need to have knowledge of the patients' relevant cultural and religious beliefs and practices to have effective communication, as well as making correct diagnoses and negotiating appropriate management plans. We need to be skilled at eliciting and understanding the patients' cultural values and learn how to work with them. This is particularly important when we are dealing with individuals who have psychological components to their physical illness. Apart from an ability to be culturally aware and sensitive, doctors also need to use their cultural knowledge effectively in transcultural consultations.

SOMATIC SYMPTOMS IN DIFFERENT ETHNIC GROUPS

Somatisation disorder is relatively common in all ethno-cultural groups and societies studied to date (Gureje *et al*, 1997; Kirmayer & Young, 1998). The major sources of differences in the frequency of somatisation disorder among the different groups include the style of expressing distress ('idioms of distress'), the ethno-medical belief systems in which these styles are rooted, and each group's relative familiarity with the healthcare system and the pathways to care. The idioms of distress are ways of communicating distress based on cultural norms, practices and beliefs, which are in turn based on their cultural perception or misperception. Somatic symptoms can serve to avoid stressful life situations and gain a legitimate entry into a 'sick role' (Parsons, 1951). Maintaining factors for somatic symptoms include an individual predisposition and a complex interaction between the individual, their family, doctor and the social system. Individual personality traits and early learning experiences also contribute to a predisposition to the development and persistence of somatic symptoms in the presence of psychological distress. Financial rewards such as disability payments may also reinforce this pattern of behaviour (Lipowski, 1988). Kirmayer & Young (1998) reported that a high level of somatic symptoms was associated with greater age, female gender, unemployment and ethnic background.

Somatic symptoms of psychological distress have also been found to be more common among Chinese-American than White services users (Hsu & Folstein, 1997), and among the Gujarati- and Urdu-speaking groups than the English speaking group (Bhatt *et al*, 1989).

Asian cultures place a great value on the family as a unit. The teachings and philosophies of a Confucian, collectivist tradition discourage the open display of feelings to maintain a social and familial harmony or to avoid exposure of what may be perceived as a personal weakness. 'Saving face', the ability to preserve the public appearance of the individual and family for the sake of community propriety, is extremely important in most Asian societies. Individuals may not be willing to discuss their mood or psychological state because of their fears of stigma and shame. It may therefore, be more acceptable for psychological distress to be expressed through the body rather than through the mind (Kramer *et al*, 2002).

MANAGEMENT OF PSYCHOLOGICAL ASPECTS OF PHYSICAL ILL HEALTH IN PEOPLE FROM ETHNIC MINORITIES

The management of somatic symptoms in people from ethnic minorities requires the bio-psychosocial model for consultations (engaging with distress, broadening the agenda, solving problems, involving relatives in rehabilitation and coping) in addition to the biomedical approach (symptoms, investigations, drugs, operations, disability and curing).

To develop a management plan, a comprehensive medical, psychiatric and psychosocial evaluation of the person is needed (the essential components of a successful management plan are summarised in Table 10). The results of a WHO collaborative study which screened almost 26 000 service users in 15 primary care centres in 14 countries reported that somatic presentation of psychological distress was more common at centres where users lacked an ongoing relationship with a primary care physician than at those where users had a personal physician (Simon *et al*, 1999). There is some evidence that both cognitive-behavioural therapy and antidepressants are effective in these circumstances, but more research needs to be done (Lidbeck, 1997; O'Malley *et al*, 1999; Kroenke & Swindell, 2000). The effects may be greatest when the person feels empowered by their doctor to tackle their problem. Active cognitive reorientation at subsequent visits based upon an understanding of the person's explanatory model, facilitated by using symptom diaries, a good doctor-patient relationship, a behavioural collaborative approach and stepped care involving a multidisciplinary team can be an appropriate model of management in these circumstances (Smith *et al*, 2003).

Table 10 Management of psychological aspects of physical ill health in people from ethnic minority groups

Assessment	<ul style="list-style-type: none"> • Establish and foster a trusting doctor-patient relationship with the same GP • Identify and use interpreter/link worker – ensure exact translation with preservation of content is endeavoured • Assure privacy and confidentiality • Evaluate the person, establish the nature and extent of any underlying pathology or overlying non-organic component, understand their individual characteristics and the social and cultural context • Elicit the person's beliefs and concerns and be aware of their cultural influence • Enquire about problems and clarify the person's complaints, identify psychosocial cues – skilful interviewing is required and conducted by staff with relevant language skills, or accompanied by an interpreter • Identify secondary gains from the existing condition and ascertain the extent of the person's motivation for change and benefits that may result from change • Enquire about the person's stress and life problems, acknowledge and respond to their distress • Find out how the person appears to members of their own culture, enlist help of their family and close friends, informants such as religious officials and traditional healers (with the person's consent and in their presence), using an interpreter if necessary • Conduct a thorough physical examination – when no disease is found, provide unambiguous information about findings
Consultation skills	<ul style="list-style-type: none"> • Use open-ended questions early in consultation • Avoid overly complex information, accompany information giving with positive verbal and non-verbal behaviour and build up partnership with the person

Table 10 Management of psychological aspects of physical ill health in people from ethnic minority groups *continued*

Management strategy	<ul style="list-style-type: none"> • Provide effective reassurance based on the knowledge of the person's worries, give precise response to their fears and explain the physiological basis of symptoms; attend to their concerns • Identify coping strategies in people who can communicate effectively • Check the person's comprehension • Allow time to reflect and encourage the person to ask questions • Avoid statements such as 'It's all in your head' or 'There is nothing physically wrong with you' • Broaden the agenda with emphasis on helping the person to address their personal concerns and life problems as well as somatic complaints • Elicit the person's own explanatory model of the illness and attempt to explain the treatment in these terms. Explanation should include bio-psychosocial factors in simple terms that the person can understand. Written information should be given early, preferably in their own language • Encourage and empower them in decision-making • Schedule regular reviews every 4–6 weeks; consultations during time of good health may provide opportunity to change attitudes that have been reinforcing illness • Set agreed goals – agree on a current problem list and encourage the person to discuss relevant psychological problems; record in the notes • Avoid further diagnostic evaluations or aggressive treatments unless physical examinations reveal new evidence of disease • Minimise referrals to specialists and, if referring, specify reasons for request. Organise joint assessments with psychiatrist or psychologist if need arises • Consider the value of traditional healing methods • During assessment use reattribution and address factors that maintain symptoms • Treat depression and anxiety where associated • Identify sources of support and strength to the individual, such as their family and community network in past adaptation, coping and problem-solving; get to know, recognise and make use of these support groups in the treatment process
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Adapted from Lipowski (1988), Bass & Benjamin (1993), Dein (1997), Singh (1998), Khouzam & Field (1999), Bass & May (2002).

LANGUAGE DIFFICULTIES AND THE ROLE OF INTERPRETER/LINK WORKERS

The knowledge of English is one of the most important factors that influence access to care and many ethnic minorities are linguistically isolated (Kramer *et al*, 2002). Accessible and appropriate linguistic services are the foundation of culturally competent healthcare and central to effective communication, making the right diagnosis and ensuring appropriate management. This is particularly important when exploring psychosocial issues with service users.

Linguistic services normally comprise four main elements:

- 1 oral services
- 2 interpretation services
- 3 written services
- 4 translation services.

