Physiotherapy Management of Functional Disorders

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Aims

- To define functional disorders in a therapy and rehabilitation context
- To describe general treatment principles with reference to published literature
- To describe practical examples of treatment based on experience
- To demonstrate a need for therapy in functional disorders

Functional Disorders

- Common (Stone et al 2005)
- Costly
  - Greater health utilisation
  - Total cost estimated £18 Billion (Chitnis 2011)
- Worthy of treatment
  - In need of help
  - Often lack of support, not taken seriously
  - High disability and distress (Stone 2009)
  - At risk of iatrogenic harm from unnecessary surgeries etc

Continuum of control

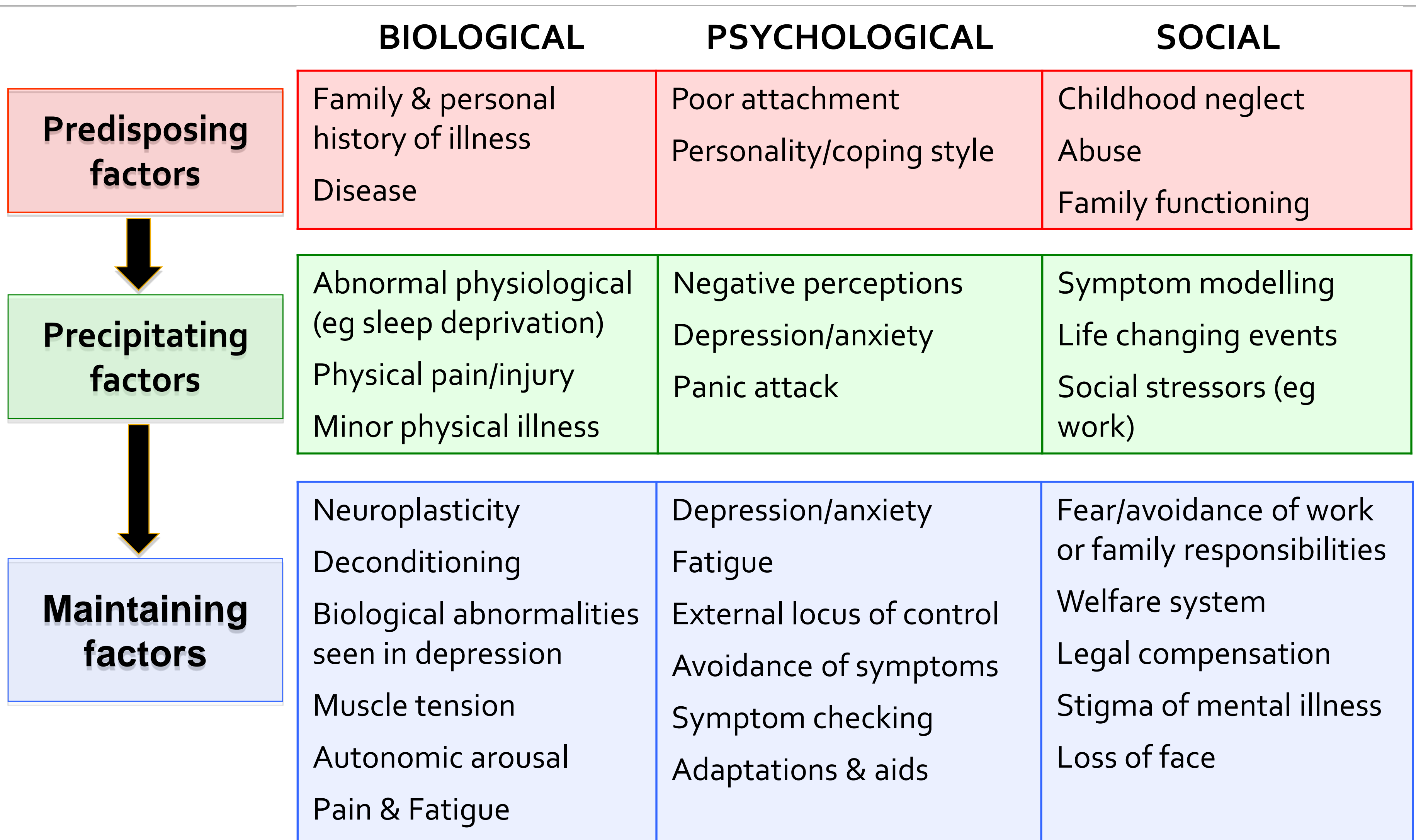
- Somatisation is distinct from malingering and factitious disorders
- Inconsistency does not equal faking (Stone 2009; Teasell 2002)
- Control may be thought of as on a continuum where thoughts and behaviours affect symptoms

