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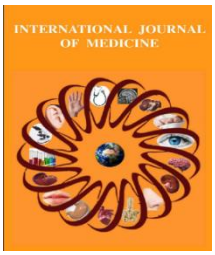

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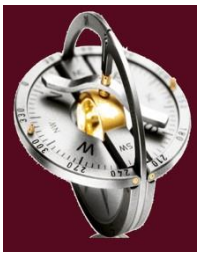

Original Research

Help Seeking Patterns in Patients with Medically Unexplained Physical Symptoms in a Medical College and Hospital In South India

Joann John[1], SJ George[2*], D Vincent[3], T Antony[4]

[1]*Assistant Professor, Department of Psychiatry, Al Azhar Medical College, Thodupuzha*
[2]*Associate Professor, Department of General Medicine, Al Azhar Medical College, Thodupuzha*
[3]*Professor, Department of Psychiatry, Al Azhar Medical College, Thodupuzha*
[4]*Assistant Professor, Department of General Medicine, Government Medical College, Konni*

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Abstract

Background: Medically Unexplained Physical Symptoms (MUPS) are very prevalent and are strongly associated with depression, anxiety and somatoform disorders. The psychiatric morbidity is often unnoticed, thereby they remain frequent attenders to health care providers. Objectives: To perform a psychiatric evaluation and study pathways of care for patients referred to Psychiatry Out- Patient Department with medically unexplained physical symptoms. ***Methodology:*** 50 patients aged between 18-60 years, with duration of illness of more than 3 months, referred to Psychiatry Out-patient department with MUPS were recruited. Following a detailed clinical interview, MINI 6.0 and selected modules of MINI Plus 6.0 were administered and pathway of care was evaluated. ***Results:*** Somatoform disorders were detected in 80% of patients, anxiety in 38%, depression in 26% and a dual diagnosis was made in 32% .Majority of the patients with medically unexplained physical symptoms consulted a doctor on first contact. The median time taken to reach a psychiatrist was 36 months (Range 12-57 months). The median time to contact the first service provider was 7 months (Range 3-24 months). More than 80% visited at least 2 service providers prior to their consultation with a Psychiatrist. ***Conclusions:*** Patients with Medically Unexplained physical symptoms are commonly diagnosed with somatoform disorders, anxiety or depression. There is a delay in the diagnosis and treatment of medically unexplained symptoms highlighting the importance of effective interdepartmental collaboration and Consultation-Liaison Psychiatry.

Keywords: *Help Seeking Patterns, Medically Unexplained physical symptoms, Somatoform disorder, Anxiety, Depression*

Introduction

Physical symptoms are the most common reason that medical help is sought for by patients. About one-third to three-quarters of the symptoms presented to a physician lack an organic pathology, and hence remain 'medically unexplained'.1,2 Medically Unexplained Physical Symptoms (MUPS) are defined as 'those physical symptoms having little or no basis in underlying organic disease3; when organic disease exists, the symptoms are inconsistent with it or out of proportion to it'. 4 The various terms used to describe majority of these clusters of medically unexplained symptoms are somatization, somatization symptoms, multiple medically unexplained symptoms, medically unexplained physical symptoms, symptom based conditions, persistent symptom syndromes, functional somatic symptoms, functional somatic syndromes etc.5 Several studies have demonstrated that the prevalence of such symptoms is high in general population and in all medical settings.6-8 It was found that atleast 33% of the symptoms were medically unexplained and these symptoms were chronic or recurrent in 20% - 25% of the patients.7

The relation between unexplained symptoms and mental health problems has been studied and it has been found that in many patients who consulted primary care physicians, mental health problems were manifested as physical complaints rather than psychological or emotional ones. Research has demonstrated that patients with medically unexplained symptoms have higher scores for depression or anxiety compared to patients with medically explained symptoms.7,9 In India, it was reported that nearly 30% of those who attended a psychiatric clinic experienced one or more somatic symptoms.

Medically unexplained symptoms are common among those who attend secondary care frequently and they occur in many specialities ,most common ones being Neurology and Gastroenterology accounting for atleast 50% referrals to these departments.10 In view of the physical nature of these complaints and as the underlying cause for these unexplained physical symptoms remain unidentified and there is minimal relief of these symptoms, they remain frequent attenders to health care providers, thereby consuming considerable medical resources to little benefit and also adding on to the economic burden on the patient and their care givers.

Address for Correspondence Dr SJ George, Associate Professor, Department of General Medicine, Al Azhar Medical College, Thodupuzha.

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Pathway of psychiatric care, is defined as the sequence of contacts with individuals and organizations, initiated by the distressed person's efforts and those of his significant others to seek appropriate help.11 In view of a paucity of studies to evaluate pathways of care in patients with medically unexplained physical symptoms, this study was undertaken.

Materials and Methods

This study was conducted in the outpatient setting of a Medical College and Hospital at Mangalore.

Sample selection:

This study was conducted between January 2014 and June 2015 by 3 consultant psychiatrists and a post graduate trainee in psychiatry. The first patient who was referred to the psychiatry out-patient department with medically unexplained physical symptoms on OPD days, who satisfied the inclusion and exclusion criteria was recruited.