In managing a person from an ethnic minority, the best option for them will be to have a doctor who can speak their language and understands their culture, as it allows direct communication and interaction. However,

in practice we often face individuals from a very diverse language and cultural background and we require an interpreter or link worker's help. It may be possible to arrange for a regular interpreter to be present during an anticipated consultation with such a person but the limitation is generally both access and availability. It is very often the case that family members, particularly the children, are used as interpreters during the consultation. This may be undesirable, especially if the symptoms are of an intimate nature or the family circumstances are contributing to the perceived problem. Limitations will be imposed too by the child's level of maturity and cognitive ability. The same problems are encountered when the child is the patient. Using siblings to translate for parents or the young person may both limit the areas that can be explored and bring a risk of bias.

Some research suggests there is an association between language barriers and higher rates of diagnostic tests, higher costs for care and delayed diagnosis. It may well be that doctors compensate for difficulties in communication by ordering additional tests and it may, as a result, be more cost-effective to employ bilingual staff or interpreters (Kramer *et al*, 2002; Green-Hernandez *et al*, 2004). However, some interpreters or link workers are willing to work on a voluntary basis.

The interpreters or link workers who support primary care consultations should receive both prior training and be skilled at medical interpretation. This is especially so in the case of individuals who have a psychological component to their physical illness. The interpreter or link worker may have their own interpretation of issues. Indeed, confidentiality and a potential conflict of interest may arise if the interpreter and the patient come from the same closely knit community, and may inhibit the patient from discussing their psychosocial problems. The other limitation of using an interpreter or link worker is communication through a third person when empathy and rapport between doctor and patient may not develop as readily. Most child patients will have been learning English, so establishing rapport with them directly will be no more difficult than for other children. Developing a shared history and formulation with the child and their parents requires skilled translation and ample time in the consultation.

PSYCHOLOGICAL TREATMENT INTERVENTIONS

COGNITIVE AND BEHAVIOURAL THERAPIES

Cognitive-behavioural therapy is a brief, problem-orientated approach that includes behaviour therapy and cognitive therapy in various combinations. It can be used from early adolescence onwards, although more skill and a greater consideration of the parents' role are required in the use of techniques with those at the edge of the age range. Behaviour therapy is mainly based upon the theory of operant conditioning – the modification of behaviour by rewarding the appropriate and ignoring the inappropriate behaviour. The rewards are contingent upon the completion of specific tasks. Such principles underpin pain management or rehabilitation programmes; for example systematic desensitisation is useful for the management of needle phobias. Individuals are taught techniques to control and reduce anxiety and are exposed to the feared object in a graded fashion. Most behavioural techniques can be used with much younger children, but it is essential to include parents in the approach.

The general aims of cognitive therapy are to:

- monitor negative automatic thoughts
- recognise connections between cognitions, affect and behaviour
- examine evidence for and against distorted automatic thoughts
- substitute more reality-orientated interpretations
- learn to identify and alter dysfunctional schemata.

AUTOMATIC THOUGHTS AND BASIC SCHEMATA

The automatic thoughts are the basic data of cognitive therapy, so called because they are the habitual and reflexive commentaries that we make to ourselves and of which we are not necessarily fully conscious. Several techniques have been described to help the therapist elicit and modify these thoughts, which maintain low, anxious or angry moods and dysfunctional behaviour (e.g. inactivity, ruminating, checking, bingeing, avoiding, etc.). The person can be helped to access these thoughts through direct questioning, inductive questioning (a series of questions that guide the person to discover the related automatic thought), using moments of strong emotion, re-enacting situations in role-plays, using mental imagery to recreate situations or using behavioural tasks to trigger the thoughts. The person is asked to keep a diary (the 'daily record of dysfunctional thoughts'), using changes in emotions as cues to monitor thinking. These records are also used to practise challenging the automatic interpretations and substituting alternative interpretations which may lead to less distressing emotions. A variety of other techniques can also be used to modify automatic thoughts, for example examining the evidence for and against, listing probabilities and collecting information that may invalidate the original interpretation. The basic principle in all these techniques is that the individual is taught to consider his or her thoughts not as facts but as interpretations that may be more or less accurate and that may be more or less functional in terms of the feelings and the behaviour that they trigger.

Identifying the basic schemata or beliefs that lead individuals to process information in idiosyncratic ways typically occurs later on in therapy and is, generally, more difficult and abstract than identifying automatic thoughts.

As with the automatic thoughts, modifying the schemata is done through collaborative discussion and the use of behavioural tasks. Thus, the person may be asked to weigh up the advantages and disadvantages of holding the belief, to examine the evidence for and against the belief, to question the validity of the personal construct, to consider the short-term and long-term utility of the deeply held belief, to disobey the rule in a behavioural assignment and test the consequences. The latter is similar to response prevention in behaviour therapy.

GROUP COGNITIVE THERAPY

Group cognitive therapy may be more cost-effective than individual work, although a relatively small number of individuals may be suitable for such an intervention (Lidbeck, 2003; Arnold *et al*, 2004). There are a number of self-help books readily available for the treatment of depression, but for the majority there is little direct evidence for their effectiveness. There is weak

evidence that suggests that bibliotherapy, based on the cognitive-behavioural therapy approach, is useful for some people when they are given some additional guidance (Anderson *et al*, 2005). Computerised cognitive therapy has also shown promise for individuals with mild symptoms of depression (McCrone *et al*, 2004). Self-help training packages in cognitive-behavioural therapy may also be useful and become more widespread in the next few years (Richards *et al*, 2003).

A recent study has also shown that combined psychological treatment and antidepressants is more effective than the usual care for the primary care service users with panic disorder (Roy-Byrne *et al*, 2005).

There are a small number of trials of cognitive-behavioural therapy in individuals with medically unexplained symptoms in primary care (McCrone *et al*, 2004), but the results have been equivocal and less impressive than in the secondary care setting.

INTERPERSONAL THERAPY

Like cognitive therapy, interpersonal therapy was initially developed to treat individuals with depression (Markowitz & Weissman, 1995). There are three phases of development. During the first phase, depression is diagnosed within a medical model and explained to the person. The major problem associated with the onset of the depression is identified and an explicit treatment contract to work on this problem area is made with the patient. Problem areas are classified into three groups: grief, interpersonal disputes and role transitions. In the second phase of the therapy, the therapist and patient work on the identified problem area, exploring ways of helping the patient deal with the problem. In the final phase of the therapy, the termination is discussed, progress is reviewed and the remaining work outlined.

Interpersonal therapy is an effective treatment for depression and other psychological disorders (de Mello *et al*, 2005). It has also been shown to be effective for the treatment of depression in individuals who are HIV-positive (Markowitz *et al*, 1992).

PSYCHODYNAMIC INTERPERSONAL THERAPY OR CONVERSATIONAL MODEL THERAPY

This form of treatment has been developed by the psychiatrist Robert Hobson (1985). It has elements of psychodynamic therapy and interpersonal therapy. It places greater emphasis on the patient-therapist relationship as a tool for resolving interpersonal issues than the interpersonal therapy and there is less emphasis on the interpretation of transference than in psychodynamic therapies. Interpersonal therapy is used from late adolescence onwards.

Key features of the model include:

- the assumption that the client's problems arise from or are exacerbated by disturbances of significant personal relationships
- a tentative, encouraging, supportive approach from the therapist, who seeks to develop deeper understanding with the client through negotiation, exploration of feelings and metaphor
- linking the client's distress to specific interpersonal problems
- the use of the therapeutic relationship to address problems and test out solutions in the 'here and now'.

Emphasis is placed upon identifying repeated patterns of behaviour within relationships that result in conflict and emotional distress. Support and encouragement is provided to the client to challenge difficult problem areas in relationships and to develop more adaptive ways of coping.

