

Medically Unexplained Symptoms and Mental Models: from failure to fusion and back to illness behavior

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ABSTRACT

Medically unexplained symptoms (MUS) are extremely common and represent difficulty for patient and provider alike. A review of explanatory models is offered to shed light on why these difficulties persist. Historical review of psychiatric models and other classification systems dedicated to MUS is delineated, citing numerous epidemiological studies, reviews, and critiques. Diagnostic and Statistical Manual of Mental Disorders (DSM) models for MUS have shifted from an etiological to consequential perspective, and neither is ideally suited to address MUS or guide clinicians in its understanding. This has led to less involvement by psychiatrists in the identification and management of MUS. Psychiatric, particularly DSM-derived, models lack holistic explanatory power and should be revised to include both etiological and consequential perspectives. Ethical implications of leaving MUS unaddressed from a mental health perspective are numerous, as they may impact informed consent and include elements of unacceptable deception. The model of maladaptive illness behavior is proposed as an integrative alternative with corresponding clinical and research imperatives.

Key Words: *Medically-unexplained symptoms, functional somatic syndromes, somatization, deception, illness behaviour*

INTRODUCTION

The quintessential exercise between physician and patient is that of addressing signs and symptoms. The former occupies an objective, empirical realm, often unambiguous in presentation – a blood-tinged cough, a positive urine drug screen, or atelectasis on the chest x-ray. But the latter is a subjective creature and suffers from considerable variability. As such, after presumably exhaustive analyses have excluded structural, anatomical, or functional causes, a symptom often remains “medically unexplained.”

Medically unexplained symptoms (MUS) are rather commonplace in clinical practice, 20-80% of somatic complaints to a physician have no known organic basis (Kellner, 1985). In a study of 550 ambulatory clinic patients, 52% of general medicine patients reported MUS (Nimnuan, Hotopf & Wessely, 2001). In a large primary care group of 620, two thirds reported MUS (Steinbrecher et al., 2011). The problem is not unique to general medicine. Various other specialties have been sampled, including rheumatology (n=203) in which 29% reported MUS (Maiden et al., 2002); neurology (n=300) in which one third reported MUS (Carson et al., 2000); and gynecology, where two thirds reported the same (Lipowski, 1988).

MUS raise a number of ethical concerns by virtue of their enigmatic yet common nature. Why are MUS so uncommonly recognized or referenced in medical records? If something is “medically unexplained,” should physicians be tasked with its

management? Should any symptomatic complaint or report that fails to fit neatly into a medical model seek attention elsewhere, outside of hospital or physician purview? And is a clinician ever entitled to seek or secure compensation if something is deemed “medically unexplained”? Are any of these already occurring?

Before considering these questions, it may prove useful to examine the typical trajectory of a patient with MUS in the current medical system. Since a wide variety of academic and other approaches have been taken to address MUS, a brief but relevant “crash course” in the history of medical ambiguity will also be presented.

Trajectory of Patients with MUS

The most common trajectory begins with a “negative workup” for symptoms at a primary care office, followed by referral to whichever specialist seems most closely aligned with the presenting complaint. The patient might be sent to rheumatology if the complaint is musculoskeletal, to cardiology if chest pain, to gastroenterology if abdominal symptoms, to neurology if numbness, and so on. The specialist conducts an evaluation to determine whether the patient does or does not have a diagnosis in the realm of that specialty. If there is no medical diagnosis found, the patient is likely to be returned to the primary clinician with a negative diagnosis, such as “no inflammatory arthritis,” “no coronary artery disease,” “no inflammatory bowel disease,” or “no multiple sclerosis.” A specialist is unlikely to opine further on the cause of the symptoms and is particularly unlikely to document the suspicion of MUS, still less likely to discuss it with the patient. The (overly-) concerned patient may then seek (or be offered by an overly-concerned physician) referral to yet another specialist (i.w., second and third opinions) with similar results.

