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The Case for Symptomatology, Impairments and a Healing Ecology

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ABSTRACT

This article presents the case for thinking about medicine from a very different perspective. An alternative is presented in relationship to the standard western medicine fragmented, reductionist, drug-based treatment. Instead of the standard approach to medical problems, the case is presented for working with symptomatology, impairments, and a healing ecology. We need to understand symptomatology in a wider context, understanding how any injury, illness, disease is pervasive within the individual's mind/brain/mind. These are never isolated, fragmented events. Secondly, rather than only spending time on diagnosis (which is important), clinicians must more importantly also focus on the impairments our patients are struggling with. Finally, we need to create a healing ecology for each of our patients. That is, a holding environment, a matrix, within which our patients can concentrate on healing. This includes the importance of the doctor-patient relationship, and the environmental context within which our patients are living their lives. We need to spend more time with our patients functioning as an organizing agent as they work through the struggle to get healthy again. Throughout the article, a case study is presented that illustrates the clinical use of this perspective.

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Introduction

Several years ago, while I was working on an Open Psychiatric Unit in a General Hospital, the following incident occurred, which I believe is very relevant to the content of this article. What I am writing about here represents what I have learned working with traumatic brain injuries patients over the past 8 years. (See the model I have developed tracking the neurodegenerative progression of trauma to the brain in Figure 1.) But my work has a social context, I am challenging our current medical models, and I want to address this social context first.

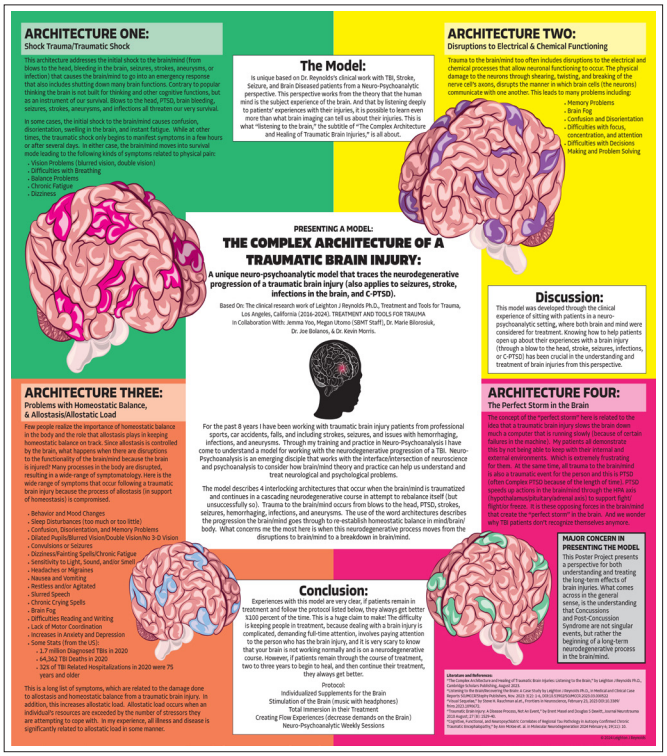

Figure 1

While working an evening shift on Hodgson 4 I heard our charge nurse calling my name from down the hall. She had her back to the door leading off our unit, my patient was threatening to leave, she appeared very distressed and was calling me for immediate help. I chose to walk down the hallway rather than run, with the idea that running toward to my patient would only distress him more, and he might bolt through the door injuring our charge nurse. As it turned out, I was right. A quiet approach diffused the situation, and the patient and I sat down to talk about what was going on with him. He admitted to his immaturity and apologized to the unit. Problem solved, end of story, right? Not quite.

The very next day, I was called on "the carpet" in the unit director's office for not following protocol. The charge nurse (whom I liked a lot and had always worked well with) had complained about my behavior, not following through with her urgent request to "come quickly." In the unit director's office, I was charged with not following instructions. At that time, I was too stunned to respond and make my case for what had worked. Instead, I apologized, accepted that there were "points against me," and went back to work. In hindsight, I could have spoken with the charge nurse that night and explained my thinking (and she could have shared her concerns with me before going to the director). But none of this happened and life on Hodgson 4 moved on. Overall, this was the best psychiatric unity I ever worked on using a psychoanalytic/milieu model that encouraged patients to talk about their experiences over totally medicating them away (although medication was a part of their treatment). But the hierarchy was still in place, and I was challenging that structure by thinking on my own. Whether I was correct and helpful did not matter as much as keeping the hierarchy in place. Lesson learned, but as you will see below, I haven't exactly stopped questioning the system.