Psychodynamic interpersonal therapy has been empirically evaluated for the treatment of individuals with irritable bowel syndrome (Creed *et al*, 2003) and functional dyspepsia (Hamilton *et al*, 2000), although not in the primary care setting. It has similar treatment outcomes to cognitive therapy in depression (Barkham *et al*, 1999) and is an effective intervention for individuals who are frequent users of mental health services (Guthrie *et al*, 1999). It can also be taught to counsellors working in the primary care setting (Guthrie *et al*, 2004).

PROBLEM-SOLVING THERAPY

Problem-solving therapy is based on the observation that emotional symptoms are generally induced by problems of living and has its theoretical roots in cognitive approaches to depressive disorders (Nezu *et al*, 1989). Problem-solving treatment has been developed as a specific collaborative treatment, with three main steps: first, client's symptoms are linked with their problems; second, the problems are defined and clarified; and third, an attempt is made to solve the problems in a structured way. By starting to tackle problems, individuals can begin to reassert control over their lives, which lifts their mood. This process usually involves six sessions with a therapist, with a total contact time of less than 4 hours (Hawton & Kirk, 1989). The skills needed to deliver problem-solving therapy can be easily and rapidly taught to a range of health professionals including GPs and nurses. In practice, with some modifications, it can be applied with children and families from the age of nine or ten, though this age group has not been studied systematically.

In a series of studies carried out by a group based in Oxford, UK, problem-solving therapy has been shown to be valuable in primary care for anxiety and minor emotional disorders (Mynors-Wallis *et al*, 1995) and as effective as antidepressant medication in the treatment of major depression, when provided by either experienced GPs or trained nurses (Mynors-Wallis *et al*, 2000). Problem-solving therapy delivered by trained community nurses appears to have economic benefits and increases patient satisfaction when compared with routine GP care (Mynors-Wallis *et al*, 1997). In the ODIN study, a multicentre European randomised controlled trial, problem-solving therapy was offered to people identified through community survey with depressive or adjustment disorders. It was acceptable to most participants and was effective in reducing diagnosed depression and symptoms and in improving subjective function (Dowrick *et al*, 2000c).

WAYS OF HELPING SARAH

Having reviewed briefly the pharmacological and psychological treatment options in primary care, let us return to the case example of Sarah (discussed in Case study 2, p. 41).

CASE STUDY 5, CONT. FROM CASE STUDY 2

Sarah is facing two major chronic difficulties in her life that are unlikely to resolve. Her physical condition is unlikely to recover and her son may require some form of care for the rest of his life.

Sarah's mood is low but she does not have a severe depressive illness, so antidepressant treatment is unlikely to be of major benefit unless her mood becomes significantly worse. Her physical condition, however, has deteriorated in the past year and the reason for this is unclear. Her physical problems are making it more difficult for her to cope. The doctor will need to consider why her walking is more difficult and whether there is any intervention (e.g. physiotherapy) from which she may benefit. From a psychological perspective, different strategies may help. There is some suggestion that her thought patterns are developing into a negative spiral in relation to her son (she gets down through caring for her son→she feels angry and frustrated with his teachers→she feels guilty at not being able to cope and having to put her son in respite care→she feels more depressed) and a cognitive approach may be very useful. She also has very clear and specific problems that may seem insurmountable to her, but which could be broken down into smaller problem areas, which she may then be able to tackle. Finally, there are relationship issues. Although she describes a happy marriage, Sarah feels that the main responsibility for caring for her son rests with her. She appears to get little practical or emotional support from her husband. This would be an important area to explore with her and see whether the balance of care for her son could be more equally shared between herself and her husband. Finally, there may be deeper psychological issues that she may or may not want to address. It is not unusual, for instance, for the parents of children with disabilities to feel guilty and in some way to blame. In addition, Sarah's early life may have been disrupted by frequent hospital admissions and treatment for her physical disabilities. This may have affected her emotionally and may be having an influence on her abilities to cope with adversity as an adult.

CONCLUSION

The development of effective treatments in primary care for medically unexplained symptoms and psychiatric problems associated with physical illness is still at a relatively early stage. Most psychological treatments in the primary care setting appear to be less effective than they are in the secondary care setting, and similar in their effectiveness to counselling. They have some advantage over usual GP care, but the results are not dramatic and they do not appear to be long-lasting. However, service users value psychological treatment interventions, including counselling, and it is probably unrealistic to expect that brief interventions should have long-term benefits over many years. They do, however, have an impact in the short term and the importance of this should not be minimised. Pharmacological treatment may also be of benefit but the evidence in primary care is again weak. Antidepressants are probably over-prescribed, but this does not mean that they should not be prescribed in appropriate circumstances.

Part III
Practitioner

9. Training

CHAPTER SUMMARY

- Communication skills are an essential component of undergraduate training.
- Medical undergraduates should be taught to incorporate brief questions about psychological issues in routine history-taking.
- Postgraduate training needs to be 'hands on' with good supervision from experienced GPs.
- GP registrars should be encouraged to adopt an open and responsive attitude to patients' wishes, as well as a willingness to examine their own practice on a regular basis.
- Trainees in psychiatry should be encouraged to gain experience of working in primary care, for example by using special interest sessions.

In this chapter we outline the key skills and competences that we believe all doctors should possess to be able to help those with a combination of physical and psychological problems. The basics should be introduced during the undergraduate training and then refined and developed further at the postgraduate level. Most of these skills are already taught to a greater or lesser extent during medical training. However, there is a tendency in most undergraduate medical courses to compartmentalise subjects, so that psychological issues are only considered when studying psychiatry and medically unexplained symptoms are rarely or inadequately covered.

UNDERGRADUATE MEDICAL TRAINING

There has been a much greater emphasis on the teaching of communication skills during undergraduate training in the past 10 years. Basic history-taking competences are essential, but medical students also need to be able to elicit their client's ideas, concerns and expectations about their illness or symptoms. From the earliest stages of training, students need to establish a patient-centred view through understanding the experience of illness from the patient's perspective. In addition, and in view of the very high prevalence of psychological distress in those with physical illness, students need to incorporate brief questions about psychological status and coping strategies in their normal history-taking practice.

CONSULTATION SKILLS

Medical students should acquire basic competence in the following skills in addition to basic history-taking:

- establish and maintain respectful and trustworthy relationships with service users and their carers
- produce accurate information about their problems through active listening skills
- elicit their ideas, concerns and expectations about illness
- increase understanding of the person's constructions and models of illness
- pick up psychosocial cues (both verbal and non-verbal) in a sensitive and helpful manner
- detect symptoms of mood and anxiety (if relevant) in the context of a normal medical assessment
- identify basic coping strategies
- accurately assess suicidal risk (if relevant) in the context of a normal medical assessment
- tailor explanations of illness according to the person's model of illness
- check that their explanations are understood
- understand cultural influences
- learn to adopt different styles to suit different people.

In addition, all training for health professionals should include the basic competence in the assessment of people's mental health.

PROFESSIONAL DEVELOPMENT

Mental health issues are particularly challenging to clinicians because clients are often frightened and emotionally vulnerable. This can be expressed in a wide variety of ways – they may conceal symptoms, make emotional demands on professionals, need a lot of time and explanation and also seek attention in ways that can sometimes be self-destructive and make helping them difficult. In addition, doctors themselves may experience strong feelings towards patients, which may make them ashamed or confused.

To support doctors, we need to enable them to be emotionally open but also strong and to teach them how to avoid both over-involvement (which can be abusive) or denial and withdrawal. This involves learning methods such as case supervision which enable students and junior doctors to develop insight into their personal impact on their relationships with patients and to become more aware not only of what is said during a consultation, but also of what is not being said. We also need to foster a culture in training that models the best of the medical values, including professionalism, service, duty and care, but also recognises the changes in power in the doctor-patient relationship over the past 30 years. We should encourage openness and responsiveness to patients' hopes wherever possible, and a willingness to examine our own practice on a regular basis. We should also ensure that training includes a focus on affective as well as cognitive areas of learning.