The inclusion criteria were patients who were referred to Psychiatry Out - Patient Department with somatic symptoms for which clinical examination and investigations revealed no abnormality or abnormality was thought to be trivial or incidental,
those who were willing to participate in the study and had the ability to give an informed consent,18 - 60 years of age, had a duration of illness of more than 3 months and patients who were able to read and write English, Kannada or Malayalam.

The criteria for exclusion were those patients who were diagnosed with Mental Retardation and Dementia, presence of psychosis and psychoactive substance use disorder excluding nicotine abuse.

The patient and the accompanying family member were explained about the purpose of the study and a written informed consent in the patient's vernacular language was taken. The patient was first clinically evaluated by a detailed interview and then various tools were used. The study was conducted after approval from the institution's ethics committee.

Assessment:

An initial proforma which included patient's socio-demographic details, duration of illness, ICD-10 diagnoses was filled, following which MINI International Neuropsychiatric Interview, English Version 6.0.0 (MINI 6), certain modules of MINI PLUS, English Version 6.0.0 like dysthymia, somatization disorder, hypochondriasis, body dysmorphic disorder, pain disorder, conduct disorder, attention deficit/hyperactivity disorder, premenstrual dysphoric disorder, mixed anxiety depressive disorders and adjustment disorders were administered after which the WHO pathway to care questionnaire was filled.

Results

Sample characteristics-

Of the total of 50 patients,35 (70%) were females while 15 (30%) were males.8% belonged to the age group 18-25 years,26 % to 26-35 years,36% to 36-45 years and 30% to 46-60 years.80% were married while 14% were unmarried.14% belonged to urban population,40% to semi-urban and 46% to rural population.44% were housewives,16% agricultural workers,20% non-agricultural workers,16% professionals and 4% were unemployed.

Diagnoses -

Majority of them i.e. 44% were diagnosed with somatoform disorders,12% were diagnosed with depressive disorders and 2% were diagnosed with anxiety disorder.20% had a comorbidity of anxiety and somatoform disorders, 14% had comorbid depressive and somatoform disorders, and 4% had comorbid depression and anxiety.

Pathway of care -

All the patients have visited a doctor at the first point of contact. More than 80% of the patients have visited at least 2 service providers prior to their consultation with a psychiatrist. The mean number of service providers contacted prior to contact with a psychiatrist was 3.7.
The majority of them (66%) have sought a Neurology consultation along their pathway of care.
Time taken to approach first service provider and for first psychiatric consultation -
The median time taken to reach a psychiatrist was 36 months (Range 12-57 months) while the median time to contact the first service provider was 7 months (Range 3-24months).

Table I: Pathways of care in patients with medically unexplained physical symptoms in a medical college and hospital in South India

CONTACT n(%) SPECIALITY	1	2	3	4	5	6	7	8	9
GP	6(12)	3(6)	2(4)	1(2)					
ENT	2 (4)	7(14)	3 (6)						
Ayurveda	5(10)	3(6)	5(10)	3 (6)		3 (6)	1 (2)		
Homeopathy	1 (2)	2(4)	1 (2)		2 (4)	1 (2)			
Massage	2 (4)	1(2)	1 (2)	1 (2)	1 (2)		1 (2)		
Medicine	12(24)	9(18)	10(20)	7(14)	1 (2)	1 (2)			
Neurology	16(32)	8(16)	8 (16)	7(14)	8(16)	3 (6)	2 (4)	1 (2)	
Orthopedics	4 (8)	6(12)	3 (6)	4 (8)	4 (8)		1 (2)		
OBG	2 (4)								
Magico religious treatment		1(2)	1 (2)			1 (2)			
Cardiologist		2(4)			1 (2)				
Psychiatry		8(16)	9 (18)	8(16)	7(14)	8(16)	4 (8)	4 (8)	2 (4)

Majority of the patients have visited a doctor at the first point of contact. More than 80% of the patients have visited at least 2 service providers prior to their consultation with a Psychiatrist. The mean number of service providers contacted prior to contact with a Psychiatrist is 3.7.

Table II: Frequency of patients attending each specialty during the course of the pathway of care.

SPECIALITY	NO. OF SUBJECTS VISITING n (%)
Neurology	33 (66)
Medicine	28 (56)
Ayurveda	15 (30)
ENT	12 (24)
Orthopedics	10 (20)
General Practitioner	10 (20)
Homeopathy	6 (12)
Cardiology	3 (6)
Magico-religious treatment	3 (6)
OBG	2 (4)

Majority have sought a Neurology consultation along the course of the pathway of care.

Table III: Time taken to approach first service provider and time for psychiatric consultation

	TIME TO FIRST SERVICE PROVIDER (In months)	TIME TO PSYCHIATRIC CONSULTATION (In months)
Mean	17.23	44.88
SD	22.51	47.13
Median	7	36
IQR	3-24	12-57

The median time taken to reach a psychiatrist is 36 months (Range 12-57 months). The median time to contact the first service provider is 7 months (Range 3-24months).

