Somatic Symptoms and Psychiatric Disorders

Management of unexplained somatic symptoms in general and dental hospital settings

Sir,

We read with interest the article on somatic symptoms and psychiatric disorders by Gada and Shah (2004). Psychiatrists differentiate the various clinical presentations into specific diagnostic categories such as somatization, neurasthenia, depression, generalised anxiety, panic, phobia, adjustment disorders, etc. The recognition of the different syndromes and the implementation of specific management strategies are complex processes.

Patients with distressing physical symptoms, without known medical causes, also frequently present to physicians working in general medical and dental hospitals. However, these patients usually have milder and less complex forms of psychiatric disorder, which are difficult to differentiate into the classical psychiatric syndromes as these individuals often have mixed presentations. In addition, the reality of general hospitals requires management strategies, which are simple and brief. Consequently, a completely different approach is required to manage such patients. Doctors who deal with such patients in busy medical, surgical or dental practices need to be provided with an alternative approach that consists of a simple model of management that is practical and appropriate for their setting. Training programmes in psychiatry for medical students, physicians and dentists should emphasize such an approach, which will empower physicians in general practice, to manage these frequently encountered psychiatric problems.

A simple protocol to manage unexplained somatic complaints in medical and dental practice (Jacob, 2004) has been successfully employed in primary care and taught to physicians, medical students and psychiatrists at the Christian Medical College, Vellore, India, for the past 6 years. It is based on the reattribution model” and on available literature on the subject (Fink, 2000; Mayou & Farmer, 2002; Bass & May 2002). The steps are briefly described. The major tasks include: (i) Building a therapeutic relationship (ii) Providing reassurance and alternative explanations for symptoms (iii) Suggesting therapeutic options (iv) Offering continued support. These tasks can be broken down into 10 simple steps:

Step 1: Acknowledge distress caused by symptoms- this
provides empathy and forms the foundation for effective rapport and a therapeutic alliance to be established.

**Step II:** Elicit patient’s perspectives regarding symptoms- this strategy allows focus for examination and for specific reassurance.

**Step III:** Focussed history, physical examination and laboratory investigations- this step is cardinal in excluding medical causes of symptoms, reassuring the patient that such diseases have been excluded and in increasing patient confidence and satisfaction in the consultation.

**Step IV:** Specific reassurance about the absence of serious physical disease while simultaneously acknowledging the reality and distress of the symptoms

**Step V:** Discussing alternative explanations for symptoms for increased patient understanding of the problem. This is very reassuring when symptoms recur or persist. Such explanations can be grouped under (i) the absence of structural abnormality with presence of benign functional disturbance (ii) anxiety, depression and stress causing physical symptoms (Eg. depression lowers the pain threshold) (iii) personality and coping style where people focus on physical symptoms and reduce the importance of psychological factors.

**Step VI:** Prescribing medication. Antidepressant medication can be prescribed if depression and anxiety are present and where pain is incapacitating (Eg. headache, atypical facial pain, irritable bowel syndrome, atypical chest pain, etc). Tricylics are useful when patients also have sleep disturbance while SSRI’s for those without. People without anxiety, depression or pain can be given vitamins

**Step VII:** Recommending general psychological measures. Yoga, meditation, regular physical exercise, involvement in religious activities, hobbies and leisure are useful for those under stress.

**Step VIII:** Specific education, discussion of stress and problem solving. Education helps people with sexual misconceptions and dysfunction and those who require advice on contraception. People with difficult social situations benefit from problem-solving skills.

**Step IX:** Discuss the individual’s role and responsibility in stress reduction and improved coping.

**Step X:** Offering continued support and planning for regular review of progress is necessary.

Such protocols can be employed in busy general hospital settings. There is a need for psychiatrists to appreciate the reality of general medical settings while liaising with physicians.

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