STIGMA AND PREJUDICE

Psychological symptoms are still experienced or thought of by many members of society as being stigmatising or a sign of weakness. Such

attitudes have no place in a modern medical curriculum and are damaging if they are perpetuated. Both tutors and students need to explore their own reactions to psychological ill health and to practise responding to patient concerns in this regard. Using expert patients and simulations or role-plays can be a highly effective way of bringing the 'patient' voice into training, but still allowing learners to be open about their own concerns and areas of perceived 'weakness'.

PSYCHIATRY AND PSYCHOLOGY

Psychological aspects of physical health should be introduced at an early stage of medical training and integrated throughout the medical undergraduate course. At some stage students will need to learn about severe mental illnesses (such as schizophrenia and bipolar affective disorder), but other conditions such as depression, panic disorder, post-traumatic stress disorder, alcohol and drug abuse, and self-harm are common in the general hospital and primary care setting. Medical undergraduate training should reflect the overall epidemiology of mental health problems and the spectrum from normal variation through functional symptoms to overt pathology, rather than just focusing on the 'tip of the iceberg' dealt with by consultant psychiatrists.

Medical students should be introduced to the following conditions in the context of coexisting physical illness:

- depression, including risk assessment and different treatment modalities
- anxiety states, including panic disorder and agoraphobia
- post-traumatic stress disorder
- drug and alcohol abuse
- self-harm
- adjustment disorders
- behavioural problems, including eating disorders
- delirium and dementia.

In addition, students require a framework in which to understand complex problems, such as medically unexplained symptoms or psychological responses to physical illness. Basic knowledge of the following will be helpful:

- Leventhal's illness model (Leventhal *et al*, 1992)
- common coping mechanisms in relation to physical illness
- attachment theory
- family systems theory
- emotional expressiveness
- processes of loss and grief
- simple behavioural strategies
- cognitive theory.

These can be usefully supported by clinical examples of emerging evidence of the mind–body interaction, for instance in irritable bowel syndrome, or psychoneuroimmunology.

POSTGRADUATE LEVEL

The status of postgraduate training in the UK is undergoing constant change, but the core curriculum and skills needed to care for people are more stable. The assessments of competence and specification of what is expected of qualified GPs and others in healthcare have been extensively updated and are available for scrutiny and adaptation. At the postgraduate level, GP registrars need to focus upon problems and conditions that commonly arise in the primary care setting. They need to develop advanced consultation skills and a patient-centred approach to care. Specific psychological techniques such as reattribution skills, basic behavioural and cognitive strategies and simple problem-solving skills will all be useful in the management of individuals with a combination of physical and psychological problems. Other psychotherapeutic techniques such as transactional analysis, humanistic counselling and interpersonal or dynamic psychotherapy can also be useful.

The GP registrar will begin to develop more confidence as a doctor, with the ability to reflect more on personal practice and his/her own role in the doctor–patient relationship. This will require some understanding of one's inner self and the particular kinds of patient problems or stressors that evoke anxiety or defensive responses. Greater time should be spent considering the 'doctor as a person' and the effect this has on both individual care and overall services.

TRAINING

GP registrars need to receive an appropriate practical experience and supervision from experienced GPs. Trainees will see many individuals with a combination of physical and psychological problems during their training in general practice and in the general hospital. Ideally, some consultations should be videotaped and reviewed with a supervisor who has a good grasp of the core theoretical and clinical approaches to the management of such problems. Finding individual supervision may be difficult, as many of the skills involved in the management of people with physical and psychological problems are not widely disseminated. If there are good community links, it may be possible to receive supervision from a local liaison psychiatry service, which should secure input to their local GP vocational training schemes where group tutorials can provide a cost-efficient alternative to individual supervision.

GP registrars can choose to spend 6 months of their training in a general psychiatry post. However, if they do this, they are likely only to see service users with severe mental illness and they will have little contact with and experience of people with other mental health problems. Changes in the provision and organisation of mental health services have meant that most general psychiatry posts focus on severe mental illness to the exclusion of most of the other problems. We suggest that a 6-month post in liaison psychiatry, preferably with some community experience, would

be a more suitable training experience for GP registrars, and this would be an excellent post to include either in specialist training or even in the early foundation years. During such a post, trainees are likely to gain experience in the assessment and management of a wide variety of individuals, including those who:

- self-harm
- develop physical problems as a result of substance misuse
- develop acute confusion in the context of physical illness
- have medically unexplained symptoms
- have a psychological reaction or difficulty adjusting to physical illness
- lack capacity to give informed consent to medical or surgical procedures.

Such posts would be equally valuable for those undergoing psychiatric training, where trainees have fewer opportunities to gain skills in the assessment and management of common psychiatric conditions such as depression, anxiety states, post-traumatic stress disorder and self-harm.

General practice placements in old age psychiatry already exist and offer greater experience of the psychological/physical interface than general psychiatry and are more community-focused.

Psychiatric trainees can also benefit from placements in general practice or special interest sessions in primary care.

CONCLUSION

Although much has been done in the past 10 years to improve the amount and quality of training that medical undergraduates receive in communication skills, most GP registrars will need to continue to work on their skills, particularly in effective listening and communication with service users who present with physical symptoms. General practice placements in liaison psychiatry services for working-age and older adults will provide GPs with a broad range of skills necessary to work with individuals with physical and psychological problems in primary care.

FURTHER READING

- Riley, B., Haynes, J. & Field, S. (2007) *The Condensed Curriculum Guide for GP Training and the New MRCGP*. Royal College of General Practitioners.
- Tooke, J. (2008) *Aspiring to Excellence: Final Report of the Independent Inquiry into Modernising Medical Careers*. Department of Health.

USEFUL WEBSITE

www.rcgp-curriculum.org.uk/educational_resources.aspx

10. Looking after yourself

CHAPTER SUMMARY

- Work-related stress in general practice may arise, for example, from the contact with some of the service users and from organisational problems of the doctor's own making.
 - Denying work-related stress is a relatively common reaction among doctors.
 - When having problems at work, doctors should seek appropriate help and support.
-

'There is something about a cupboard that makes a skeleton terribly restless.'

Anonymous

Consultations can be very stressful for doctors, especially consultations with individuals who have psychological or psychiatric components to their physical illness and particularly for doctors who tend to have a biomedical or purely physical approach to their own symptoms. Doctors' work-related stress also affects service users, therefore it is essential that it is recognised and dealt with. A prolonged stress can develop into 'burn-out', a syndrome of emotional exhaustion, depersonalisation, low productivity and feelings of low achievement.

HOW TO RECOGNISE YOUR OWN STRESS

The signs we should all look out for include the following:

- poor concentration and time-keeping
- low productivity/efficiency
- difficulty digesting new information
- feeling uncooperative, irritable and aggressive
- increased mistakes
- resistance to change
- physiological changes: poor sleeping, changes in eating patterns, etc.

The sources of stress in general practice may be service users themselves, but also organisational problems, such as overbooking, opening surgeries late, making insufficient allowance for extra service users and responding to inappropriate interruptions such as phone calls (Simon *et*

al, 2002). Arranging other commitments due to start very shortly after the anticipated end of surgery can also introduce additional time pressures into the consultation.