For the purposes of this article, what I want to take away from this incident was my not choosing to follow protocol on the unit and not following the charge nurse's instructions. And what it means in general to question authority and chart your own course. I have been involved with medicine for over 40 years now, giving me an opportunity to observe the system very closely. In my experience, Western Medicine (which does save lives everyday) is defined by being reductionist oriented, fragmented by many, many specialties, and drug based for treatment. This system, while serving some things well (emergency medicine), is not in my opinion "a good enough system" and needs to be replaced, not just tuned up. I am entitling my replacement: "the case for symptomatology, impairments, and a healing ecology." Exactly what do I mean here?

By **symptomatology** I am referring to the collection of symptoms a person is struggling with, because of major disruptions to their homeostatic/allostasis processes (mind/brain/body). Then all injury, illness, and disease are seen as the result of allostatic load. This definition is very different from Merriam Webster's definition that symptomatology is "the complex of a disease." Or the Oxford University Press definition that symptomatology is the "study of the signs and symptoms of a disease." In essence my view is looking at medicine in an entirely different way. I came to this conclusion while observing my patients experiencing multiple symptoms as a result of trauma to the brain. What I observed with my patients was not just the symptom complex of one disease. I was observing the result of tremendous imbalances in homeostatic balance and the process of allostasis which keeps this balance from being interrupted. Allostatic load occurs as the result of too many demands on the mind/brain/body system overwhelming the individual's ability to "cope up" (to use a Filipino expression). When the accumulated effect of physiological stress leads to health problems, illness and disease, and/or death, we are seeing the results of the body turning against itself, allostatic load. What I believe is missing in our understanding of injury, illness, and disease is the recognition that constantly having to adapt to stress causes significant wear and tear on the body. In turn, this constant need for adaptation to stressors in a person's life creates a negative effect on the immune system, metabolic processes, and their cardiovascular system. This leads to an increase in blood pressure, lipid and glucose levels and inflammation, all leading to an increase in health risks. My conclusion, again: all illness, disease, and injury problems are the result of allostatic load. Hence the patient needs to be treated in a much broader context [1-3].

While I was participating in the 2023 World Brain Congress in Los Angeles we discussed that while a diagnosis is important, it is not as important as understanding the **patient's impairments** resulting from what was diagnosed. And if we really want to help our patients, this is what we need to focus on. The patient's specific impairments (unique for every patient), which have resulted from the symptomatology the patient is struggling with.

The Third Aspect of this Model Involves Setting up a "Healing Ecology" for each Patient

The key aspect of this perspective is the willingness of the clinician to enter the patient's experience. To be with them in their experience of illness, disease, or injury. This is a neuro-psychoanalytic approach involving understanding the connection/interface/interaction of brain and mind and body. Pulling together what neuroscience has taught us about the brain with what psychoanalysis has taught us about the mind.

I don't believe much will change for patients unless the clinician is there with them in their experience as one of my patients put it succinctly, an organizing agent. Helping them to organize their experience. So many of my patients have expressed that they really didn't understand what was happening to them as a result of the traumatic events they experienced, either psychological or organic. What I find is that there is always a combination of both: psychological and organic issues occur no matter what the origin of the trauma. And the clinician's work is not to remain outside of the patient's illness, disease, or injury giving only medication, physical techniques, or cognitive-behavioral therapy. We must be with the patient in their experience. With highly traumatized individuals this is very difficult work requiring a lot of training on the part of the clinician to be able to act as an organizing agent for these kinds of cases. I note here that my psychoanalytic training has been invaluable in helping me "be with patients" who are experiencing extreme situations, severe trauma, brain injuries, and psychosis.

Here is an example of the Protocol I use, which supports a healing ecology in a total sense:
Making sure we know the patient's history.
Nutrients for the brain/mind, not drugs.
Total immersion in the healing process (constructing a daily context within which to heal).
Stimulating the brain/mind (here I recommend music with noise cancelling headphones as the best way to facilitate this).
Developing "flow experiences" (when the brain/mind is totally captured by the patient's experience sending them into "the zone").
Neuro-Psychoanalytic sessions at least once a week to be an organizing agent for their difficulties (sometimes my patients need 5 times per week sessions).
Now, let's look at a case that illustrates this perspective.

The Case

Mr. Q. is a TBI/C-PTSD case which I now understand is best understood as the "perfect storm" in the brain. Traumatic brain injury issues slow the brain down through physical symptoms, cognitive decline, social and emotional problems and sleep disturbances. While C-PTSD speeds up the brain/mind through excessive and long-term stress hormones. This is a clash of 2 opposing influences/forces in the brain/mind that makes persons feel crazy. Mr. Q. was referred to me after he had "gone off" in a county building requiring intervention from security and the police because his behavior was very scary.