Such a patient continues the cycle of seeking a medical diagnosis, undergoing a potentially harmful series of evaluations, receiving a report that “all medical tests are negative,” becoming disappointed with the lack of a clear answer, and then potentially repeating this process with differentor “better” clinicians (perhaps “super”-consultants or other clinicians operating in rather specialized clinical settings). This experience is exacerbated by clinician reluctance to recognize, discuss, or acknowledge MUS in any form other than the absence of medical explanation. As a result, a patient lacks the opportunity to discuss MUS in a more nuanced manner, including exploration of psychological, emotional, sociocultural, or other explanations for symptoms. Although each patient will respond to their MUS differently, a (i.e., variable) number of consultation cycles is pursued; the extent of such a medical crusade depends on a patient’s reluctance to accept non-medical explanations, financial/insurance limits, or other social or cultural pressures.

Psyche and Soma

Physicians have long ascribed the medically unexplained to poorly understood, abstracted or inaccessible realms, be it sorcery and spirits in the pre-scientific era or the complex machinations of the psyche thereafter. Psychogenesis and somatization dominated

medical parlance for approximately a century after the revolutionary contributions of a Freudian theory of the unconscious; patients with MUS were assigned a number of psychiatric diagnoses thereafter. Such diagnoses resulted in a somatoform disorder category described most recently in the fourth version of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV). They included hypochondriasis, somatization disorder, conversion disorder, and body dysmorphic disorder.

Problems abound with the many naming iterations for MUS, including “somatoform” itself. Greek for “resembling a physical disorder,” the term is highly confusing and uninformative. Even more cumbersome nomenclature includes “psychosomatic,” “conversion,” “psychogenic,” and “somatization” (Lipowski, 1988). Still in use today, these have served as descriptors of psychological processes, proposing a mental origin to physical symptoms and signs. They promote mind-body dualism (psychosomatic), imply directionality from psyche to soma and rarely, if ever, in the reverse order (psychogenic), propose the patient either volitionally or unconsciously transforms mental conflict into physical problems (somatization, conversion), and oversimplify pathophysiology (all of the above).

It is through these methods that this group of terms has resulted in significant patient stigma. The impracticality of the DSM constructs (for instance, somatization disorder requires very stringent diagnostic criteria with somatic complaints emerging in no less than 4 separate organ systems) also contributed to serious underuse despite the high prevalence of MUS. In a sample of 28 million patients covered by one insurance company, only 0.17% carried hypochondriasis as a diagnosis, 0.2% were diagnosed with somatization disorder, and 0.95% were classified as conversion disorder (Levenson, 2011). In another ambulatory sample of 206 patients with MUS, only 4.4% were diagnosed with a somatoform disorder (Smith et al., 2005).

The psychiatric classification system, though problematic, is not entirely to blame. The twentieth century saw significant advances in medical knowledge and technology allowing for the confirmation of less obvious mechanisms of disease; inflammatory models and the field of psychoneuroimmunology are recent examples. Pharmaceutical pressures invited overtly medical and pharmacological as opposed to psychotherapeutic or behavioral solutions to ailments (Kirmayer & Sartorius, 2007). Third-party payers followed suit, reimbursing such treatments more handsomely than nebulous ones. Civil rights movements, patient autonomy surges, and an increase in the risk of physician liability have likely disincentivized the use of psychiatric labels instead of medical ones, even if at the expense of therapeutic mislabeling, a phenomenon rarely discussed openly (Boissy & Ford, 2012). Psychiatry itself shed its psychoanalytic legacy, similarly embraced pharmacology, and focused on neurotransmitters rather than neuroses.

The “Medicalization” of Somatization

A proliferation of functional somatic syndromes resulted, largely replacing somatoform classifications. Functional somatic syndromes validate patient complaints and experiences in

the absence of clearly understood or demonstrable structural pathology. These disorders became and remain commonplace across medical specialties. They include, but are certainly not limited to, chronic fatigue syndrome (infectious diseases), chronic pelvic pain (gynecology), fibromyalgia (rheumatology), tension headache (neurology), atypical chest pain (cardiology), and irritable bowel syndrome (gastroenterology).

