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Key Factors to Avoid Mind-Body Dualism in Diagnosis and Focus on Functional Improvement for Patients with Elusive/Complex Medical and Neurological Symptoms

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Disclosure: Richard J Seime, PhD, ABPP

- With respect to the following presentation, there has been no relevant (direct or indirect) financial relationship between the party listed above (and/or spouse/partner) and any for-profit company which could be considered a conflict of interest

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Background

- Mayo Clinic & Behavioral Medicine Program provided “front row seat” to observe issues of mind/body dualism
- Patient’s seeking another opinion and a medical/diagnostic “answer”, definite diagnosis for vexing and often longstanding problem
- Previous workups in “siloed” systems, repeated evaluations, sent from one specialist to another
- Clinical presentations that are complex, unusual, hard to diagnose, symptoms not consistent with a particular disorder, i.e. “medically unexplained symptoms”

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Dichotomous hierarchy—time to discard it!

- “medically explained” vs “medically unexplained”
- False dichotomy
- Leads to use of terms such as “non-cardiac chest pain”, “non-epileptic seizures” (i.e, medically unexplained)
- Reinforces false conclusion that “if not A then must be B” (this only possible if A & B are only possibilities)
- Can lead to patient perception that no treatment effective, symptoms “are all in my head”
- Incredibly simplistic diagnostic thinking

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Dichotomy has no empirical support

- UK & Multinational studies- total symptom burden most important
  - Explained patient satisfaction, explained health status and utilization *Jackson, et al., Br J Heal Psychol, 2004; Creed, Psych Clin N Am, 2011; Tomenson, et al., Br J, Psych, 2013*
- Mayo Clinic Behavioral Medicine Program studies
  - Study 1of 154/794 pts.
  - Classified symptoms as : explained by final dx, functional by established criteria, conversion d/o, unexplained by previous categories.
  - Symptoms categorized by 2 internists & psychiatrist

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Dichotomy has no empirical support

- Results: patients with at least one explained symptom (90%), all symptoms consistent with final diagnosis (30%), patients with F,C,U (60%), most had mix of symptoms
- Disability predicted by depression and illness (health anxiety, neurological dx or cancer dx not symptom category *Staab, Collins, & Collins, APM , 2015*
- Study 2 of 794 patients
- Depression and illness/health anxiety predicted disability *Craft-Favazza et al., in preparation*

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Mind-Body Dualism- Even in this 21st Century!

- Overuse of “non” as prefix
- If somatic symptoms are elusive likely psychological
- Formulation of a functional problem is undervalued or misinterpreted
- Focus is too heavy on “rule out” rather than “rule in”
- Absence of a specific disease etiology or neurological condition to account for symptoms = “they don’t know what is wrong!” or “There is nothing wrong! (of course that doesn’t make sense for the patient who has persistent problem)

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Countering Mind-Body Dualism

- Avoid defining something by what it is not, *Stamp out use of "non" in diagnoses!*
- Don't use terminology such as "real" vs "not a real" symptom
- Avoid organic vs functional dichotomy
- Help patients focus on "what is known" vs. "what is not known", i.e. what has been ruled in as much as ruled out
- Emphasize that regardless of diagnosis there comes a time to move forward to recovery of function—When is the time to stop diagnostic quest?

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Shift focus to Functional Improvement

- Take a biopsychosocial approach early in diagnostic process
- Counter any bias on either patient's or health care professionals part to attribute elusive symptoms to either a psychological problem (e.g. "stress") or exclusively a physical problem ("62.5% opinion")
- Develop a shared (patient/health professional) model/language/understanding of the presenting problem that incorporates biopsychosocial and behavioral factors
- Shift focus from "What caused this problem?"
  - Wild fire metaphor helpful
- Helpful language: "Structural/cellular" and "Functional"

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Shift focus to Functional Improvement

- Provide a model for conceptualizing what is wrong, how the problem developed, what maintains the problem or symptoms, and what can be done to regain health and function
- Give the problem a name! *Some specialties such as Gastroenterology have led the way, i.e., classifying 42 functional GI disorders (Rome III)*
- Describe models of how problems can be learned behaviors and conditioning principles are relevant.
- Case formulation for problem(s) that addresses:
  - Cause/Onset/Initiating Factors
  - Maintenance/Perpetuation of symptoms
  - Factors affecting Recovery/Functional Improvement

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Case formulation: Initiating factors

- Disease/ syndrome
- Sudden sensation (e.g. panic attacks)
- Infection
- Injury
- Traumatic events/adversity/childhood adversity
- Acute illness followed by developing chronic symptoms

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Case Formulation: Maintaining factors

- Partial recovery/residual symptoms
- Body vigilance “Oh God its happening again”
- Noisy body and misattribution of cause
- Health anxiey
- Conditioning (e.g., negative reinforcement)
- Behavioral avoidance
- Habit pattern
- Lack of dx or formulation that makes sense
- Depression
- Social factors

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Case Formulation: Functional Improvement

- Behavioral activation
- Rehabilitation
- Relearning
- Habit reversal
- Medications
- Relaxation/self-regulation strategies
- Acceptance
- Medications
- Management of health anxiety

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Case Formulation: Functional Improvement

- Treating anxiety
- Treating depression
- Providing a “bridge” back to health
- New conceptualization of problem and ways patient can discuss with others a different model of how the mind/body are one
- New skills, learning what to do if/when symptoms recur
- Promote sense personal agency and self-efficacy

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Mayo Clinic *BeST* Movement Disorders Program

- Shared conceptualization of movement disorder
- Rule out “sinister” or “ominous” neurological conditions
- Address depression or anxiety but these are viewed as the effect of having movement disorder rather than cause of disorder
- Conceptualize problem as analogous to a “software” vs. “hardware” problem, use metaphor of the “Yipps” experience by a golfer
- Emphasize a learned pattern of abnormal movements have developed that requires retraining.
- BeST is 2 wk program of daily OT/PT

Czarnicki, et. al, Parkinsonism Relat Disord, 2012

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Mayo Clinic Vestibular Rehabilitation for Persistent Postural-Perceptual Vertigo

- Diagnostic team from ENT, Neurology, Psychiatry/Psychology, Vestibular specialists-vestibular testing
- Shared understanding of vestibular disorders, vestibular migraines, and etiology of chronic dizziness/vertigo into syndrome now called *Persistent Postural-Perceptual Dizziness*
- Provide case conceptualization that explains how an acute vestibular insult transforms to a learned/conditioned persistent dizziness
- Treatment with medications and vestibular training and prescribed home exercises

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