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Training practices in reattribution for medically unexplained symptoms

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SUMMARY

Across the medical specialties, 20–40% of patients present with physical symptoms that cannot be attributed to disease. These are time-consuming, expensive and often unsatisfactory cases to manage. One strategy is to train GPs in reattribution, which is a technique that seeks to change patients' beliefs about the origins of their symptoms through psychologically based explanation. Reattribution has been shown to reduce mental disorder and health costs, and to improve function and both GP and patient satisfaction.

In this RCT, all the GPs in eight practices underwent reattribution training; eight other practices in the same areas served as controls. Researchers screened patients to identify those with MUS for at least three months. The ensuing consultations between these patients and their GPs were audiotaped and then assessed for evidence of reattribution by raters who were masked to the intervention. While the trial was powered to assess communication outcomes, clinical outcomes including service use were also measured over the ensuing three months.

From 4,483 screened consultations, 141 patients entered the trial, 66 saw GPs trained in reattribution and 75 saw control GPs. Reattribution training had a major impact on how doctors communicated with these patients, with 31% v 2% of the interviews consistent with the full reattribution model. The clinical outcomes were mixed. Patients who saw trained doctors were more likely to acknowledge an emotional cause for their symptoms, and to be more satisfied with the consultation. However, they self-rated their overall health as significantly worse. They also tended to become more anxious about their health, and to consult their GPs more often during the following three months.

OPINION

The quality of this trial is exceptional. This is a difficult area to research with many pitfalls and potential biases, but other than underpowering for secondary outcomes the design is robust.

Previous research found GPs' communication styles were resistant to change when managing patients with mental health problems, but this reattribution package was accepted and applied appropriately by most GPs who underwent training. Additionally, GPs gained confidence in managing MUS patients after reattribution training, which is crucial for the consultation to be effective.

What was unexpected was that better communication did not improve clinical outcomes. The main trends were in the opposite direction. How might this paradox arise? The authors acknowledge their reattribution package will often be either an incomplete or an inappropriate solution for MUS patients with all the complexities of an established disorder. Crucially, these patients frequently have difficulty recognising, expressing or attributing their feelings correctly. This limits the effectiveness of a technique that focuses on emotions and may undermine rather than modify patients' beliefs about their illness. This then has knock-on psychological consequences, such as greater health anxiety. The researchers propose a didactic and somatic-focused approach in future, which in effect means teaching in the patient's language of symptoms rather than translating to emotional concepts.

Developing insight as a precursor to symptom relief and behavioural change has been a cornerstone of psychotherapeutic practice. However, challenging self-awareness can sometimes take patients' thoughts and emotions in unpredicted directions, as occurred here. Perhaps progress will depend on separating patients amenable to psychological therapy from those who are not, but this may require the skills of a psychiatrist.