MUS + NAD = DNA

No engagement without communication

Liaison Psychiatry Conference
Royal College of Psychiatrists
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Hertfordshire Rapid Assessment, Interface & Discharge Service
Aim of Presentation

To highlight the importance of skilful and sensitive communication with patients with persistent physical symptoms who present to Liaison Psychiatry.
Learning outcomes

To enhance successful treatment outcomes in the PPS population and reduce the attrition rate
Content overview

- Confusing Terminology
- Why is communication a particular concern with the persistent physical symptoms population?
- Barriers to communication
- Engaging patients in Liaison Psychiatry
Linguistic Confusion
Nomenclature

- Somatic Symptom disorder
- ‘It’s all in your head’
- Somatoform disorder
- Functional motor/movement disorder
- Functional neurological disorder
- Functional sensory disorder
- Functional symptoms
- Persistent physical symptoms
- Dissociative symptoms
- Psychogenic
- Psychosomatic
- Hysteria
- Medically unexplained symptoms
- Conversion disorder
- Chronic fatigue symptoms
The number needed to offend...

Terms need to be helpful to doctors AND acceptable to patients (Stone, 2002)
What does functional mean to patients?

‘Altered functioning of the nervous system’
(Trimble, 1982; Stone, 2002)
Why focus on this population?

ICD and DSM definitions highlight difficulties in patient-doctor communication;

Therapeutic GP-patient relationship depends upon effective doctor-patient communication;

Many doctors over-estimate their ability to communicate (Fong & Longnecker, 2010);

Expectation (from doctor and patient) that GP/OPA consultations will focus on physical health;

15-30% of GP consultations are for conditions that lack a sufficient organic explanation (Guthrie, 2008); 50% of Hospital OPAs
Why focus on this population? – cont’d

Pressure of time/ lack of expertise/ desire to keep patient satisfied:

- Collusion
- Unnecessary tests/investigations (Ring et al, 2004)
- Delay in starting effective treatment;
- Increase in symptoms;
- Negative impact on patient’s quality of life;
- Stress/burn-out in GP;
- High health-care utilization;
- £££
Or….

Confront, alienate and don’t be surprised when they DNA!
Barriers to Communication
1) A different language?

- Disease
- Illness
- Sickness
### Speaking a different language

<table>
<thead>
<tr>
<th></th>
<th>Patient</th>
<th>Consultant</th>
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</thead>
<tbody>
<tr>
<td>Disease (objective: pathology, biology)</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Illness (subjective): ‘deserters … from the army of the upright’) (Woolf, 1926)</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Sickness (socially/culturally prescribed/negotiated) (Parsons, 1951)</td>
<td>Yes</td>
<td>Ambivalent</td>
</tr>
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</table>
Medical narratives are canonical and confer validity on the patient.

If the consultant does not endorse the patient’s narrative, his/her suffering is de-legitimised or reduced to an lesser category of illness.

Outcome: discredited/stigmatised identity (Goffman, 1963); frustration and anger
2) Emotion

- Old wisdom: persistent physical symptoms triggered by emotional trauma (e.g. CSA)
- New wisdom: impaired emotional repertoire perpetuates persistent physical symptoms
Alexithymia

TAS-20

- TAS <51: Definite Alexithymia 44%
- TAS 52-60: Probable Alexithymia 41%
- TAS <61: No Alexithymia 15%
Vignette 1: Alexithymia

Patient, 36 years
Bullied at school;
Emotional script in family of origin: ‘We don’t talk about emotions’; pt
was emotionally passive;
Acrimonious divorce;
Stress at work; collapsed at work;
Admitted to Stroke Unit;
MRI, CT: NAD.
Off work, incurred debt.
**Developed dissociative episodes characterised by dysarthria and spasmodic dysphonia – rubbish words; functional gait disorder**

Very assertive/aggressive partner; angry re. lack of treatment;
complained to MP.
Vignette: Internalising grief
3) Belief systems

Extreme Cartesian bias in chronic PPS patients
Liaison Psychiatry: an integrated understanding of PPS
What our patients believe
Refuting beliefs

Motivated scepticism: information consistent with our attitudes becomes entrenched (Taber & Lodge, 2006)

Pick your battles carefully! (Cook & Lewandosky, 2011)
Correcting misperceptions

If you start with the myth, you will end with the myth!
Correcting misperceptions – cont’d

If you start with the fact, you will end with the fact
4) Lack of empathy/understanding

‘We’ve got another one for you!’ Liaison psychiatry’s experience of stigma towards patients with mental illness and mental health professionals (Bolton, 2012)

Clear clinical communication helps overcome prejudicial attitudes and pre-empt discriminatory behaviour towards patients
5) Discomfited by psychological issues

Neurologists on Conversion Disorder:

‘Not real neurology’;
Psychological explanations not their concern;
Some struggle to distinguish between CD and malingering
Uncertain about how to explain or communicate
(Kanaan, Armstrong, Barnes & Wessely, 2009)

