LECTURE

Thinking differently in rheumatological psychosomatic conditions

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Abstract
The concept of a «health care realm» is introduced. The healthcare realms considered were those patients who have only Physical Health Problems (PH), patients with neither physical nor mental health issues and who are seeking advice to remain healthy (HP), patients only with Mental Health Problems (MH), patients with both Physical Health and Mental Health Problems (PH&MH) and patients with Psychosomatic Health conditions (PS).
Described is how patientsX minds and bodies interact and its relevance to rheumatology practice. Presented is the culmination of 34 years of the author's experience of rheumatological disorders based in Family Medicine in a United Kingdom General Practice. Also presented are 2 small studies supplementing the main conclusions.
The first small study counted the main consultation content of 246 patients, as considered by the principals in the practice. Of these 73.5% were for physical health conditions, 13.3% for health promotion, 11.5% for mental health conditions and 1.8% for psychosomatic conditions.
The second small study was a survey of experienced GPs, Physicians and Psychiatrists, asking about their opinions on how well the patients in different health care realms were being managed across the healthcare system. Of the 5 realms, the collective view was that it was the patients in the PH realm who was clearly received the best care. The least good care was being given to patients in the PS realm and only marginally better were patients in the MH Realm.
This paper argues that clinicians need a different thinking approach when meeting patients from different healthcare realms. It is known that when doctors treat PH patients, they consider the patient's symptoms against templates of knowledge for the conditions in the differential diagnosis. Furthermore, HP patients are assessed by comparing the patient's bio-measurements against known markers of good health
When being consulted by patients in the MH or PS realms, it is advocated, not to follow the approach of PH patients. For patients in the MH realm it is best to address the patient's life as a whole and to consider, how did the person arrive to the situation he is in and what needs to be done to restore the patient's life back on track. For patients in the PS realm, ideally the aim is to help the patient make the link between the physical symptom and its psychological aetiology. A step towards this is to describe how the body physically mediates the symptom.

Keywords: *Mindfulness, Symptoms, Clinical decision making, Health Promotion, Rheumatology, Medically unexplained Symptoms, Mental Health, Somatoform disorders, Fibromyalgia.*
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Introduction

Mindfulness has been defined as «the self-regulation of attention with an attitude of curiosity, openness, and acceptance.» [1] For the purpose of this paper, this definition is taken as also including the ability of an individual to be aware of his own thinking.

As humans, we are not always aware of our own thinking, nor that we may be aware how our personal cognitive processes influence our well-being and the life decisions that we make. It has been noted that «the potential for improvement is huge.» Through mindfulness, not only is there a positive effect on health and wellbeing, but also, «it is likely to improve one»s ability to make high-quality judgments and decisions.» [2]

Like everyone else, clinicians are human. A pilot study on British newly qualified doctors, implied that mindfulness to this cohort would give greater wellbeing, improved working life, and more satisfactory relationships with patients. [3]

For many doctors, the decisions made may be literally between life and death. And when not, they can significantly affect a person»s lifestyle and/or livelihood. Do we sufficiently understand how we make those life changing decisions? Are we making them in an optimum manner, that ensures the best possible outcomes for the patient?

Based on his work experience over 34 years, as a Family Physician (General Medical Practitioner-GP) in a small family practice in Manchester, UK, the author of this paper, has considered these questions. Over this time a cohort of patients moved through a generation and a half. For much of this time a single list system was in operation. Thus, the very many actions undertaken would have provided inevitable feedback.

Over the years many individuals with all the common adult rheumatological conditions were encountered, e.g. osteoarthrosis, rheumatoid arthritis and also some of the less frequently seen

conditions, e.g. Systemic Lupus Erythematosus, septic arthritis. Later an interest in psychology, mental health, mind-body interaction and psychosomatic medicine developed.

The evidence and ideas presented here are the culmination of those years of practice. The conclusions drawn are valid equally for rheumatological conditions and all other physical health conditions.

Those ideas are supplemented by two small studies.

What this paper is aiming to achieve is to describe a paradigm of reconceptualising certain conditions and how they should be best considered and managed. Specific focus is given to psychosomatic conditions, e.g. Fibromyalgia, Chronic Fatigue Syndrome. It is henceforth hoped that doctors interested in rheumatological conditions will be encouraged to be self-aware of their own thinking, and how it should be applied when presented with different types of clinical scenario. For some specified clinical conditions, it is suggested a different approach should be considered. Hopefully, the benefits will be both, greater job satisfaction for the doctor and improved outcomes for the patient.

Method

Undertaken was years of direct observation, personal reflection and an understanding gained based on the sound clinical premise of validating all patients» symptoms, even when there is no obvious physical illness underlying those symptoms. The ideas developed. They represent 34 years of experience. Perpetual cycles of practice and reflection allowed the optimisation of clinical consultation.