Denying stress, however, is a relatively common reaction among doctors. They say that they get 'too involved' in their patients' problems and may 'take them home' with them or 'get wound up' by demanding (or 'heartsink') patients. It is difficult in such circumstances to provide the appropriate level of care.

LOOKING AFTER YOURSELF ('PROFESSIONAL ARMOURING')

Adler (1970) described 'helplessness in the helpers' as a situation in which his helplessness with a patient caused him to summon up the image of the omnipotent teacher who would have no trouble in dealing with the patient. This resulted in feelings of depression or anger after his own attempts to carry out the fantasised intervention had failed. Individuals with psychological components to their physical illness can become 'problem' patients and evoke strong feelings in their doctors, like 'angry impotence' (such as that experienced with 'heartsink' patients) and a frustration arising from the fear of opening the Pandora's box and consequently being overwhelmed with problems (Corney *et al*, 1988; Mathers *et al*, 1995). Recognising such feelings in oneself and accepting that they are common reactions in many doctors is an essential first step in looking after oneself when dealing with service users. Sharing such feelings with colleagues and partners can help to reduce their power over us and the likelihood that they will be acted out. Doctors may have learnt at medical school that such feelings are inappropriate or unworthy in dealing with patients and as a result they may feel that the best coping strategy is denial. However, such 'professional armouring' leads only to more isolation, suffocation and job stress.

Recognising and using such feelings (but not acting them out) can be helpful in difficult consultations with individuals with whom doctors feel helpless or powerless – some of the anger or frustration the doctor is experiencing may be coming from the patient. Such insights can enable doctors to manage their own emotions when confronted with what may sometimes feel like an emotional onslaught. Denying one's own feelings or their usefulness in consultations is unhelpful to both patients and ourselves – emotional skeletons will always make themselves heard eventually.

Some service users will remind us of people we know – relatives, colleagues or other patients. When the person reminds the doctor of someone they dislike, they may experience the negative feelings (e.g. anxiety, frustration, inferiority or antagonism) that are aroused by those others and unwittingly transfer them on to the patient (Neighbour, 1996).

Dealing with these negative reactions can be difficult unless we recognise the inappropriateness of our response. To do this we need to develop our self-awareness and learn how to gauge our own reactions to patients. One way of doing this is to share our feelings about patients with others in a supportive environment such as a doctors' support group or a Balint-type group.

Asking such questions as 'When else have I felt like this?' or 'Who does this person remind me of?' can enable one to begin to address the issue. It is often enough just to ask these questions 'out loud' to be able to consciously deal with the issues in future consultations. If, however, these troubling feelings persist when the person consults, it can be helpful to write

down some of the differences between them and the person of whom they remind you.

A related problem to transferring our feelings to a particular service user is stereotyping – ‘When you’ve seen one, you’ve seen them all’. This is particularly likely to happen when doctors have strongly held attitudes towards identified groups, such as those with deeply held beliefs, sexual preferences or from an ethnic minority backgrounds. It may be outright prejudice based on deeply held beliefs or a way of simplifying the complex realities of individual patients. Such stereotyping has no place in the consultation and will not only be difficult for both doctor and patient but will also prevent the diagnosis and appropriate interventions being undertaken (Neighbour, 1996).

The first step in dealing with this is honest recognition of the problem and the sharing of these attitudes and beliefs with supportive partners and colleagues. Doctors may need to learn to distinguish between their ‘personal’ and ‘professional’ egos. Although one may feel very comfortable with one’s personal attitudes (personal ego) and find them very difficult to change, one’s professional ego can and should be addressed. During the consultation doctors assume their professional role, which requires them to be impartial to their patients regardless of where their sympathies lie. On the other hand, if the disparity between one’s personal and professional roles is significant, this can create considerable stress. Toon (1999) has described the ‘virtuous practitioner’, one that espouses the values of faith, hope and charity. He goes on to suggest that we can become virtuous by practising virtuously – these values can become part of the consultation repertoire, if one acts as if they were already inherent to one’s professional behaviour. Service users will usually help doctors to help them, provided we are open to their feelings and meticulous in our observations.

EMOTIONAL CUES

When a person offers emotional cues in a consultation doctors need to recognise that these feelings have originated in the patient rather than from within ourselves – distinguishing between the feelings that ‘belong’ to us and those that ‘belong’ to the patient is an important skill that can be developed and used to help the patient. For example, if a person is clearly distressed and unable to find their words when first addressed, a simple reflective statement, such as ‘You are full of tears this morning’, can be very helpful. Such a statement can encourage the person to share their distress by giving three messages:

- 1 encouraging them because the doctor recognises how they feel
- 2 recognising that it’s OK to feel like that and we accept their feelings
- 3 we have created an opportunity for them to share those feelings if they wish to do so.

In this case, the boundaries are quite clear in that the feelings of distress belong to the patient rather than the doctor. However, if a person becomes angry with the doctor, they may start to feel some of the angry feelings that the person is clearly experiencing. At this point in the consultation, the doctor has a choice:

- 1 ignore the person’s feelings, pretending they don’t exist

- 2 allow the angry feelings to grow and act them out, in turn becoming angry with the person
- 3 recognise that those angry feelings originate in and belong to the other person, in which case a simple reflective statement such as 'I find it very difficult to talk to you when you're so angry' can be helpful.

Similarly, when after a good day we suddenly become lethargic, hopeless and dispirited during the course of one consultation, it may well be that those feelings have originated in the patient. Recognising and using such feelings arising in ourselves can be very helpful diagnostically, if there is a difference between what the person is telling us and the feelings that they engender in us. Using further simple reflective statements may bring the person's feelings to the surface. For example, saying to them 'You seem to have run out of energy this morning' can elicit symptoms clearly suggestive of depression.

The more in-depth discussion of such psychotherapeutic skills outlined here is beyond the scope of this text – we recommend *Forms of Feeling* by R. F. Hobson (1985) and *Individual Psychotherapy and the Science of Psychodynamics* by D. Malan (1995).

Becoming 'emotionally literate' can be very helpful in understanding and recognising the causes of doctors' own work-related stress. For example, if the doctor is a parent themselves, seeing a mother who brought to the consultation her seriously ill child may engender feelings in the doctor that properly belong in their own family rather than this consultation. Sharing our feelings for the child with the mother may be particularly unhelpful in such circumstances – panic and distress are both infectious. However, a simple statement of reflective understanding can be very helpful (for example 'I've got children of my own and it can be very worrying when they're ill').

Other ways of looking after oneself and reducing work-related stress usually involve ways of restoring some control to consultations and professional lives in the face of an overwhelming emotional demand. Such measures include developing specific skills for use with individuals who provoke an emotional response in us and changing the way we think about particular service users. For example, a simple act of de-stereotyping by looking for the features of the person in a consultation that do not fit with one's own prejudices and expectations can help one to start on the process of challenging one's own assumptions and the way one interacts with particular service users. In terms of skill development, the use of the reattribution model (Mathers & Gask, 1995) or other psychotherapeutic techniques can help one to deal with individuals who have associated psychiatric and/or psychological aspects to their physical illness.

CONCLUSION

Ian McWhinney (2000) has come to see medicine as complex, context-dependent, poignant and a reflection of the human condition. He invites doctors to be open in the face of suffering and to follow the eastern medicine traditions with their emphasis on listening. He points out that we are too often tempted to 'shy away from suffering' because we are driven by our unexamined egocentric emotions – fears, helplessness, self-interest, likes and dislikes. Also, it is so easy to turn away when we are protected by those defences by which we justify ourselves. It is this 'lack of openness in the

face of suffering that closes off compassion and stops us from being healers'. We need to achieve a 'detached involvement' and for this we need self-knowledge, emotional intelligence and peace of mind (McWhinney, 2000).