Although there is considerable evidence to suggest certain functional somatic syndromes feature psychoneuroimmunological or other neurobiological mechanisms, significant critique has been directed at this broad classification group (Anderson, Maes & Berk, 2012; Grover, Herfarth & Drossman, 2009; Sperber & Drossman, 2011; Tanaka et al, 2011; Perez et al., 2012). Kanaan et al (2007) for one note no clear etiology to these conditions and demonstrate each as defined by one to two “essential” features along with various “supportive,” albeit nonessential, features. Using chronic fatigue syndrome (CFS) as an example, the authors note the Centers for Disease Control (CDC) require 6 months of persistent fatigue (i.e., an essential feature) with *or without* supportive symptoms of sore throat, headache, and swollen glands. They also demonstrate considerable overlap between the various functional syndromes (i.e., unexplained headache is very common in IBS; gastrointestinal symptoms are prevalent amongst migraine sufferers), concluding that functional somatic syndromes serve as speculative explanatory models at best. Others propose one overarching functional somatic syndrome, noting shared mechanistic traits (e.g. serotonin dysfunction, sympathetic overactivation), overlapping symptoms, significant psychiatric comorbidity, and response to the same treatment (e.g. cognitive behavioral therapy, mindfulness-based stress reduction) (Wessely & White, 2004). As such, a certain “medicalization” of somatization ushered in an era in which specialized medical consultants operate as the primary caretakers of patients at times riddled with significant degrees of anxiety, depression, cognitive distortions, delusions, or otherwise traditionally “psychiatric” problems, a phenomenon compounded by patient preference and avoidance of stigma.

Physician attitudes towards this predicament are paradoxical, reflecting a blend of frustration and defeatist acceptance. Interestingly, whether practicing in an industrialized United Kingdom practice (Reid et al., 2011) or in Pakistani primary care settings (Husain et al., 2011), general practitioners have consistently become disillusioned regarding MUS while also believing they - and not mental health specialists - are best suited at its management. Evidence also confirms general physician difficulties in managing emotional reactions to MUS patients (Ringsberg & Krantz, 2006). Atkins et al (2013) revealed physician concerns around the general lack of awareness or education regarding MUS as well as the lack of an organic target or goal in its management. This has been corroborated by demonstrated consensus amongst medical schools in their need for curricula dedicated to MUS (Howman et al., 2012).

As such, classification systems have failed these frustrated physicians, but the reasons for this should be explicated. The functional somatic syndromal and DSM-IV approaches to MUS are alike in that definitive mechanisms are not articulated, though theories are entertained, including but not limited to that of a mental origin. The “verdict” is never clear, sparing patients of

stigma but also not necessarily delineating the illness process in any clear way. For various reasons, the use of negative or absent criteria (i.e. no explainable symptoms) in the pursuit of diagnosis is highly problematic. The extent of any lack of explanation for MUS depends on the medical examiner and the examination; enormous variability may exist between clinicians and their awareness of pathophysiology. MUS also depend on a current state of general medical knowledge – what was once unexplained may be explained eventually. Certain conditions, such as Parkinson’s disease, multiple sclerosis, systemic lupus erythematosus, may be heralded by atypical MUS in their early or prodromal presentations; ignoring this possibility may delay diagnosis or treatment. Finally, diseases present heterogeneously, and MUS may be part of each patient’s particular presentation (Dimsdale, 2011).