Discussion

Comorbidity existed between anxiety, depression and somatoform disorders in 40% of the patients. It is comparable to the 50% comorbidity in a study by Lowe B et al12 in primary care.20% of the depressed patients have comorbid anxiety, somatoform disorders or both;26% of the anxiety patients have comorbid depression or somatoform disorders or both;36% of somatoform disorder patients have comorbid anxiety, depression or both. Lowe B et al12 suggested in their study that the above values were 75%, 57% and 54% respectively. Such findings in our study could be because of the small sample size.

The overlap among anxiety, depression and somatoform disorders may be due to partially overlapping diagnostic criteria.13 It can also be attributed to one syndrome acting as a risk factor for the development of another syndrome, e.g. A patient developing depression after being diagnosed with an anxiety disorder.14

In our study, 80% were diagnosed with somatoform disorders,32% were diagnosed with depression and 28% with anxiety .These results are consistent with a study by Chaturvedi et al15, among visitors to a community clinic, in which neurotic depression was the most common diagnosis in 33% and the next common diagnosis was anxiety neurosis in 19%. Somatoform disorders are also prevalent according to Fink P. et al.16 In our sample, 80% were diagnosed with somatoform disorders. This could possibly be because patients from non-western cultures and developing countries deny psychological symptoms, minimize affective and cognitive components and attribute their complaints to physical causes.17,18 One of the reasons for the same could be alexithymia-inability to recognize and express emotions.19 In India, it could also be as a result of lack of education, superstitions and reluctance of women20, and grim chances of getting matrimonial proposals in our culture. The perceived social stigma associated with psychological presentation is so high that although depressive and somatic symptoms were equally distressing, depressive symptoms were deemed as a disadvantage in the society.21 It is evident that 32% of the patients initially presented to a Neurologist with their somatic complaints while 24% consulted a General physician and 10% consulted a General practitioner. This is in contrast to previous western literature in which General Practitioners22, Psychiatrists followed by Non-Psychiatric Physicians including primary care doctors23, emerged as the most common first contact service provider. This can be attributed to the pattern of health services followed in western countries in which the General practitioner is the first contact service provider, who in turn will refer to the mental health services. This could also be because the above studies studied help seeking behaviour in mental disorders as such and was not confined to patients presenting with somatic symptoms.

The general trend leaned towards seeking Allopathic specialty care rather than the indigenous treatments like Ayurvedic system of medicine.24 In our study, the mean number of care givers contacted prior to contact with a Psychiatrist was 3.7 comparable to an earlier study by Steel et al25 in which it was 3. Patients exhibited a wide range of consulting pathways with more than 80% having contact with 2 or more professionals. There is a wide degree of variation across the sample in terms of the duration to approach the first service provider which ranges from as early as less than a month to 8 years of onset of symptoms and the time taken to consult a Psychiatrist ranges from 3 months to 15 years. The possible reasons for the delay in contact with a Mental Health Professional could be the lack of awareness among people about the somatic presentations of mental disorders thus prompting the patients to seek care from other specialties or the stigma associated with visiting a Psychiatrist. It could also be attributed to inadequate treatment with anti-depressants by non-psychiatric physicians, or due to premature discontinuation of antidepressants by the patients once partial remission of symptoms is achieved.

In contrast to other psychiatric illnesses like Schizophrenia and Bipolar mood disorders where in magico-religious healers were the primary helping agency26, the present study reveals that more than 80% of them have consulted a doctor initially. We also see that 3 patients from our sample have approached magico-religious healers in the quest for relief from their somatic symptoms, though they were not the first service providers. This further highlights the lack of awareness about psychiatric disorders among the general population and also opens our eyes to the pattern of seeking such treatments after seeking help from doctors. It also points to the continuing belief of supernatural causation of diseases.

Knowledge of psychiatric disorders among patients and patient's families plays a key role in early engagement with psychiatric services, significantly reduces cultural myths, beliefs and stigma related concerns, promotes favourable help seeking behaviour and shortens pathway of care.

The limitations of this study are that the size of the sample is relatively small and although this sample size is adequate for statistical purposes, a larger sample needs to be studied for validation of the conclusions drawn. There is limited generalizability of the results of this study as it was conducted in a general hospital setting with availability of all medical and surgical specialities under one roof, thus enabling quicker referrals to a psychiatrist. Another important limitation of this study was that there is a possibility of information bias and retrospective falsification as the WHO encounter form collects retrospective information regarding service providers and details of consultation. Data was collected between 2014-2015. Psychiatric diagnoses were assigned according to ICD-10 diagnostic criteria, which were in clinical use at the time. Retrospective reclassification using ICD-11 was not performed.

Conclusion

This study highlights the need for a multidisciplinary approach of treatment by effective interdepartmental collaboration, spreading awareness about psychiatric disorders in the community, sensitization of non-psychiatric physicians about early identification of somatic presentation of mental disorders, optimum management and timely referral to a Mental Health Professional for appropriate interventions.

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