(D) "What do you think you have the most difficulty with?"

(P) "My anger. I just can't control it. I feel like I just erupt and then I regret it later."

(D) "Where do you think this is all coming from?"

(P) "I really don't know. It just strikes me especially when I'm stressed."

(D) "Do you know what was stressing you out that day?"

(P) "Yes! I think people are always out to get me. And they were that day."

(D) "Do you black out at all during these incidents?"

There was a long pause.

(P) "Now that you're asking me, I think I do black out during these episodes……"

(D) "Because in those moments you're just enraged, and the rage just takes over your brain."

Another long pause.

(P) "Yeah, Doc, I guess that's about it. I get enraged and I can't control it. Now look at the trouble I'm in!"

What is the background here? How did my patient end up in a criminal case?

Beginning in childhood, Mr. Q suffered a number of blows to the head from his abusive father. And during the summer between his 5th grade and 6th school years his father locked him in the attic for the entire summer.

(D) "Did you feel like you were in a prison? Like solitary confinement?"

(P) "Definitely! And I cried myself to sleep every night on a hard wooden floor."

(D) "Torture?"

(P) "Most definitely!"

(D) "Did your father give you any access to books, magazines, video games, television, radio, any stimulation?"

(P) "The only thing I had was what I could find in the attic. So, I used to find ways to build things with whatever objects I could find in the attic. Sometimes, it was pretty interested what I found."

(D) "That's how you passed your days?"

(P) "Pretty much…….. occasionally I found some pretty interesting stuff.

(D) "That kept your mind occupied?"

(P) "That's how I managed. But it was damn lonely up there in the attic until some family member would come up with food once a day."

Symptomatology

In a complex case like this, I don't believe it possible to stick with the standard definition of symptomatology as the complex set of symptoms created by the injury, illness or the disease. What we are really seeing in these cases are much wider problems created by the original injury, illness, or disease. And accordingly, our scope of diagnosis and treatment needs to be much wider to recognize and understand how trauma to the brain, mind, or body really creates systems wide problems. This is my definition of symptomatology. Much of my work involves trauma to the brain resulting from physical trauma to the brain, a stroke, seizures, infections in the brain, illness and disease in the brain, and major mental illness (schizophrenia, manic depression/bipolar, and psychosis. But I believe this wider perspective is valuable in the treatment of all injury, illness, and disease that our patients are struggling with. (#4, #5) Recognizing and treating from this perspective for Mr. A, first there will be disruptions in mind/brain/body functions that are pervasive. And if left untreated, will lead to a breakdown in mind/brain/body functioning at, again, at a pervasive level for the patient.

Again, symptomatology by my definition looks at this much wider scope of what the patient is struggling with. Mr. Q for example has medical issues in all 4 areas addressed by the 4 Baskets of Symptoms: physical symptoms, cognitive decline, social and emotional problems, and sleep disturbances. Because mind/brain/body are all interconnected, patients need to be treated recognizing this much wider scope. Is this more difficult for both patient and doctor? Yes!

Impairments

At the World Brain Congress in Los Angeles in 2023 (sponsored by the Society for Brain Mapping and Therapeutics) we discussed the importance of impairments over simply diagnosis. There is no question that diagnosis is important for all our patients. But what good is a diagnosis if we don't understand exactly how it impairs our patient's ability to function in their daily lives. And this will be individual and unique for all our patients. In Mr. Q's case he was not able to deal with his daily life because of chronic pain, chronic, fatigue, chronic headaches, dizziness and balance problems, memory problems, difficulties with rage and impulse control, increased issues with depression and anxiety, constant brain fog and difficulties with confusion and orientation, difficulties with concentration, focus, and attention span, and chronic insomnia. Is it any wonder that he was able to function at all.

Creating a Healing Ecology

Creating a healing ecology in a world that is increasing stressful and distressing to all of us, is not easy. In my experience, brain injuries require full-time attention (with a daily schedule), and the patient needs to find ways to reduce the demands on their brain. Over time working with patients, I came to understand that demands on the brain of any kind interfere with the healing process. A brain injury is different than any other kind of injury, illness, or disease in the body. You can place a broken arm or leg in a cast and not use it while it heals. This is not true for the brain, it is in use constantly, in charge of every aspect of our lives. For us to survive, the brain/mind must perform even when injured. How do we work with this dilemma, and how does this wider perspective apply to Mr. Q's treatment?