Consequently, conceptual alternatives to the MUS-based DSM-IV constructs emerged over time. One model proposes depression reduces pain thresholds, leading to hyperalgesia, in turn producing a negative view of one’s health which then results in increased somatization (Robbins & Kirmayer, 1996). In another view, untreated depression leads to alexithymia – or an inability to verbally articulate mood and emotional states – shifting a patient’s focus away from the psychological and toward the somatic (Kirmayer, Dao & Smith, 1998). Attachment theory cites abnormal or insecure attachment or bonding styles as somehow producing somatization, itself resulting in increased health care utilization as a means towards increased interpersonal gains such as attention or reassurance (Bowlby, 1969). Specifically examining the clinical presentation of hypochondriasis, authors have described four very different models possibly at play:

- psychiatrically, a syndrome composed of “functional” somatic symptoms, fear of disease, bodily preoccupation, and the persistent pursuit of medical care
- psychoanalytically, a derivative of aggressive or oral drives or as a defense against guilt or low self-esteem
- perceptually, an abnormal amplification of bodily sensations and their cognitive misinterpretation
- socially, a learned illness behavior eliciting interpersonal rewards (Barsky & Klerman, 1983).
- As with many complexities in medicine, this type of multi-layered, biosychosocial approach may ultimately be the most nuanced manner to understand MUS.

The very multitude of theories suggests no appropriate method of classification or consensus and illustrates medicine’s confusion in understanding the phenomena. Starcevic (2006) painted a bleaker picture, arguing that nomenclature should be patient-friendly (but never will be), etiologically-neutral (but never can be), and physician compatible (but consensus will always be lacking). He added that terminology should not be altered or replaced simply due to political pressure or stigmatization concerns, proposing that criteria such as MUS are the best we can hope for, given how honest and etiologically neutral the construct is.

The Empirical Approach: illness burden

Ultimately, how are the functional somatic disorders any different from the MUS-based, DSM-derived somatoform disorders? Do functional somatic disorders provide a patient-palatable and perhaps industry-sustaining distraction from underlying, unaddressed psychopathology? Is there any clinical benefit to switching from one seemingly unfalsifiable, untestable, and pseudoscientific construct of somatoform disorders to the somewhat equally unfalsifiable, untestable, and pseudoscientific construct of the functional somatic disorders? Why bother with these questions at all? The debate is more than a mere pontification. Tomenson et al. (2013) reviewed nine population-based studies looking at a total of over 28,000 subjects who were assessed for total symptom score and correlated with health outcome. The association with health status was significantly stronger for total somatic symptom score than for number of MUS, even after controlling for confounding effects of comorbid anxiety and depression. Degree of healthcare utilization was also correlated more directly to this measure than to MUS. Total somatic symptom score, regardless of its etiology, is a superior proxy for ultimate outcomes.

In line with these observations, the DSM offered a radical change in the somatoform disorders classification system with its fifth edition release in 2013 (American Psychiatric Association). Now known as *somatic symptom disorders*, the focus of criteria has shifted to overt outcomes rather than speculative etiology or lack of thereof. The attention to positive criteria, including consequences such as somatic burden, high healthcare utilization, and actual illness behavior should please the traditionally empirical medical corpus. None of these criteria comment on etiology while relevant, negative outcomes and consequences of the underlying phenomenon are themselves pathologized. These can be characterized further via subtypes capturing the particular output of the disorder, be it predominantly emotional, cognitive, or behavioral. This approach highlights genuine functional impairment while theoretically sparing the patient from stigmatizing labels that imply “psychogenesis.” Additionally, this method argues for clearer therapeutic targets, such as excessive health utilization or rigid illness beliefs. Other advantages to this system include less stringent criteria that may capture many more cases as well as less confusing terminology for both psychiatrists and non-psychiatrists to utilize in describing the highly somatic patient. Out with the descriptive yet arcane terminology of “somatoform” and “hypochondriasis” and in with the measurable and observable variables of care use and overt distress.

Of course, as warned by Starcevic (2006), there are no easy fixes, and this system carries its host of disadvantages. Despite ample evidence of over-utilization of care by those with somatic burden (Hiller & Fichter, 2004), Schroder and Fink (2010) argue that measures of behavior such as health utilization are far too complex and multifactorial to be utilized reliably as criteria. As such over-utilization may not solely be due to somatic preoccupation (as is the case in malingering or factitious disorders). Absence of such utilization behavior similarly does not preclude other illness. Other authors (Abramowitz & Moore, 2007) propose hypochondriasis as a subtype of obsessive-compulsive disorder (OCD), while still others (Sakai et al., 2010) argue these patients are simply somatic

variants of personality disorders, citing comorbidity with obsessive-compulsive personality disorder and avoidant personality disorder as high as 55.7% and 40.9%, respectively. And not to mention the complex topic of how culture impacts the understanding of illness and symptoms; Asian traditional medicine, for one, offers explanatory, albeit often unscientific, models for *all* symptoms (Fritzsche, 2011). MUS are ultimately only “medically” unexplained, implying many potential, alternative explanations for symptoms within cultural, spiritual, and societal models.