USEFUL WEBSITE

<http://familymed.musc.edu/> (Balint groups)

11. Inter-professional teamworking

CHAPTER SUMMARY

- Optimum care in general practice for individuals with psychiatric and psychological components to their physical ill health requires effective teamwork.
 - The General Medical Council's (GMC) guidance (1998) on maintaining good practice states that one of the key tests of a good team is that members can be 'open and honest about their professional performance', both together and separately.
 - Characteristics of high-quality inter-professional collaboration and teamwork include: a shared vision, clear shared objectives, mutual support, effective participation, task orientation, appropriate management structures and support.
-

Primary healthcare teams have a wide range of skills and resources that can be mobilised to help the service user. The development of a 'therapeutic triangle' of a doctor, a service user and a counsellor can be particularly beneficial if the counsellor has skills complementary to those of the doctor. Discussions between the doctor and the counsellor before the referral of the service user can be very helpful in establishing the roles, responsibilities and boundaries in the person's care. Similarly, if the person agrees, the feedback from the counsellor to the doctor and the coordination of their care of the person, who may continue to see both professionals on different occasions during the therapy, can also be very helpful.

Other members of the primary healthcare team – nursing staff (including midwives and district nurses), physiotherapists, occupational therapists and social care professionals – can also play an important role in patient care. However, in practice often the professionals with whom the doctors work and collaborate are simply the people who happen to be there (McWhinney, 1997). For effective teamwork, one should not only pay attention to the principles of high-quality inter-professional collaboration, but also focus on team-building activities. All teams should meet frequently and regularly to discuss service users and review the team's functioning and the support that members give one another. Both good communication and individual support are vital for effective teamwork.

INTER-PROFESSIONAL COLLABORATION AND TEAMWORK

The characteristics of good inter-professional collaboration (West, 1997) are similar to the requirements for good teamwork (Headrick *et al*, 1998). The attributes cited by West with the literature on successful teams both in and

out of healthcare are compared in Table 11. In the care of individuals with psychological symptoms in physical illness, collaboration (with the wider team) and teamwork (with the core team) are clearly essential.

Table 11 Characteristics of high-quality inter-professional collaboration and teamwork

Collaboration	Teamwork
Attainable, evolving shared vision	<ul style="list-style-type: none"> • clear direction • engaging and motivating mission • goals and objectives are stated, restated and reinforced • member roles and tasks are clear and known
Clear, shared objectives	<ul style="list-style-type: none"> • respectful atmosphere
Mutual support	<ul style="list-style-type: none"> • responsibility for team success is shared among members • member participation is balanced appropriate to task at hand • conflict is acknowledged and processed • goals fit organisational goals
Effective participation	<ul style="list-style-type: none"> • achievable task • clear specifications regarding authority and accountability
Task orientation	<ul style="list-style-type: none"> • regular and routine communication and information-sharing • well-resourced environment • ongoing testing of assumptions
Information and appropriate management structures	<ul style="list-style-type: none"> • mechanism to evaluate outcomes and adjust accordingly
Support for innovation	

Headrick *et al* (1998).

The GMC states that one of the key tests of a good primary healthcare team is whether members can be 'open and honest about their professional performance' both together and separately – a prerequisite for this is a willingness by all team members to engage directly across boundaries that may have long been impermeable (GMC, 1998). This requires a cultural shift in members' attitudes towards one another and substantial changes to undergraduate education in both clinical and classroom settings (Finch, 2000). A good place to start is by agreeing common goals with other members of the team – this can be a very difficult process but is substantially helped by ensuring an explicit focus on the service users' needs.

BARRIERS TO INTER-PROFESSIONAL COLLABORATION

Some of the barriers to inter-professional teamwork in patient care are outlined in Box 14. Two areas that need particular attention when dealing with individuals who have psychological components to their physical ill health are language barrier and differences in clinical responsibility between team members, especially where doctors are primarily orientated towards a biomedical (physical) approach. Counsellors, for example, may challenge the concept of somatisation and the manifestation of psychological distress through physical symptoms because of their different theoretical orientation.

Other counsellors may focus primarily on the emotional agenda to the exclusion of the physical symptomatology and, in turn, doctors may be supportive of the biomedical model and limit their interventions to the physical symptoms.

What is required from all members of the team in these circumstances is a commitment to an integrated model of care – integrated not only in terms of addressing the philosophical issues of a mind/body split, but also in terms of the practical coordination of the approaches of the different team members to the patient. For example, doctors usually refer to service users as patients but counsellors refer to them as clients (as do some other members of the primary healthcare team). This illustrates not only different professional views of the power relationship between the professional and the patient/client but also the difference between the health professional as expert and the 'expert' patient (Muir Gray, 1999; Department of Health, 2001b). The latter can become an expert in their chronic illness through partnership and shared decision-making.

Box 14 POSSIBLE BARRIERS TO INTER-PROFESSIONAL COLLABORATION

- differences in personal history and culture
- past inter-professional and intra-professional rivalries
- differences in English language proficiency and jargon
- differences in schedules and professional routines
- varying levels of preparation, qualifications and status
- different requirements, regulations and norms of professional education
- fears of diluted professional identity
- differences in accountability, payment and rewards
- concerns regarding clinical responsibility

Headrick *et al* (1998).

Apart from the team members' different approaches towards the patient/client that result from their different models of care and philosophical orientation, a number of other issues need to be addressed for optimal patient care, such as rivalry and bureaucracy, which require explicit attention by the team (Owens *et al*, 1995). An 'emotionally safe' environment needs to be provided for discussion and above all for the development of mutual respect for the different skills and expertise that each member brings to the team. Poor teamwork with uncoordinated and inconsistent approaches by different team members towards the service user can encourage the development of medically unexplained symptoms – when, for example, a team member appears uncertain and unable to provide an explanation of symptoms to a patient or when a patient does not have his/her concerns about a particular explanation of their symptoms addressed appropriately.

In addition, the failure by one team member to ensure that the person feels understood and that all team members believe their symptoms to be genuine may also reinforce their belief that they cannot be helped. General reassurance without an explanation, as well as ambiguous or contradictory advice, are unhelpful as they may enable some individuals to antagonise team members against one another. Repeated investigation and different treatment plans should be avoided as far as possible (Mayou & Farmer, 2002).

Corney *et al* (1988) identified three attitudes often associated with 'difficult' patients (defined as individuals with problems whom doctors find it difficult to manage), which may also be experienced by team members with individuals who have psychological aspects to their physical illness:

- 1 a professional feeling of a lack of 'control' grounded in frustration
- 2 a feeling that somehow a stalemate had been reached and it is no longer possible to help the person
- 3 a fear of opening the Pandora's box associated with the person and being overwhelmed with insoluble problems.

Two methods can be useful in helping the team reassess such individuals: gathering information from team members with different perspectives and sharing observations of the person's behaviour under different circumstances. Box 15 is adapted from the simple problem-solving scheme that is recommended for use by individual practitioners when 'unsticking' the doctor-patient relationship. It can be useful as a guide for the discussion of a case by members of primary healthcare teams.

Box 15 A GUIDE FOR TEAM DISCUSSION OF A CASE

- What is the precise problem with this patient/client?
- What do we want and what can we achieve with this patient/client?
- What key sources of support are available to us? Has the time come for the patient/client to be referred? If so, to whom?
- What sources of relevant training in these issues do we have? Can we make use of them?
- Are the expectations that we have of ourselves and the patient realistic or unrealistic?
- Are we guilty of undervaluing what we have achieved so far?
- What is our agreed plan of action now?