This experience is supplemented by 2 small studies. Study 1 involved asking each of the principal Family Physicians (GPs) to assign after each consultation, the consultation type, i.e. whether the consultation was primarily about, health promotion, physical health, mental health or psychosomatic health. (See definitions below.) The figures were totalled for each consultation type and compared.

Study 2 was a survey of experienced doctors. They were a group of GPs, Physicians and Psychiatrists. On a scale of 0 to 10, (With 10 being the best possible) they were asked to rate their personal views to how well they believed the UK National Health Service (NHS) manages each of the 5 realms listed below. They were then asked to give a qualitative reason for the quantitative value they had just given. The realms in the order that they appeared in the survey was as follows:

1. Patients with physical health conditions (PH)
2. Healthy patients who wish to remain healthy (HP)
3. Patients with mental health conditions (MH)
4. Patients who have both physical health and mental health problems. (PH&MH)
5. Patients with mind-body (psychosomatic) health conditions (PS)

For each realm the quantitative scores were averaged. Text analysis was undertaken on the qualitative comments. These were organised according to the emerging themes and ordered according to an implied positive or negative meaning. The balance between positive and negative meanings were used to compare the qualitative outcomes between realms.

Outcomes

Consultations may be categorised by the nature of the patient»s condition(s) being discussed. Consultations are deemed to be either high or low with respect to physical health and high or low with respect to mental health. Thus, there are four types. See Table 1.

Table 1. Types of clinical scenarios faced by clinicians in practice. Each has its own consultation type.

		Psychological	
		Low	High
Physical	High	Physical Health (PH)	Psychosomatic (PS)
	Low	Health Promotion (HP)	Mental Health (MH)

Table 2. Primary focus of the consultations in Study 1.

	Health Promotion	Physical Health	Mental Health	Psycho-somatic	Totals
Numbers	23	176	37	10	246
%ages	13.3%	73.5%	11.5%	1.8%	100%

Table 3. A summary of the outcomes of Study 2.

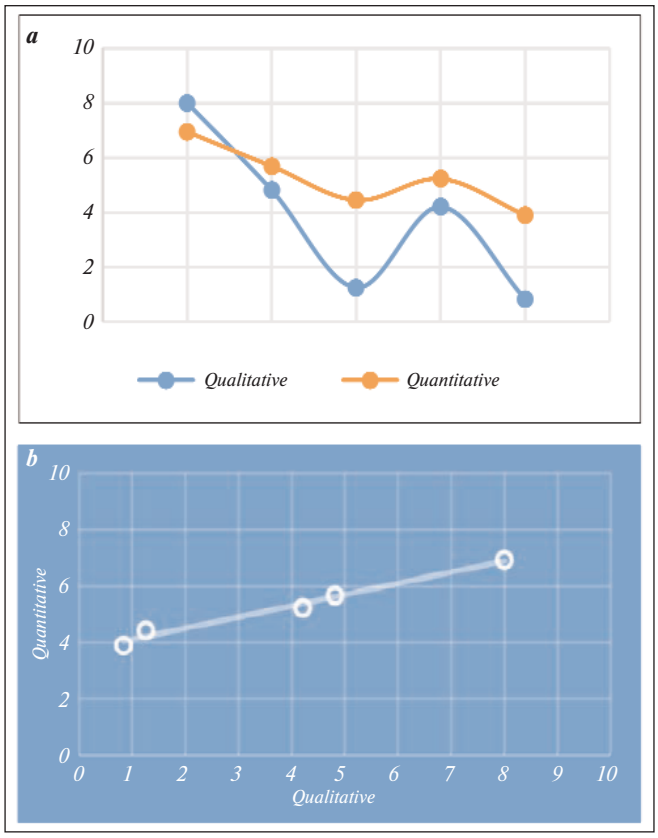
Realm		Physical Health (PH)	Health Promotion (HP)	Mental Health (MH)	Physical & Mental (PH&MH)	Psycho-somatic (PS)
	Respondents	59	55	51	52	50
Quantitative average		6.94	5.69	4.45	5.23	3.90
Qualitative	Positive comments	20	13	4	8	2
	Negative comments	5	14	28	11	22
	Total comments	25	27	32	19	24
	Percentage positive scaled to 0-10	8	4.81	1.25	4.21	0.83

Physical Health consultations and Mental Health consultations are obvious. Health Promotion is the consultation in which the patient is seeking advice in a state of physical and mental well-being and wishes to remain healthy. Health promotion may be primary or secondary. Primary Health Promotion is a healthy person. Secondary health promotion is where the patient has a known medical condition, feels well with this condition and is seeking advice to remain well with the condition.