Despite these limitations, preliminary evidence suggests the DSM5 somatic symptom disorders are significantly superior at capturing both mental and physical functioning than the DSM IV somatoform disorders (Voigt et al., 2013); pilot “symptom clinics” are also showing promise in reducing burden when compared to usual care (Burton et al., 2012). It is hoped that a focus on outcomes and burden will encourage a greater usage of DSM-derived diagnostic criteria in aiding the identification and management of MUS. Nonetheless, the presumed (and likely) psychological etiology of *some* degree of MUS remains unaddressed in current psychiatric guidelines, incompletely capturing the phenomenon.

Illness Behavior

In order for a more comprehensive consideration of psychological underpinnings, behavioral medicine and psychiatry at large need to feel confident in their assertions regarding MUS, perhaps in the form of an explanatory model coalescing factors both etiological (i.e., lack of medical indication) and consequential (i.e., care utilization and illness burden). Such a comprehensive approach might alleviate aforementioned pressures contributing to superficial medicalization of psychological or psychiatric processes, which, in their worst form, would represent therapeutic mislabeling (Boissy & Ford, 2012) and thus employ a degree of deception, eroding the possibility of informed consent.

A holistic appreciation of *illness behavior* is needed. Mechanic (1995) aimed to showcase variability in reactions to symptoms and illness as driven by socio-cultural, psychological, and environmental factors. He described illness behavior as how an individual experiences, perceives, evaluates, and responds to his or her health status, focusing on the impact of these psychological and behavioral responses to illness on measures of function or disability. Pilowsky (1997) suggested the possibility of “*abnormal illness behavior*,” or a certain maladaptive mode of this perceiving, experiencing, evaluating, and responding to health status “despite...lucid and accurate appraisal of the situation and management...based on adequate assessment of all relevant biological, psychological, social, and cultural factors”. The implication in this definition is that of a certain degree of confidence in the medical consideration of contributing variables, as well as recognition of cultural and psychological rituals or patterns that may inform illness behavior. Pilowsky et al. (1984) attempted to capture attitudinal, affective, and other aspects of illness behavior in a 62-item self-administered survey instrument (the “Illness Behavior Questionnaire”), but was later criticized as lacking control for objective medical factors and thus absent of discriminant validity (Zonderman et al., 1985). Others have offered excellent, more recent reviews on the biological, psychological, and

sociological dimensions of abnormal illness behavior (Kirmayer & Looper, 2006); however, systematic clinical and academic attention to this model of understanding MUS and somatic burden is lacking.

The reasons for this absence are many and are similar to the concerns already discussed. The existing models (i.e., aforementioned DSM approaches, functional somatic syndromes, etc.) dominate, with little focus on how a person responds and reacts to his or her illness. The previously described medicalization of both psychiatry and somatization has reduced psychological attention paid by psychiatrists to patient behaviors. Defensive medicine drives a never-ending search for medical explanations, be they functional, esoteric, or both. A lack of agreed upon definitions or validated screening tools for identification of abnormal illness behavior also prevents its serious consideration. Its biopsychosocial complexity is also daunting and nebulous. Lastly, a patient-centered, autonomy driven, and morally relativistic plurality in which Western modern medicine operates removes incentives from clinical discussion of patient “behaviors” unless extremes are reached, such as overt self-harm or harm to others.

Ethical Implications

MUS remain a complex, poorly understood syndrome, and the reluctance of clinicians to recognize, acknowledge it or discuss it raises a host of ethical issues. These include informed consent, honesty, transparency, and justice.