Malingering ⟷ Absence of control

- Over emphasis of symptoms in order to be taken seriously (Chitnis et al 2011)
- Distinguishing between malingering and somatisation is not always possible (Stone et al 2005)

Aetiology

(Adapted from Stone et al 2005)



	BIOLOGICAL	PSYCHOLOGICAL	SOCIAL
Predisposing factors	Family & personal history of illness Disease	Poor attachment Personality/coping style	Childhood neglect Abuse Family functioning
Precipitating factors	Abnormal physiological (eg sleep deprivation) Physical pain/injury Minor physical illness	Negative perceptions Depression/anxiety Panic attack	Symptom modelling Life changing events Social stressors (eg work)
Maintaining factors	Neuroplasticity Deconditioning Biological abnormalities seen in depression Muscle tension Autonomic arousal Pain & Fatigue	Depression/anxiety Fatigue External locus of control Avoidance of symptoms Symptom checking Adaptations & aids	Fear/avoidance of work or family responsibilities Welfare system Legal compensation Stigma of mental illness Loss of face

Hughlings Jackson Ward

MDT Inpatient Rehabilitation Programme at NHNN

- The team
  - Neuro-Psychiatrists
  - Neurologist
  - Mental Health Nurses
  - Therapists – CBT, OT, SLT, Physio & RA
- Four week programme
- Goal focussed rehabilitation
  - Weekly patient focused MDT goal setting & timetabling
  - Weekly ward round + team meeting
- Patients selected for programme at MDT clinic

Principles of Treatment

- Combined physical and behavioural approach
- Communication
- Establish detailed treatment contract early on
- Functional focus
- Goal setting
- Consistent approach
- Be aware of patients suggestibility
- Involvement of family
- Praise positive behaviours, ignore negative
- Patience – expect ups and downs

Brazier & Venning 1997; Chitnis et al 2011; Mai 2004; Ness 2007; Smith 2007; Speed 1997

Initial Assessment

- Detailed and specific
  - Acknowledge and validate suffering
  - Summarise
- Start by clarifying patients understanding of diagnosis
- Bleed the symptoms dry
- Timeline of symptoms
- 24 hour routine
- Social History
- Impairment vs Functional assessment
- Establish the patients priorities and goals

Chitnis et al 2011; Stone et al 2005

Physiotherapy Management

- Treatment – set boundaries
  - Agree on number frequency and length of sessions
- Education
  - Facilitate patients understanding
  - If no psychological acceptance – "work on the changeable"
  - Normalise & reassure while recognising disability
  - Provide expectation of recovery
  - Provide rationale for treatment
  - Identify and challenge unhelpful thoughts & behaviours

Chitnis 2011; Hansen 2010; Silver 1996

Physiotherapy

- Correct abnormal movement patterns
- Address pain – See Hansen et al 2010
- Address fatigue
- Exercise nonspecific strengthening and CV (Dufour 2010)
- Equipment – often a point of contention. Avoid issuing, agree on plan to wean
- Practice strategies to control symptoms
- Relapse prevention
- 6-12 month plan with long term goal
- Discharge planning & Handing over

Chitnis 2011; Hansen 2010; Heruti 2002; Ness 2007; Speed 1996; Teasell 2002

Outcome Measures

- Visual Analogue Scale (VAS)
- Canadian Occupational Performance Measure (COPM)
- Function Impairment Measure (FIM)
- Goal Attainment
- Gait and Balance measures
- Back pain scales – eg Roland-Morris Disability Questionnaire
- Fatigue Impact Scale
- Video
- Quality of life measures (GHQ)
- Others… Functional OCM's more useful than impairment based

Evidence for Physiotherapy

- No RCT's
- Expert opinion – a combined physical, behavioural and psychological approach is effective
  (Stone et al 2005; Chitnis 2011; Smith 2007)
- Case Reports
  (Duck et al 2005; Ness 2007; Hughes & Alltree 1990; Withrington & Parry 1985)
- Assessment of MDT rehab programme
  (Moene 2002; Speed 1996)
- Difficulties with research
  - Heterogeneous population (Mai 2004)
  - Different treatment approaches
  - Question the literature! Is this right for my patient??