A psychosomatic condition is one in which the physical and mental components of the condition are fused into one. Fibromyalgia with both its physical and psychological properties is one example. There are hybrid consultations in which separate physical health and mental health conditions are both present, irrespective of whether the one was contributory to the other or not. An example may be the patient who is depressed and has lumbar spondylolisthesis.

Each condition/consultation type has its own optimum approach. The clinician»s optimal thinking for each consultation type can be described. The clinical cognitive processing for one type is sub-optimal for the others. If clinicians are not aware that they are using a sub-optimal cognitive approach, good clinical care may be undermined.

Table 3 presents the outcomes of Study 2. Presented are both the quantitative averages awarded and the percentage of qualitative comments that were positive. Not all doctors offered a comment. There were no discernible differences in opinion between the GPs, Physicians and Psychiatrists.



Figures 1a and 1b. *Figure 1a on the left shows the qualitative and quantitative scores for the 5 Realms. They are from left to right, PH, HP, MH, PH&MH and PS. Figure 1b on the right is a plot of the qualitative score against the quantitative. It clearly demonstrates the linear agreement between them. From left to right (worst to best) the plot points are PS, MH, PH&MH, HP and PH.*

Figures 1a and 1b below, shows the stong agreement between the quantitative scores and the qualitative comments. The care of patients with physical health problems is clearly considered the best. The psychosomatic realm is considered the least positive, and only a little less poorly is the realm of mental health.

Discussion

As far as I am aware this division of patient problems into the 4 categories as described in Table 1 has not been described before. Study 1 was looking at consultations and assigning the dominant presentation of the patient to the consultation. In reality it is the dominant patient that has determined the consultation category.

The figures of 11.5% and 1.8% for primary mental health and Psychosomatic health is considerably less than the known prevalence within primary care consultations. In Denmark the estimate is 35% with any mental health disorder excluding somatoform disorders, 36% for somatoform (Psychosomatic) disorders and 50% with either. [4] More recently there is an estimate of around 30% for somatoform disorders. [5]

The low percentages obtained for all consultation types other than Physical Health (PH) obtained in Study 1 reflect that what was being asked was the overriding presentation. The contrasting previously published data is looking at all conditions within the consultation. If the published evidence represents healthcare need, it does recognise that there is a shortfall, between need and practice. While this data is from primary care, there is no reason to suppose it would be very different within the rheumatology setting.

For Study 2 the term «Clinical Realm» had to be created. Prior, there was no suitable expression to describe precisely what was meant. The Clinical Realm describes the patient characteristics and is patient focussed. All other terms such as «Psychiatrist», «Rheumatologist», TPrimary care», «Secondary care», «Acute sector», are either doctor or service-centric terms.

The Physical Health Realm is the realm of all patients with a physical health problem who are essentially psychologically well. The Psychosomatic Health Realm is the realm of all patients with a psychosomatic health condition. The Psychosomatic Realm should not be mistaken for the hybrid Realm of patients with both a physical health problem and a mental health problem.

Physical healthcare out-patient departments are designed to help those patients who are in the Physical Health Realm. They do poorly when managing those in the Psychosomatic Health Realm. A patient with Fibromyalgia in a rheumatology clinic is a patient in the PS Realm, attending a PH Clinic. 40% of patients in a rheumatology clinic will be labelled as having medically unexplained symptoms. [6] In UK hospital outpatients» departments 69% of back pain and 17% of joint pain remained unexplained. [7]

These same studies note that often, the same patients attend multiple out-patient departments and are over-investigated. There is inappropriate medicalisation with more harm. Their emotional support is often over-looked. Historically patients in the psychosomatic health realm were turned away by both physical and mental health services. The patient did not fit the design of either type of service. Neither service had the expertise to help.

Patients in the psychosomatic realm are a drain on resources. Patients with fibromyalgia double healthcare costs for all their other co-morbidities. [8]

The effect on doctors is negative, particularly amongst junior doctors. Two studies, the first in 4 medical specialties including rheumatologists, and the second in junior doctors within two years of qualifying had similar outcomes. When doctors need to manage cases where the patients» symptoms remain unexplained, it led to feelings of anxiety, frustration, incompetence in managing these conditions and exhaustion. [9] [10]

It may be stating the obvious, but physicians and psychiatrists alike need to have some understanding of the Psychosomatic Realm and how physical and mental health relate so that both can be more effective with these patients. Table 4 describes the various interactions between the mind and the body from a clinician»s perspective.

The different styles of thinking that are required to manage patients in each realm in the rheumatological setting are now described.

Physical Health

Physical Health thinking is what doctors naturally do. It comes from the basic training in medical school. Any new clinical situation, such as the new patient in out-patients will start with a physical health consultation.