Informed consent typically includes (1) the nature of the decision/procedure, (2) reasonable alternatives to the proposed intervention, (3) relevant risks, benefits, and uncertainties related to each alternative, (4) assessment of patient understanding, and (5) acceptance of the intervention by the patient (Faden & Beauchamp, 1986). By this definition, a patient with known MUS would have an atypical, indeed bizarre informed consent process, particularly in the third and fourth elements.

Risks and benefits are included in the third element of informed consent. Risks can be significant in diagnostic testing, such as the risk of intestinal damage from colonoscopy during evaluation of abdominal pain or the risk of a coronary artery perforation from a cardiac catheterization during chest pain assessment. An honest discussion of risks and benefits for evaluations and procedures in known cases of MUS would communicate the presence of some (or even high) risk without any possible therapeutic benefit. Patient understanding, the fourth element of informed consent, requires explanation of the medically unexplained nature of MUS with supporting notice that all medical testing will be negative.

Given these constraints, it is difficult to imagine even asking for consent; offering risk for no benefit is not part of medical practice. Nonetheless, when posed to patients with presumed capacity to consent to treatment, such an imbalanced equation (i.e., no benefit, only risk) should dissuade them from being evaluated or assessed. In fact, a patient's idiosyncratic request for testing despite this equation (“I just need to know, just in case this one is positive”) may itself be evidence of a lack of ability to consent, regardless of how low the risk (or how common the procedure) may seem to a clinician. Consultants routinely performing an evaluation

(e.g., cardiologists performing catheterizations, gastroenterologists conducting colonoscopies, etc.) are particularly prone to order such testing as a function of just how many they perform, desensitized to the fact that essentially zero benefit will emerge from the exercise.

Honesty is central to the practice of medicine, more so currently than ever given the emphasis on autonomy and patient self-determination. Gone are the days of lying to patients about their diagnosis, even if in order to protect them out of paternalistic ethical justification as has been suggested in past generations (Novack et al., 1989). Patients are now told they have cancer, schizophrenia, or XY chromosomes with androgen insensitivity syndrome despite a lifetime of living as a female. Given this, how could clinicians justify not telling patients that after a thorough medical evaluation, he or she suffers from MUS (perhaps better-explained psychologically, existentially, culturally, or spiritually) with no need for further testing? Most clinicians agree we cannot lie to or deceive patients. In a sample of over 1,800 practicing physicians, 89% of responders felt physicians should “fully inform all patients of benefits and risks of procedure or course of treatment” and 83% felt physicians should “never tell a patient something that is not true” (Iezzoni et al., 2012, p. 388). Interestingly, 45% of doctors in this same cohort had “described a patient's prognosis in a more positive manner than warranted” in the past year, revealing a discrepancy between physician values of honesty and actual practices (p. 388). In the case of MUS, many clinicians may fall back on the often-articulated notion that “just because we haven't found anything, it doesn't mean there is nothing there. So perhaps we keep looking until we do find something.”

Honesty includes transparency, which means clinicians ought to disclose what they know. It is not sufficient to avoid lies or deception; clinicians must be forthcoming with a discussion of MUS once it is recognized. Early inclusion of MUS as part of a differential consideration ought to be no different than a one including probable rheumatoid arthritis or likely multiple sclerosis. After a certain amount of time and evaluation, rheumatoid arthritis or multiple sclerosis either becomes obvious (i.e., allowing a definite diagnosis) or disappears (i.e., allowing rejection of the diagnosis). MUS could be approached similarly. If no medical explanation of symptoms is apparent after a reasonable amount of time and evaluation, MUS should be recognized and this information communicated to the patient.

Justice issues become especially significant once MUS is recognized. At that point responsible stewardship of medical resources would require shifting from multiple costly, unhelpful, potentially dangerous evaluations that offer no relief to more appropriate care. Such care utilization concerns may be partly addressed by the DSM-5 shift in somatic symptom classifications, although a consideration of the totality of a patient's health beliefs and consumption (namely, illness behavior) is warranted.