A Treatment Plan

As I stated earlier, when working with trauma to the brain, physical and/or psychological, I set up the following 6-point protocol, and individualize it for each patient:

Make sure to explore and understand the patient's history. In Mr. Q's case, it took years to unravel his complex, traumatic history, and understand the wider scope of his symptomatology. Something our current system does not prioritize enough. The use of nutrients/supplements for the brain, not drugs (which in my experience are counter indicated with brain injuries).

Total Immersion in the healing process (a daily schedule for healing which works to drastically reduce demands on the brain). This is not easy to because all of us need to be using our brain/minds to negotiate the world every second we are alive.

Stimulation to the brain for healing (I suggest special music using noise cancelling headphones). See the music of Steven Halpern at stevenhalpern.com. The creation of "flow experience" (order and organization in consciousness).

Neuro-psychoanalytic sessions 1-5 times per week to track difficulties and progress using the 4 Baskets of Symptoms referred to earlier [4,5].

In Conclusion

What I believe is most important about this approach is the formation of the "treatment relationship." It is a doctor-patient relationship with both parties engaging in the healing ecology. And for this to occur, the clinician must be willing to join the patient's experience, not remain outside of it. This does not mean getting "absorbed" into their experience. Then the clinician has no objectivity which is so essential to our work. But this does mean being willing to "listen to the brain/mind" very carefully.

We need to be open to what our patients are experiencing and give them "the space" they need to express whatever they are experiencing. This is not easy for either the doctor or the patient. Because for brain injured patients like Mr. Q they have constant problems with brain fog, memory loss, confusion and disorientation, and chronic fatigue and pain. In general, it takes a lot of energy on their part to be able to "process" their world and they are always running behind in working to this. But I have found this aspect of the treatment to be the most helpful. For brain injured and traumatized persons this partnership experience is crucial to their recover.

I end with the following exchange between myself and Mr. Q:

(P) "Hey, Doc. Can we run by my symptoms one more time? I have a difficult time absorbing everything, you know. I think we're talking how my brain injury leads to mental health problems."
(D) "Where would you like to start?"
(P) "Complex-PTSD, I think……"
(D) "Do you mean when we were talking about intrusive thoughts, flashbacks and nightmares?"
(P) "Yeah, when we were talking about all that stuff. I get those every day."
(D) "What about avoiding unpleasant memories, persons, and places associated with the traumatic events you've experienced throughout your life?"
(P) "Yes, I do that."
(D) "What about negative changes in your thinking and your mood?"
(P) "Well, I'm definitely not able to think very clearly most of the time, and I'm always going through mood swings. I get enraged pretty easily."
(D) "Have you noticed that you are often hyper-aroused? There have been significant changes with your arousal reactions and your reactivity button is easily pushed?"
(P) "Most definitely. That's me. React on a dime, and don't think about what I'm doing."
(D) "What about dissociation? Your mind is not in the room with you. It automatically goes somewhere else when you're really stressed."
(P) "You mean like I kind of blank out?"
(D) "Yes. It's actually an unconscious protective mechanism to keep you away from the traumatic events that can simply overwhelm a person."
(P) "That's what my mother tells me. When we start arguing, I'm just not there anymore."
(P) "That's it? This is what I'm dealing with?"
(D) "I think there is more."
(P) "More? Isn't this already enough?"
(D) "Unfortunately, the whole picture also includes avoiding social situations, changes in a person's appetite, a decrease in the person's productivity, a real sense of despair and probably a lot of guilt, difficulties with concentration and focus, chronic fatigue, a feeling of hopeless, a lack of motivation to do much of anything, and low self-esteem."
(P) "That definitely sounds like me! Plus, I get too aggressive, and I really don't sleep well at night, because I have a lot of nightmares."
(P) "So, Doc, am I hopeless? This is a lot of crap to have to go through."
(D) "I believe you're already on the right road to recovery."
(P) "Sometimes that's hard for me to believe."
(D) "What do you doubt exactly?"
(P) "I guess I wonder if I have enough faith in myself and you, to make it."
(D) "My experience in working with brain trauma and Complex-PTSD is that if we keep 3 things in mind during our work together, you can make it!"
(P) "And what are the 3 things? You probably told me already. See, I can't remember anything."
(D) "Not a problem. The 3 things are: One, paying attention to your symptomatology, the total scope of all your symptoms. Which as we have just discussed is pretty broad. Two, we pay attention to the impairments you face in your daily life as a result of your symptomatology and work to change and improve these impairments. And three, we establish a healing ecology that includes you and me, your family, and the environment you live in."
(P) "That's a lot to ask, Doc."
(D) "True, but in my experience this approach does work very well. Patients get better! And you're right, it is a lot of work for both the patient and the doctor. Bottom line, I believe that if you and I continue to work on this, I have no doubt that you will get better!"

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