In physical health thinking the clinician is asking:

- What is the problem? And...
- What What is the solution?"

The first is equivalent to what is the diagnosis. The second, how to best manage this patient. Through study, learning and experience the clinician will have a knowledge base of all the relevant medical conditions and how they present. As the clinician

Table 4. Clinical scenarios were mind and body interact. Realms: HP-Health promotion, PH-Physical Health, MH-Mental Health, PS-Psychosomatic.

	Interaction	General Examples	Rheumatological Examples	Realm	Typical Approach and Challenges
1	Symptom presentation that could represent either a physical or mental health condition	Tired all the time, sleep disturbance	Aching muscles	Not yet defined	History, examination and investigation as appropriate, being mindful neither to miss important physical health nor to reinforce somatisation. The need is to clearly define the physical and/or the psychological nature behind the symptom.
2	Distinct Physical Health Condition and Mental Health Condition	Diabetes and Bipolar Affective disorder	Unconnected conditions, e.g. Rheumatoid arthritis and OCD	PH, MH	Manage the physical health and psychological health conditions separately Treat the physical and the psychological separately. Requires good communication to ensure that optimum management of each are compatible with each other
3	Psychological response to a Physical Health Condition	Fear of exercising after a coronary thrombosis	Becoming depressed due to pain and disability.	PH, MH	Rehabilitation including appropriate physical healthcare and if necessary additional psychological support Common psychological responses to the physical health condition should be pre-empted and managed by the physical healthcare team.
4	Mental symptoms as a recognised feature of a Physical Health Condition	Depressed mood due to Hypothyroidism	Memory and behavioural changes from Systemic Lupus Erythematosus	PH	Treat the physical condition appropriately Personality changes can make the physical management harder
5	Reduced physical self-care secondary to a mental health condition	Reduced exercise or smoking due to psychosis	Muscle wasting due to lack of volition and exercise	HP, MH	Sponsor physical health promotion Mental health services should be becoming familiar good physical health promotion.
6	Behaviour giving rise to physical health condition	Smoking giving rise to lung disease	Alcoholism giving rise to gout	HP, PH	Treat the physical condition and give lifestyle advice for the behaviour May be deemed to be a self-inflicted condition
7	Physical Health reaction to a Mental Health Condition	Hyper-ventilation due to anxiety and panic attacks	Myalgia due to stress	PH, MH	Attribute the physical response and appropriately manage the underlying psychological state. Important to help the patient make the connection.
8	Severity of symptoms out of proportion to the degree of Physical Health pathology	COPD with mild reduction in Fev1 but severe breathlessness	Minimal osteo-arthritis with severe pain	PH, PS	Manage the physical health appropriately and the psychological component of the symptoms separately Helping the patent focus on the psychological may be difficult because the patient will attribute the symptoms to the physical. May require a joint team.
9	Known Physical-Psychological Condition	Irritable Bowel Syndrome	Fibromyalgia	PS	Manage either by physical means or psychological means or if required both More resistant cases may require highly skilled psychological help
10	Somatoform/ Conversion Disorder	Medically unexplained symptoms.	Unexplained, joint pain or stiffness	PS	Treat psychologically Will require a Specialist psychological service
11	Persisting symptoms after initial physical illness/trauma has settled	Chronic Fatigue Syndrome	Chronic back pain after initial Prolapsed Disc has settled	PH, PS	Reinvestigate the physical and properly ascertain the aetiology of the symptom. Will require very precise re-investigation and language to ascertain

is taking the history, he will be attempting to match the patient's complaints against the condition templates within his own personal knowledge database. This has been well worked out. [11] Figure 2 gives a diagrammatic description. of how we compare what the patient is describing against what we anticipate will be the typical presentation for a specific condition.

The doctor will note the likelihood of the patient»s complaints being a particular condition and its potential for doing harm. While it may not always be possible to give a definitive diagnosis without further investigation, clinical wisdom will ensure that even low probability conditions with high potential for harm will be considered.