Adapted from Mathers & Gask (1995).

CONCLUSION

Primary healthcare teams need to work collaboratively and effectively. As more specific services develop for particular patient groups, GPs may work as members of several different teams. Principles of good teamworking will apply whatever the circumstances.

12. Referral to specialist care and developing services

CHAPTER SUMMARY

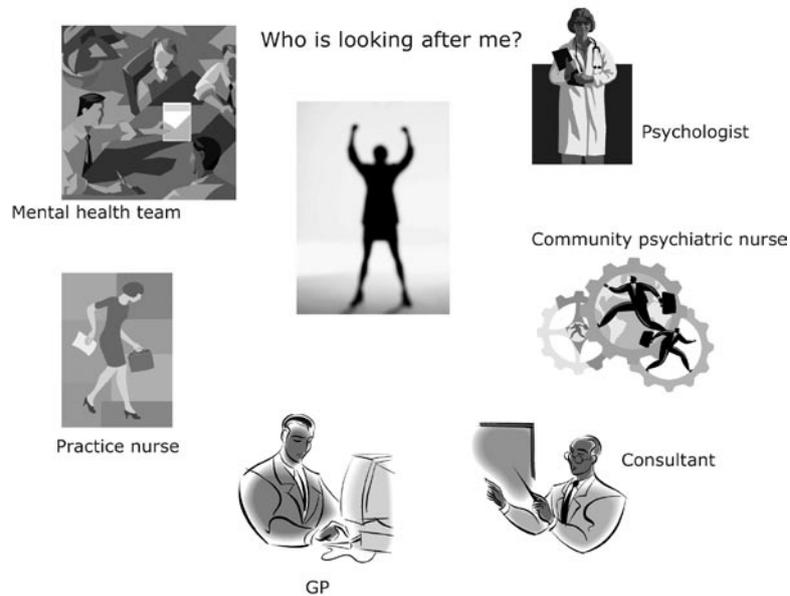
- One of the greatest challenges for clinicians is using services appropriately to help their patients the most effectively.
 - Doctors need to be very specific with anyone to whom they refer the patient.
 - It is worth keeping in touch with the patient by follow-up appointments and phone contact.
 - Appointing a key worker or a named person/people from the practice may be useful to lead on discussions for each patient.
 - Written letters (emails) may be very valuable, as they may help to follow the events and explanations with the patient.
 - Explaining the reasons for referral in the referral letter may help to avoid false expectations, giving clear positive indications of what a given test or treatment can achieve, while reminding the person of how the mind can affect the body's functions and *vice versa*.
 - Speaking personally to the referrer may be more productive than writing them a letter.
-

This chapter focuses on key general principles of managing care and the expertise that you may wish to draw on (including liaison psychiatry). We will consider how current services for mental health in the NHS in England may most effectively be commissioned and developed to avoid therapeutic disruption.

MANAGING REFERRALS

When a strong therapeutic relationship has been established between the doctor and the patient, referring them for further consultation may be difficult as they may easily feel rejected or vulnerable. This may be even harder if this relationship is dysfunctional or when the doctor's understanding of the nature of the problem differs substantially from the patient's – for example, if they think a referral to a neurologist is important where the doctor wishes to refer to a psychiatrist. A patient may get lost in the system and their care may be fragmented by the need to see a number of different staff (Fig. 4). Finally, a carefully balanced description of how the mind and body interact can unintentionally be destroyed by other staff of different expertise (Case study 6).

Fig. 4 Different healthcare workers who can become involved with a patient with physical and mental health problems



CASE STUDY 6

A 64-year-old male patient with known ischaemic heart disease is admitted from general practice after 3 days of increasingly severe chest pain. The referral letter says:

'I do not know this gentleman well as I am doing a locum for his regular GP. The records show that since his heart attack he has been seen quite frequently, with complaints including fatigue, dyspepsia, recurrent chest pains in the left parasternal area and poor sleep. I understand from his wife that he has been rather depressed, but that the tablets given to him by the GP did not suit him. For the past 72 hours the pain has been rather different and although his BP, pulse and heart sounds are normal and a resting electrocardiogram (ECG) ditto, I cannot exclude crescendo angina and so am admitting him for your opinion and swift management as appropriate.'

The patient is seen by the triage nurse, the senior house officer and the senior registrar in an accident and emergency department and because of equivocal changes on the ECG is sent on to the coronary care unit. There he is seen by a number of different doctors and nurses, all of whom explain to him that he is there while they rule out a further heart attack. However, he overhears one of the junior doctors telling the charge nurse that his GP has been treating him for depression and that his pain may be 'overlay'. When his wife comes to visit, he is very upset and tells her that he always thought the GP believed him when he told him about the pains in his chest. In spite of her attempts to reassure him, he remains distressed that the doctor 'thought it was all in his mind'. On the ward round the next day, he asks the consultant whether he thinks the pain is real or not and the consultant says, 'Of course your pain is real, we just aren't quite sure what is causing it yet, but there is no evidence of a further heart attack.' On discharge 2 days later, the junior doctor suggests he might benefit from some counselling to help him get over the shock of his recent illness and writes a referral to the community mental health team. The man does not attend.

GUIDING PRINCIPLES

The core communication principles are as before – transparent dialogue following and exploring the patients’ and carers’ understanding. In particularly challenging cases, where individuals have multiple symptoms, it may be worth being very specific with whomever the patient is referred to, stating exactly how the situation has been explained to the patient so far. Follow-up appointments and phone contact, as well as written records (letters, emails) of primary care treatment, are important for continuous care. Also, appointing a key worker/workers for each patient may be useful, a practice more common in mental health than in other disciplines.

Explaining your reasons for referral may help to avoid false expectations:

‘You know we talked about stress and excess acid secretion. Well, a lot of acid for a long time can cause an ulcer so I think we need to know whether that’s the cause of your pain or not.’

Being clear about expectations of your colleagues when referring for assessment is also important:

‘I would be grateful if you could advise me about the management of Jeannette’s eating problems and her tendency to self-mutilate, which is becoming more frequent and severe. She is already seeing our practice counsellor and it may be that the exacerbation of her symptoms is related to a difficult stage in her therapy. In view of her current engagement with our therapist, we are referring for a psychiatric opinion and advice on drug treatment, rather than psychological intervention *per se* (etc.).’

THE SPECIALIST ROLE OF LIAISON PSYCHIATRY

One of the grave difficulties of the current service configuration is that there is often both too much and too little on offer for individuals with significant mind–body problems. By the time they have been seen by a gastroenterologist (to rule out colitis), a physiotherapist (for their stiff back and joints), the neurologist (to exclude a brain tumour), various GPs and nurses and a selection of self-referred therapists for possible dietary allergy and acupuncture, their illness behaviours may be quite entrenched. Working their way through the mental health team may not be much simpler! Apart from the GPs, the key workers in the NHS whose role is to manage the mind–body interface in mental illness are liaison psychiatrists. This is not a universal service in the NHS for England, but one assessment appointment may prevent numerous others. Psychiatrists will be able to make a full diagnostic assessment and advise on the best use of local mental health services. They can also help the GP decide which ‘physical’ referrals need to proceed and, as experts in liaison, their ability to explain the situation to patients and their families is likely to enhance rather than undermine the GP’s own attempts. They may see the patient with their GP to improve communication across the primary/secondary care interface. Most liaison psychiatrists are currently hospital-based but as services for users with chronic and complex problems become more based in the community, the rationale for having liaison services with a greater community focus will increase.

