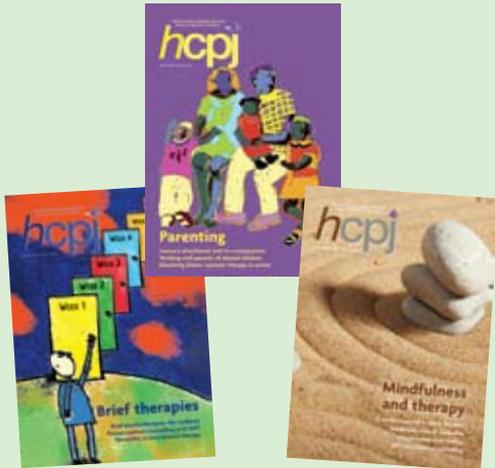


Editorial

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Up to one-third of people consulting a GP in primary care will have medically unexplained symptoms (MUS) – symptoms or signs of physical distress that cannot be accounted for by any physical disorder – as part of their problem. The financial burden of this phenomenon is huge – up to 16 per cent of the total cost of healthcare services in the developed world, excluding the run-on costs into social care, disability pensions and the wider community. There's also an emotional cost for patients, who can experience considerable frustration with the inability to achieve resolution.

Serious consideration about how to treat MUS, writes Tim Webb in our leading article, has reached its moment. Major changes in how to deploy and train clinical staff and creating a system that positively identifies and treats psychological causes of MUS is a challenge, argues Webb, but for therapists working in healthcare, developments will offer 'unlimited possibilities'.

A growing interest in MUS in medical and therapeutic circles is evident. Research is ongoing, and practitioners are coming together to discuss ways forward in best practice. In his article on tension myoneural syndrome (TMS) – a diagnosis that means that patients are told their pain is quite real, but is caused by a physical response to a psychological process rather than structural damage – Alan Gordon argues that when Dr John Sarno first pioneered the idea, mind and body were looked at as separate entities. Now, a paradigm shift in the way we view physical pain is taking place. MUS, Gordon states, will soon be part of mainstream medicine.

Teaching trainee doctors about MUS is an initiative that could contribute to this shift. Marta Buszewicz outlines her work at University College London (UCL) medical school, with sessions aimed at helping students to identify symptoms and discuss client management.

But how best to treat MUS? Richard Morriss considers the technique of psychological attribution of MUS – which shows patients how anxiety and depression might be related to bodily symptoms. Its limited success in the past, he says, may be related to the way it has been delivered. As ever, the quality of the relationship with patients is paramount – people who remain unconvinced that psychological factors play a role may be willing to entertain this possibility because they trust their clinician or therapist to act in their best interests.

Jean Penman's study, though on a small scale, potentially provides an opening for counsellors and psychotherapists, in partnership with clients, to investigate whether the approach of exploring their experience of emotion and feeling around physical symptoms could bring benefits. In an article which will be of great interest to practitioners, Penman outlines her qualitative pilot study, undertaken to explain patient stories.

There may also be openings for counsellors and psychotherapists working with MUS when it comes to commissioning services. With the current changes taking place within psychological services, practitioners are being increasingly asked to put their case to commissioners. MUS is one area they could consider. In an interview which outlines her work as a primary care psychological services commissioner, Helen Hardy offers advice on how therapists can usefully contribute to providing holistic care.

Sarah Hovington

Primary care counsellor, FHCP Executive member and HCPJ Associate Editor