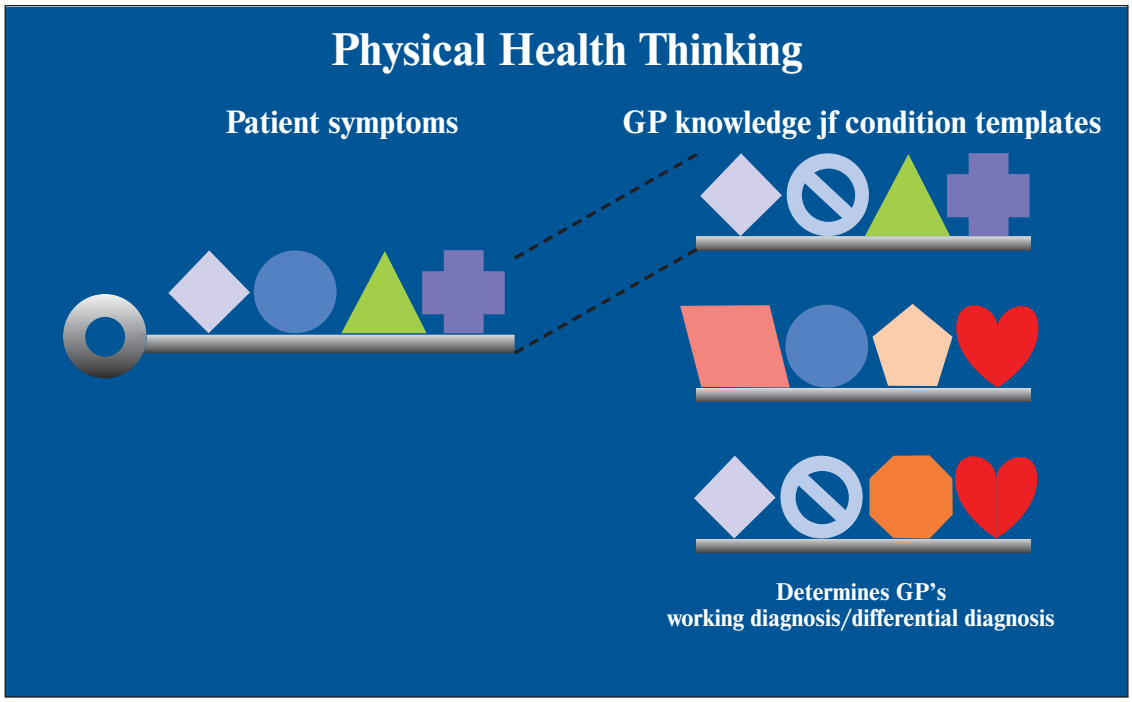


Figure 2. *Diagrammatic description on how the physician matches the patient symptoms to his knowledge. For illustrative purposes only, let us imagine a patient presenting to clinic with asymmetrical joint pain (), multiple joints are affected (), there is aching non-tender, minimal morning stiffness () and the patient is systemically well (). The doctor considers the most likely diagnosis to be osteoarthritis. Other conditions considered where rheumatoid arthritis and psoriatic arthritis respectively. Legend: Some joints affected (), Symmetrical condition (), swollen tender painful, prolonged morning stiffness (), eye soreness (), skin psoriasis ()*

Health promotion

The thinking in health promotion is not to assume that because the patient has no complaints, all is well with the patient. Health promotion thinking is to make certain that all markers that are known to denote good health are present. If they are, then advice is given to maintain those markers as they are. If any are missing the patient is guided accordingly.

Primary and secondary health promotion should not be confused with primary and secondary prevention, although there will be similarities and an overlap. Prevention is about illness or complication prevention and is focusing on the activities of the clinicians and what they need to do. Health promotion focuses on maintaining the patient»s health and well-being, either with or without the condition. The focus is on what the patient is doing.

Primary health promotion will not be seen in rheumatological out-patients. Secondary health promotion will. This will be when the patient is returning for a regular routine review, and in answer to the question, «How are you feeling?», the response is, «Very well, thank you Doctor.» The doctor is no longer enquiring about a symptom but needs to ensure that all is indeed well with the patient. The presence of health markers will be ascertained. For Rheumatoid Arthritis, these will be when on examination there are normally feeling joints, and normal haematological values for White Blood Cell Count, Platelets and Erythrocyte Sedimentation Rate.

If all the described markers are within the normal range the clinician can consider how best to maintain the patient»s well-being. Considerations may include advice with regard to exercise and maintaining joint flexibility and/or reducing medication to reduce the risk of unwanted side effects.

Those same tests that were considered as being markers of disease are now being considered as markers of health. If well-being cannot be confirmed, the clinician will need to use physical health thinking to consider what if any is the problem and what needs to be done about it.

Mental Health

A Rheumatologist should not be seeing patients who are only in the Mental Health Realm. But they will be seeing patients who will be in either the Physical Health and Mental Health Realm or the Psychosomatic Health Realm. Depending on the method of diagnosis, the incidence of depression amongst patients with rheumatologic conditions ranges from 16.8–48%. With depression, there are poorer outcomes in Rheumatoid Arthritis. [12] When anxiety and depression are both considered, psychological morbidity appears to be beyond 80% of patients with acute inflammatory rheumatologic conditions, a frequency that implies that psychological morbidity is to be expected and therefore should be screened for. [13]

For these reasons it is considered important that rheumatologists at least have a basic understanding of what is good mental health thinking when managing their patients. It is proposed that the two fundamental questions to be asked are:

1. What are the events that led the patient into this situation?
2. What needs to be done for the patient to get their life back on track?