CRITERIA FOR REFERRAL TO A LIAISON PSYCHIATRIST

Consider referring to liaison psychiatry if first- or second-line interventions for individuals with both mental and physical problems have failed to be of benefit. For those with medically unexplained symptoms, interventions are most likely to be of help when the symptoms have existed for less than 2 years. Referring individuals with more chronic problems is entirely appropriate but the aim for the liaison service would not be to cure, but to provide advice about appropriate management and to try to work with GPs to limit healthcare contacts to those appropriate and helpful for the individual. More intensive treatment could also be offered, provided that appropriate resources were available. Individuals with chronic physical illness and depression or anxiety symptoms that have not responded to treatment should be referred to the liaison psychiatry service, particularly if there is concern about possible drug interactions (e.g. using combinations of antidepressants in a person on anti-viral treatment for HIV). Individuals with chronically painful conditions (e.g. pancreatitis) who have become dependent upon large and inappropriate amounts of analgesia can also be helped by liaison services. Individuals with schizophrenia or bipolar affective disorder are best managed by conventional community mental health services.

PREPARATION FOR REFERRAL

Before the referral to liaison psychiatry or other mental health services, a person should be identified in the practice to prepare the individual and make the necessary arrangements. The nominated person should discuss with the patient the difficulties inherent in dealing with their particular chronic illness and the expertise of the services to which they are being referred. It is important to avoid any suggestion of rejection and to emphasise the continuing support from primary care – in a perfect world, the specialist/liaison psychiatrist would conduct a joint consultation in the practice with the nominated lead team member.

COMMISSIONING SERVICES

The Department of Health (1999) prioritised the care and development of services for people with severe mental illness (i.e. schizophrenia and bipolar affective disorder). However, there was no incentive for mental health trusts to provide mental health services for individuals with physical problems. Equally, there has been little incentive in government targets for acute trusts or primary care trusts to develop mental health provision for service users with physical problems. The National Service Framework for Older People (Department of Health, 2001a) made reference to mental health needs of older people with physical illness, but services have been slow to develop in this area.

However, more recently there has been greater interest in the psychological welfare of the people with physical ill health – the recent *National Service Framework for Long-Term Conditions* (Department of Health, 2005) may provide an opportunity for primary care organisations to develop and focus certain aspects of mental health provision for individuals with complex psychological and physical needs (Box 16). The NICE guidelines for the management of irritable bowel syndrome in primary care refer to the psychological needs of such individuals and recommend psychological/

psychotropic treatment (including psychotherapy, hypnotherapy and cognitive therapy) as second-line interventions (NICE, 2008). The Department of Health programme of improving access to psychological therapies (2008) will provide 3600 new therapists to work primarily in the primary care setting.

Box 16 EMOTIONAL NEEDS OF PEOPLE WITH LONG-TERM CONDITIONS

The *National Service Framework for Long-Term Conditions* (Department of Health, 2005) highlights the emotional needs of patients who have a chronic illness and refers to the:

'Psychosocial and emotional effects of the condition for the individual, such as potential personality changes after a brain injury and the emotional and psychological effects of living with a longterm condition generally on the individual, their carer and family. These can include stress, depression, loss of self-image and cognitive/behavioural issues, which may lead to relationship breakdown if not addressed.'

Quality requirement 8 of the document is concerned with providing personal care and support, which includes counselling and emotional support and the treatment of depression.

Active case nurse managers now work closely with seriously ill or disabled individuals and 'manage' their care. Appropriate training, support and supervision to help these nurses manage the mental health and emotional needs of service users will be important, if high-quality community services are to be delivered.

There is to be greater patient choice through 'payment by results', which will be extended to primary care and will include individuals with long-term conditions. Although local services are often the most convenient for those with chronic and disabling conditions, services that provide the 'best' care are more likely to expand than those that take less account of users' needs.

Tier 2 services are developing and liaison psychiatry has already been successfully incorporated into some integrated clinical assessment and treatment services. This means that individuals with certain physical health problems (e.g. musculoskeletal symptoms) can rapidly access appropriate physical and mental healthcare within the same Tier 2 service.

In light of these developments, there is a strong case for all those commissioning services in England to consider the following:

- Training both generalist and specialist mental health staff in relevant consultation skills and models of reattribution (see Chapter 8).
- Training generalist staff in the detection and treatment of depression and anxiety disorders.
- Ensuring that relevant information is available for service users and their families on the information given in this booklet.
- Being aware that individuals often have both mental health and physical problems, and that the current configuration and funding of services encourages splitting and unnecessary and wasteful use of resources.
- Encouraging the development of specialist GPs with expertise in mental health problems, who can work with liaison services.

- Funding liaison psychiatry services for working-age and older adults (psychological medicine service) for advice on more severe problems individuals encounter with mind–body problems. Such a service, in addition to liaison psychiatrists, should include a range of health professionals, including nurse therapists trained in behavioural and cognitive therapies, psychologists (clinical and health) and physiotherapists trained in behavioural techniques. The advantage of commissioning a team that can work closely with practices over a specific area is that this avoids the disjointed and inefficient referral processes that can often occur with those who have both physical and mental health problems. Such a service could also span the primary/secondary interface to reduce unnecessary referral and investigation by secondary services.

CHILDREN AND ADOLESCENTS

Young people with persistent medically unexplained physical symptoms are perhaps luckier than adults, as in many places they will be referred to a general paediatrician rather than the range of specialists available to adults. However, even for this age group, especially in proximity to tertiary paediatric services, referrals may have included an orthopaedic surgeon, paediatric neurologist or gastroenterologist. The concerns of parents will almost certainly be the major reason for referral and the young person themselves may feel relatively uninvolved and sometimes have difficulty contributing to the consultation. Thus the negotiation about referrals and investigations needs to actively engage the young person with their parents.

Paediatric liaison services are even more patchy in their distribution than for adults, but may be better developed around tertiary facilities, rarely with a full spread of relevant skills. Most paediatricians (and GPs) will rely on a referral to their local generic child and adolescent mental health service (CAMHS). Ideally, joint appointments with a GP and a child psychiatrist, or a paediatrician and a child psychiatrist (or other experienced CAMHS professional), should be arranged and it is always worthwhile to ask whether this is possible. The *National Service Framework for Children* (Department of Health, 2004) has made paediatric liaison services an area for development and it is important, while services are resourced and developed, to clarify local arrangements. Many CAMHS services will have clinicians with an interest in this area and some will already have developed integrated teams with input from child and adolescent psychiatry, psychology, nursing and sometimes child psychotherapy, to address liaison issues.

OLDER ADULTS

Liaison services for older adults are patchy and focused on secondary services. However, the *National Service Framework for Older People* (Department of Health, 2001a) and a report by the Royal College of Psychiatrists (2005) have highlighted the need for joined care in relation to physical and mental health problems in the elderly. A large proportion of liaison work carried out in the general hospital involves elderly people as the majority of people admitted to acute hospitals are over 65 years of age.

Many elderly people with complex needs require detailed discharge planning with the full involvement of primary care services.

CONCLUSION

The focus of this report by the joint working party from the Royal College of Psychiatrists and the Royal College of General Practitioners has been to encourage an integrated model of care for individuals with physical and emotional problems. This is very much in line with current government policy, which states that

'assessments of community care needs should be holistic, determining the person's overall level of need by taking into account their physical, cognitive, behavioural and emotional requirements and what support they need to participate in society and to fulfil family roles.' (Department of Health, 2005)

The success of this laudable aim will depend to a large extent upon GPs and other members of primary care and community teams. We hope that this report will be of help, not only to GPs in training, but also to other health professionals who work on a daily basis to improve the lives of people with physical and mental health needs.

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