beliefs or delusions.[5] There is hope that research such as this will begin to have an impact on clinical practice by highlighting these brain–mind links.

As a specialty we need to be far more proactive in promoting psychiatry as clinical neuroscience at both the undergraduate and postgraduate level. We must make sure that the scientific underpinnings of psychiatry are explicit within mental health services and in our interactions with patients and the public in general.

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Reflections on the management of medically unexplained symptoms

We read with interest the article by Röhricht & Elanjithara.[1] They have succinctly presented outcomes associated with delivering a liaison service for medically unexplained symptoms in a community setting. They usefully highlight the absence of current guidelines for the management of medically unexplained symptoms in primary care.

Evidence for treating medically unexplained symptoms has, until now, been dominated by talking therapies.[2] Patients often describe a perceived mismatch between their physical problems and the offered psychological solutions. They have come to associate body-based problems with body-based solutions and this mismatch may contribute to reluctance in considering psychological therapy. Only 29% of patients referred to body-oriented psychological therapy (BOPT) participated in assessment and treatment, predominantly from an Asian background.[1] As Röhricht & Elanjithara propose, talking therapies may be less acceptable, especially to Black and minority ethnic populations seeking body-based solutions. While the authors have given us an introduction to BOPT, one still does not grasp how this therapy was delivered in practice.

For instance, 106 out of 113 patients received a mental health diagnosis. One wonders what the remainder were thought to have. The importance of this is that most existing models for treatment of medically unexplained symptoms have been limited by the 'uni-professional' nature of treating teams,[3] including the one described. Distress associated with unmet social needs may indeed undergo 'conversion' to physical symptoms and where expertise is limited to any one professional discipline then outcomes may be affected. This study highlights what may be flawed about the current policy focus on only psychological treatments for these patients. It shows the value of establishing or clarifying diagnoses. It may also be that establishment on psychotropics can help patients to then engage in psychological therapy.

The authors noted that about a quarter of those who received a referral did not attend their initial appointment. Current models of treatment depend on patients turning up for appointments that they may not even remember. They may have been too disabled by their symptoms at the time of appointment or may have considered non-acute services as not useful. These problems are further compounded by the frequently different location of liaison services. Perhaps commissioning for co-location of services and the adoption of assertive outreach approaches may be ways around this block.

Persons with medically unexplained symptoms are often not perceived as having chronic, enduring, mental and physical illness. There is a need for greater awareness of the suffering experienced by this group of patients and the enormous toll that they may take on acute and community services.[4]

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Corrections

Book review: Play. *Psychiatr Bull* 2014; **38**: 95. The subtitle of this book is 'Experiential Methodologies in Developmental and Therapeutic Settings'. The online version of the review has been amended post-publication, in deviation from print and in accordance with this correction.

Perspectives: Dr Aashish Tagore. *Psychiatr Bull* 2014; **38**: 185–88. In the paper the author is referring to 'classical stages of the grieving process, as described by Prochaska and DiClemente'. This should state 'as described by Kubler-Ross'.

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