Conclusion

The role of psychiatrists and other mental health clinicians should be expanded, promoting a fused, multidisciplinary approach to uncharacteristic or medically unexplained illness burden and care utilization. In this era of increased attention to integrated

and collaborative care, blurring the lines between mind and body may only be possible after erasing the historical and unfortunate distinctions between medicine and psychiatry. Abnormal illness behavior offers promise as a guiding concept, though much work is needed in development of consensus regarding what exactly constitutes departures from adaptive illness behavior. As clearly adaptive features of patient behavior have been demonstrated (Katon, Ries & Kleinman, 1984; Kirmayer, Dao & Smith, 1998; Keyes & Ryff, 2003), it may thus prove useful to regard abnormal illness behavior instead as “maladaptive illness behavior” (MIB). This semantic distinction is purposeful as it recognizes that, although atypical illness behaviors may seem problematic or unhealthy to some extent, they nonetheless may be deemed “normal” or understandable within a larger context. “Maladaptive” thus implies a previously adaptive value to a behavior that has become problematic, extreme, or unhealthy. This reframing is intended to reintroduce the abnormal illness behavior concept into the clinical lexicon while remaining attuned to patient needs, reducing stigma, and hinting at the origins of abnormal illness behaviors (such as stoic defenses in underutilization or preoccupied attachment styles in overutilization). Qualitative (i.e., medical indication as per DSM-IV) and quantitative (i.e., care utilization as per DSM-5) approaches to MUS may require equal, balanced attention in capturing the essence of MIB; see Figure 1; Jimenez, 2014). New measures at assessing MIB are thus essential, and discussion is needed among all stakeholders – patients, providers, and payers – around the financial, political, and sociocultural drivers of such behavior.

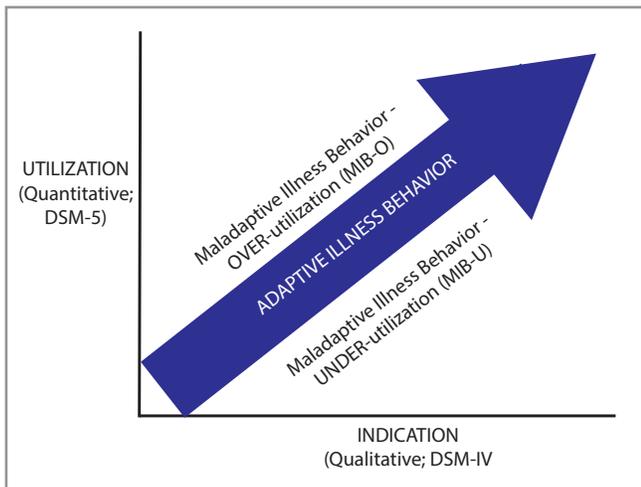


Figure 1: Maladaptive illness behavior (MIB) as a conceptual model fusing DSM-IV (qualitative) and DSM-5 (quantitative) approaches to medically-unexplained symptoms (MUS).

As complex as this task may seem, clinicians currently offer judgments on a number of psychosocial intricacies, ranging from gender dysphoria to how much a person owns before it becomes pathological hoarding. As such, psychiatrists already operate as determinants of aberrant behaviors, often guided by markers of functional impairment and other agreed upon measures. Combined with medical background, a tradition of behavioral judgment, and inherently biopsychosocial appreciations of disease, psychiatrists may thus be best suited at identifying and addressing MUS and the closely related phenomenon of MIB. Ethical and moral obligations call for the safeguarding of patient

self-determination. Autonomous and informed decision-making would call for a fundamentally patient-focused consideration of illness behavior and MUS from all dimensions, including psychological and psychiatric. Future efforts of medical and mental health care integration may offer fertile opportunity for just this to occur. In the meantime, patients will present symptoms and providers will pursue pathologies, while persons on either side of the encounter avoid difficult discussions surrounding illness reaction and behavior.

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