Figure 3 is a graphic depiction of a person's life.

The healthy attitude in managing patients with mental health presentations is to consider that the patient»s psychological distress is a compilation of life's events overwhelming the individ-

ual»s abilities to cope. Restoring mental health and therefore restoring well-being is to return the person back to the lifeline, ideally where they would have been if not overcome by those adverse life events.

It is important to note that by this definition, having psychological symptoms is not a sign of psychological illness. It is this false premise that is one of the impediments to improving psychological care. For a rheumatologist, the intervention by a physician with his special skills, restoring physical well-being is the most obvious way that mental health is being indirectly promoted. [14] When this is insufficient to restore the mood of the patient, an exploration of issues and if necessary onward psychological support and advice are reasonable.

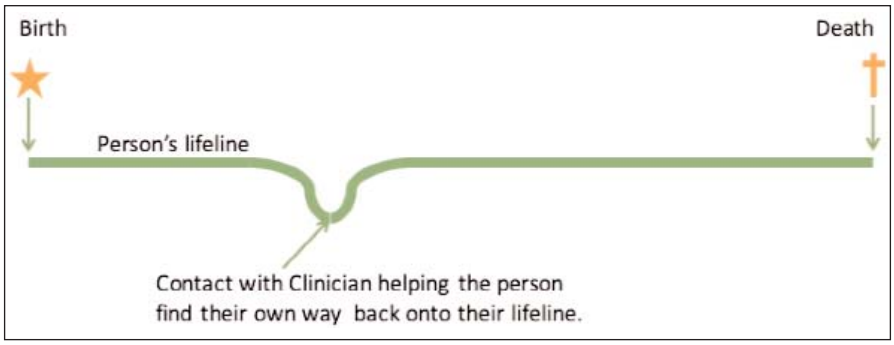


Figure 3. *Depicting a person»s lifeline in which for whatever reason, there is a downturn in the person»s life with reduced mental health well-being. The correct support is required to ensure the patient is guided back onto their lifeline. Note the importance of both the past and the future*

Even in situations of palliation, by saying that there is always something that can be done to help, would be making a truthful statement that can provide hope. A lack of hope is conducive to the emergence of a person questioning their own need to live. Hope, and the patient having a personal vision of their future is very important.

Psychosomatic Health

In Psychosomatic conditions, such as Fibromyalgia, the psychological has become enmeshed with the Physical. By being both physical and psychological, they require both approaches. Also required is for the patient to have a personal understanding why the condition developed.

Additional to the Physical Realm and the Psychological Realm questions being asked, the best resolution of the psychosomatic condition is for the connection between the physical and the psychological components to be unlinked. Thus, the question to ask is:

• How do I help the patient make the connection between the psychological aetiology and the physical symptoms?

It is not for the physician to diagnose the link but for the patient himself to make the connection and understanding for himself that will help him to resolve the symptoms.

Breaking this link can range from easy to impossible. It may be difficult because usually there is a powerful emotion «locked» into the symptom. When the patient makes the connection, the emotion is released. Thus, the patient is emotionally disincentivised to recover. By the time the patient arrives in clinic, helping the psychosomatic patient is unlikely to be simple and straightforward. Frequently, neither the patient nor the physician will be aware of the link between the psychological and the psychosomatic. Therapists who wish to engage with patients on a psychological level need to be prepared to deal with any emergent emotion.

Making the link is not the only way of being able to help the patient. Generally behavioural approaches, while maybe not achieving complete resolution will have benefits akin to the benefits obtained through cognitive behavioural therapy. In Fibromyalgia specifically, CBT has provided a small incremental benefit over control interventions in reducing pain, negative mood and disability at the end of treatment and at long-term follow-up. [15] Exercise as well as being a significant component of CBT may also help to prevent or reverse physical deconditioning. [16] There is an array of other physical therapies and some have shown benefit in combination. [17] A pro-active, individualised, patient-centred, multi-modal, integrated bio-psychosocial approach is currently recommended. [18]

It is important to manage the potentially psychosomatic patient appropriately. At first presentation, the patient»s clinical condition will be unknown, and the initial approach will be that of a physical health problem. The psychosomatic condition is also a physical health problem and the clinician»s knowledge base will have a template for its diagnosis. There may be certain clues within the history that may lead the clinician to consider a psychosomatic disorder. These are listed in Table 5. A person with one psychosomatic condition is more likely to have others. [19] Due care must be shown not to jump too quickly to a psychosomatic conclusion. The unwanted consequence will be invalidating the patient»s symptoms and perpetuating its psychological nature.