Consultants adapt their disclosure to their patients;
Facilitates communication, but limits truthfulness.
(May even change their diagnosis.)
(Kanaan, Armstrong & Wessely, 2009)
Discomfited by psychological issues – cont’d

“Go to the PPS Clinic: they’ll help you with your pain” (Locum Rheumatologist to patient with Fibromyalgia)
6) Hypoactivity in Temporoparietal Junction

Region where actual and predicted sensory feedback are compared (Edwards, 2012)
• TPJ is also associated both with processing and observation, and Autistic Spectrum Conditions (impaired social cognition)

• Most PPS patients similarly demonstrate deficits in social interaction and concrete cognitive patterns, e.g. catastrophising, dichotomous thinking, over-generalising
CONSEQUENCES OF POOR COMMUNICATION
Patient’s quality of life deteriorates

‘[Patients with severe somatoform disorder] have significant disabilities, comparable to those seen in severe mental illnesses such as schizophrenia and chronic depression.’

(Bass, 2016)
Doctors think you are lying

Not being believed (severity of symptoms)

Not being listened to

Not being taken seriously

Too many medical terms

Lack of information and answers

Made to feel like a child

‘Nothing we can do’ (attitude from health professionals)

Not knowing who you are

No empathy

Frustrated

Feeling dismissed

Poor eye contact

‘It’s all in your head”

If you don’t tick the box, you’re out

Not being trusted by health professionals

Farmed through like cattle

Focus on only one symptom at a time

Lack of information and answers

Feeling rushed; long waiting times but only seen for 10 minutes

Inept

Being lied to by health professionals

Making assumptions

Not listening to people

Being patronised

Poor eye contact

Feeling dismissed

Don’t trust the doctors

Nowhere else to go if people don’t listen

Feeling out of control

Lack of communication

Inept

Feeling rushed; long waiting times but only seen for 10 minutes
Quality of Life and Functioning

QUALITY OF LIFE
MENTALISATION
EMOTIONAL REGULATION

CHRONICITY
COMPLEXITY
DISTRESS
Communication in the PPS Clinic
**Cognition**

Self: Loss; view of self as sick; Others: uncaring & unfair; ‘People don’t understand’

Future: hopeless: ‘I’ll never be better’

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**The feeling/talking body**

Symptoms are the idiom of distress: Pain, Tremors, NEAD, Fatigue, Motor Weakness, Sensory disturbance

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**Behaviours**

Give up; Avoid; Withdraw; ‘Boom or bust’; Complain

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**Impaired mentalization & alexithymia**

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**A model of chronic functional symptoms**

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**COGNITION**

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**THE FEELING/BODY**

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**THE FEELING/TALKING BODY**

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**BEHAVIOURS**

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**Impaired mentalization & alexithymia**

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**A model of chronic functional symptoms**

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<thead>
<tr>
<th>PATIENTS</th>
<th>PHYSICIANS</th>
<th>PPS CLINIC</th>
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<tbody>
<tr>
<td>Biomedical discourse</td>
<td>Psychosocial discourse</td>
<td>Biopsychosocialspiritual</td>
</tr>
<tr>
<td>Discourse of conviction</td>
<td>Discourse of scepticism</td>
<td>Discourse of curiosity</td>
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<tr>
<td>Aetiology</td>
<td>Pathology</td>
<td>Experience</td>
</tr>
<tr>
<td>Demanding</td>
<td>Depriving</td>
<td>Accepting</td>
</tr>
<tr>
<td>Request interventions</td>
<td>Decline interventions</td>
<td>Offer Treatment Protocol</td>
</tr>
<tr>
<td>Cartesian</td>
<td>Non-dualistic</td>
<td>Brain-Mind-Body</td>
</tr>
<tr>
<td>Want time to explore</td>
<td>No time to explore</td>
<td>Plenty of time to explore</td>
</tr>
<tr>
<td>Experience symptoms</td>
<td>Measure symptoms</td>
<td>Treat the person (not the symptoms)</td>
</tr>
<tr>
<td>Dr. Google</td>
<td>Organic medicine</td>
<td>Liaison and Care Planning</td>
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<tr>
<td>Scientific</td>
<td>Non-scientific</td>
<td>Experiential</td>
</tr>
<tr>
<td>Suffering</td>
<td>Non-suffering</td>
<td>Compassionate</td>
</tr>
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<td>-----------------------------------------</td>
<td>-------------------------------------------</td>
<td>-------------------------------------------</td>
</tr>
<tr>
<td>Certain that they are right</td>
<td>Certain that they are right</td>
<td>Accept patients’ narrative</td>
</tr>
<tr>
<td>Frustrated</td>
<td>Frustrated</td>
<td>Acknowledge patients’ frustration</td>
</tr>
<tr>
<td>Demand respect</td>
<td>Demand respect</td>
<td>Give respect/UPR</td>
</tr>
<tr>
<td>Fear of something being missed</td>
<td>Fear of missing something</td>
<td>Focus on functioning and Quality of Life</td>
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</table>
Bass, C. and Pearce, S. (2016) Severe and enduring somatoform disorders: recognition and management. BJPsych Advances, 22 (2) 87-96


THANK YOU

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