The patient who does not get better

- A certain percentage of patients will not improve – predicting can be difficult (Stone 2009)
- Stick to your treatment contract (Heruti 2002)
- Preserve therapeutic relationship (Stone 2005)
- Maximise independence
- Minimise secondary changes and harm
- "Do I give them a wheelchair?"

Managing Non-epileptic Attacks (NEA)

- Role of physiotherapy will vary
  - Addressing other functional symptoms – present in up 90% of cases
  - Facilitate understanding of diagnosis
  - Address avoidance behaviour – Increase function, graded exposure
  - Facilitate internal locus of control – pts with NEA report more external LOC than epilepsy
- Techniques to avoid NEA
  - Distraction & suggestion
  - Grounding techniques
- Dealing with a NEA
  - Try to appear unconcerned
  - "Its ok, you are safe, we will continue when you are able"
  - Avoid positive reinforcement

Reuber 2008

Managing Functional Tremors

- Realistic expectations
  - 27% improved (12% of these following treatment) (McKeon 2009)
  - Positive indicators: presence of anxiety, medication.
- Characterieristics (McKeon 2009; Jankovic 2006)
  - Distractibility: 60-73%
  - Variability: 62%
  - Entrainment: 8-18% of cases
- Management
  - Normalise – practiced movement, anxiety & stress, rationale for Rx
  - Explore the effect of positions and postures
  - Explore the effect of entrainment, distraction and relaxation
- Develop management strategies based on above and discuss rationale for your intervention

Case Study – Functional Gait Disorder

Mrs A

- HPC
  - 2007 – Fatigue
  - 2008 – Back pain with p&n's
  - 2008 – Hospitalised for chest infection & developed LL paralysis
  - 3 months rehabilitation & community input
  - 20010 – Referred to NHNN MDT programme for conversion disorder
- Social Hx
  - Difficult first marriage
  - Current social issues at home
- Predisposing factors – previous experiences
- Precipitating factors – social stressors (work and family) & illness
- Maintaining factors – pain, fatigue, carers, sickness benefits, relationships, self esteem, aids & equipment

Gait on admission

video

Case Study – Functional Gait Disorder

Mrs A

- Problem List
  - Ataxic gait
  - Dependent on walking frame
  - Difficulty dressing
  - Dependent on carers for ADLs
  - Fatigue
  - Low back pain
  - Dizziness
  - Anxiety
  - Secondary muscle changes
  - Agoraphobia

Case Study – Functional Gait Disorder

Treatment

- Neurologist
  - Exclusion of organic illness prior to admission
  - Introduce idea of psychological cause
- Psychiatrist
  - Rationalise meds, pharmaceutical Mx of anxiety & depression
  - Expand on psychological nature of symptoms & oversee treatment
- CBT
  - Cognitive formulation
  - Cognitive restructuring
  - Addressing agoraphobia and anxiety
- OT
  - Fatigue management - education, planning, pacing
  - ADLs – washing, dressing, kitchen activities
  - Self esteem – Grooming, personal attention
  - Vocational Ed – advice and planning

Case Study – Functional Gait Disorder

Physiotherapy

- **Education – challenging illness beliefs**
- **Chronic pain management**
- Practice components of gait
- Body alignment & feedback using mirror
- Stretching programme for tight muscles
- Avoid practicing poor movement patterns
- Wean from walking aids
- Increase exercise tolerance
- Outdoor mobility & stairs
- Addressing aches & pains from increased activity

Case Study – Functional Gait Disorder
Outcome

video

Summary

- FD's are complex!!
- Maintain boundaries, stick to contract, preserve relationship
- Have realistic expectations
- These patients are worthy of your time
- Therapy input can
  - Be cost effective
  - Produce impressive results
  - Rewarding

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- Key Resources
  - www.neurosymptoms.org Jon Stone
    Information aimed at patients
  - Stone J et al (2005) Functional symptoms and signs in neurology: Assessment and diagnosis / Management. Journal of Neurology Neurosurgery and Psychiatry. 76(Suppl) i2-i21

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