Table 5. When the clinical condition suggests a psychosomatic disorder

• Suggestive of a known psychosomatic disorder
• The patient has another known psychosomatic condition
• The periodicity of the symptom
• Why does this patient have the condition, and another does not?
• Why did the condition become symptomatic when it did?
• The symptom is out of proportion to the underlying pathology
• The symptom does not make biological sense

In coming to a conclusion that's the condition is psychosomatic; it is best to make the diagnosis on its positive features rather than by exclusion. However, excluding other conditions is also important. Table 6 gives an order of exclusion when considering the patient with muscle ache.

After the initial consultation, when it is believed appropriate, the management of the patient with the psychosomatic condition

Table 6. Common causes of muscle ache. Note even when other causes are excluded it is best to make the diagnosis based on the condition»s positive features

• Bacteriamia/Viraemia/Sepsis
• Trauma, acute or minor repeated
• Drugs, e.g. statins
• Metabolic conditions, e.g. Vitamin D deficiency, thyroid disease
• Auto-immune disorders
• Stress
• Psychosomatic conditions: Fibromyalgia, chronic fatigue syndrome, etc

does not need to be done within the physical health clinic, unless a particular physician has a keen interest in the topic. Rather, it is about having a conversation with the patient that gently facilitates the patient»s mind to a place where the psychosomatic nature of the condition can be more readily accepted. To reinforce the message, every opportunity needs to be taken. Thus, this conversation is best undertaken by any and all clinicians who meet the patient. This includes the specialist, the family physician and the ancillary clinical staff. The conversation should start even before any necessary investigations are undertaken.

The physician needs to be mindful to balance the need of investigating to exclude serious physical illness with not over-investigating the physically normal. «The pursuit of inappropriate investigations in an effort to find the cause of patients» symptoms or avoid litigation can cause significant harm to the patient.» [20] There needs to be judicial use of tests. If it is believed the patient»s complaints are not physically based, the patient should be given the suggestion that ultimately the investigations and other health parameters will be normal; and that the symptoms may prove not to be due to physical illness. Further discussion with the patient considering the symptoms in this light can take place with the benefit of the test results.

It is important to be very precise and careful in the words used to the patient. Patients will remember words and their meanings in a way that was not intended. It should also be noted that «psychosomatic» does not necessarily equate with stress or depression or any other specific psychological syndrome. For example, telling the patient that his physical symptoms are due to anxiety when he does not feel anxious is most unhelpful.

The quality of history taking, and explanations given are always important. With these patients more so. Musculo-skeletal pain may be complex with more than one component. The pain from different tissues may give rise to different cognitive sentience. See table 7.

Table 7. Different structures in the back may give rise to different awareness

Structure	Description	Typical Conditions
Muscle	Ache, eased by heat, worse after prolonged rest and prolonged use, "shooting"	Muscle spasm, Muscle injury
Bone (static)	"Gnawing", dull ache poorly located	Paget's, Cancer secondaries
Joint	Point tenderness, worse on leaning back. May be "Bone on Bone"	Facet Joint arthritis
Bone on Bone	"Grinding"	Spondylosis,
Disc, Annulus Fibrosus	Midline back pain, worse on high pressure, e.g. coughing, sitting worse than standing, bending forward	Prolapsed intervertebral disc, Degenerative Disc Disease
Ligament	Consistently worse after a specific movement	Sprains, Whiplash
Nerve	"Shooting", burning, associated numbness, follows a dermatome	Radiculopathy

As a typical example, the prolapse intervertebral disc may give rise to the pains of annulus fibrosis rupture, radiculopathy and muscle spasm. At the onset, these are important to highlight and note. As the pathology settles, the patient may be still symptomatic. It may be relevant for the physician and patient alike to understand the physiology maintaining them. While there may have been good physical reasons for the onset of the pain, it may be perpetuated by psychological factors.

Clinicians need to be cognizant when the intensity of the symptoms is out of proportion to the degree of pathology, e.g. severe symptoms in the presence of minimal radiographic or arthroscopic changes.

The psychosomatic patient came with a symptom and at the very least it needs to be discussed. When having the conversation with the patient no clinician should be placed in a position where they are going beyond their expertise. But having a consultation, listening to the symptoms, validating the symptoms, avoiding analyses such as Tit is all in the mindУ and giving a description in physiological terms are all well within the capability of all clinicians.

Figure 4 presents the mind-body cycle and the genesis of the symptoms. Our upbringing is such that physical symptoms imply physical illness. When investigations for physical illness have proven negative, and the patient is still symptomatic, he will attribute a physical cause to the symptoms. Giving a physiological explanation, for example, «I can feel your tight muscles are in spasm», will aid the understanding and bring the patient closer to achieving a psychological understanding. There are potentially seven of these. They are listed in Figure 4 under the pneumonic of «BIG ITCH.» [21] It would only be for the trained therapist to explore these but being aware of them can help provide the understanding of potential psychodynamic processes.

In Study 2, based on the views of clinicians, the implication is that the management of mental health and psychosomatic conditions is undertaken poorly. There is much evidence to confirm this view. It is hypothesised that if we adapt our thinking determined by the nature of the condition being presented, particularly to those patients with a large mental health or psychosomatic component to their condition, a «win-win-win» situation can be created. Clinicians will win because they will feel better able to manage the patients with these conditions. Patients will win because their health will improve. Health budgets will win because with less morbidity there will be smaller costs.

Conclusion

This paper introduces the idea of clinical realms. There are four. Three are relevant to the practice of rheumatology. The patients in each realm need to be approached differently. There is a call for clinicians to be self-aware of how we engage with our patients and of our own thinking processes during consultation. When approaching the patients in each realm, it is believed and proposed that if we can adapt our own thinking to the

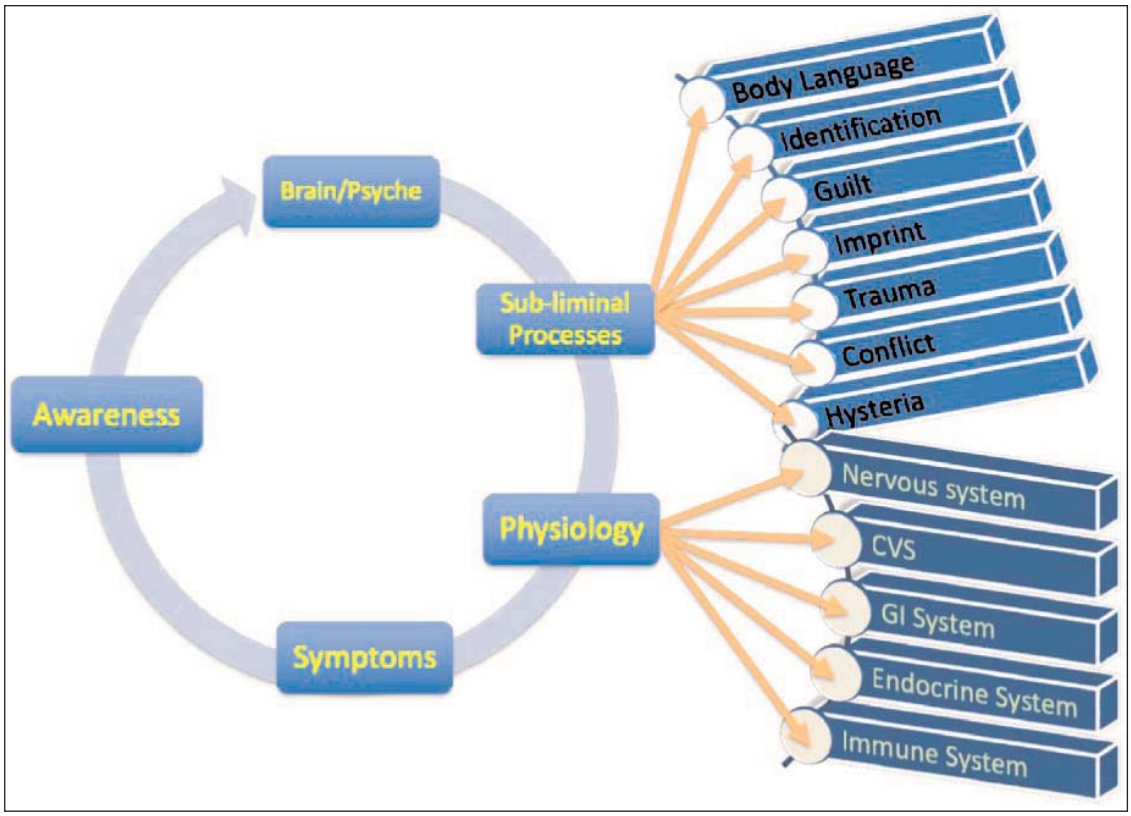


Figure 4. *The Mind-body cycle indicating the psychological and physiological generation of the symptom. This cycle can start in the body or in the mind. Sub-liminal processes reflecting emotional distress manifest in the body through physiological mechanisms*

needs of the patient and the consultation, that that will produce the best outcomes. It is not that clinicians should be thinking about each style and consulting in a given manner for each scenario. Ideally, they should be familiar with each so as to be able to move freely and imperceptibly between styles as the demands of the consultation dictates.

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Conflict of Interest Statement
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