BJPsych Open (2023)
9, e131, 1–2. doi: 10.1192/bjo.2023.524

Editorial

Mindsets matter for every patient and we can all help†

David Ring

Summary

People seek care when a sensation becomes a symptom (a concern). Levels of discomfort and incapability are associated with feelings of distress or unhealthy misinterpretation. To limit mental health stigma, it is important to emphasise that this is about how the human mind works (mindsets) and not just about mental illness. Experts in mental health and in pathophysiology can work together, each doing their part to optimise mindset.

Keywords

Stigma and discrimination; anxiety- or fear-related disorders; cognitive–behavioural therapies; depressive disorders; psychosocial interventions.

David Ring is Associate Dean for Comprehensive Care, Professor of Surgery and Perioperative Care, and Courtesy Professor of Psychiatry/Behavioral Sciences and Health Social Work at Dell Medical School, The University of Texas at Austin, Austin, Texas, USA.

The evidence that mindsets and circumstances are key contributors to levels of discomfort and incapability is strong.[1–4] Now we are working to implement these facts into everyday care.[5] The rationale for addressing mindsets along with physical symptoms is straightforward. The human mind is constantly interpreting,[6] and the autopilot part of the mind is programmed to prepare for the worst. Patients present with a sensation that has become a symptom, meaning the sensation has become a concern.[7] Consequently, we can be on the lookout for misconceptions, even small ones, because they are so common.

There is evidence that common misconceptions about sensations are more fixed and impactful the greater one's level of distress (feelings of anxiety and depression).[8,9] Some small or large feelings of worry or despair are experienced by humans every day. And these feelings are important even if they do not reach a threshold level for application of a diagnosis. In other words, mental health is continuous, not dichotomous. And all of us can strive for a healthier mindset. Dichotomising mental health as mental illness, or a mental health diagnosis, is a false dichotomy that reinforces mental health stigma. Co-management of diagnosed mental health and musculoskeletal conditions is one option, often referred to as collaborative care.[10] An alternative, perhaps more suitable approach might be the crafting of care strategies (outlined herein) that treat the whole person. Every person, every time.

The health benefits of accommodation

Everyone over age 50 has at least one musculoskeletal disease and some level of sensations from that disease. For instance, most of us develop osteoarthritis of the trapeziometacarpal[11] and knee joints[4] and rotator cuff tendinopathy[12] as we age. It is important to adequately distinguish the following: people with a disease (pathophysiology), people who notice sensations from the disease, people who become concerned about what the sensations signal about their health (people with symptoms) and people concerned enough about the symptoms to seek care. Musculoskeletal care is largely discretionary and infrequently necessary. Those of us who see a specialist are usually satisfied with a single visit.[13] In other words, accommodation is an effective and highly utilised health strategy. The key aspects of accommodation may be healthy mindsets and healthy circumstances (security in employment, finances, home, food, relationships and roles).[14]

The importance of mental and social health in musculoskeletal illness can be seen in the marked discordance of levels of disease (pathophysiology severity) and levels of illness (the state of being unwell – discomfort and incapability).[2,15] People with musculoskeletal pathology are less comfortable and less capable in proportion to symptoms of depression and anxiety and levels of unhelpful thinking such as worst-case thinking and fear of painful movement.[1,3]

Comprehensive whole-person care

The trial proposed by Teixeira et al[10] will measure the feasibility and acceptability of adding a case manager to prioritise alleviation of symptoms of worry and despair as part of non-operative musculoskeletal out-patient care. That goal will be served not by diagnosing people with anxiety or depression, but rather by anticipating some level of distress and strategising care so it alleviates that distress, and by anticipating misinterpretation of sensations and making sure the care identifies and gently reorients those misconceptions.

I enthusiastically support the strategy of leveraging the average person's high regard for physical, occupational and hand therapy and incorporating aspects of mindset training into their care. The combination of physical and mental training (variations of cognitive–behavioural therapy) is referred to as psychologically informed physical therapy[16] or cognitive functional therapy.[17] Every member of the care team can be attuned for common misconceptions and feelings of distress in every patient. And the way we address symptoms can be constructed to promote healthy mindsets.

† See Teixeira et al.[10]

https://doi.org/10.1192/bjo.2023.524 Published online by Cambridge University Press

David Ring, MD, PhD, Dell Medical School, University of Texas at Austin, Austin, Texas, USA

Correspondence: David Ring. Email: david.ring@austin.utexas.edu

First received 17 May 2023, final revision 8 Jun 2023, accepted 8 Jun 2023

Data availability

Data availability is not applicable to this article as no new data were created or analysed in this study.

Funding

This article received no specific grant from any funding agency, commercial or not-for-profit sectors.

Declaration of interest

D.R. reports royalties from Skeletal Dynamics, personal fees for *Clinical Orthopaedics and Related Research* (as a Deputy Editor), the US Health Services and Resource Administration, US Department of Justice, Premier Healthcare Solutions, Wolters Kluwer Health and Everus, and stock options from MyMedicalHub, all outside the submitted work, and a grant from the National Institutes for Health related to the work.

References

1 Miner H, Rijk L, Thomas J, Ring D, Reichel LM, Fatehi A. Mental-health phenotypes and patient-reported outcomes in upper-extremity illness. *J Bone Joint Surg Am* 2021; **103**: 1411–6.

2 Crijns TJ, Brinkman N, Ramtin S, Ring D, Doornberg J, Jutte P, et al. Are there distinct statistical groupings of mental health factors and pathophysiology severity among people with hip and knee osteoarthritis presenting for specialty care? *Clin Orthop Relat Res* 2022; **480**: 298–309.

3 Teunis T, Al Salman A, Koenig K, Ring D, Fatehi A. Unhelpful thoughts and distress regarding symptoms limit accommodation of musculoskeletal pain. *Clin Orthop Relat Res* 2022; **480**: 276–83.

4 Kim KW, Han JW, Cho HJ, Chang CB, Park JH, Lee JJ, et al. Association between comorbid depression and osteoarthritis symptom severity in patients with knee osteoarthritis. *J Bone Joint Surg Am* 2011; **93**: 556–63.

5 Zion SR, Crum AJ. Mindsets matter: a new framework for harnessing the placebo effect in modern medicine. *Int Rev Neurobiol* 2018; **138**: 137–60.

6 Kahneman D. *Thinking, Fast and Slow*. Farrar, Straus and Giroux, 2011.

7 Hay MC. Reading sensations: understanding the process of distinguishing "fine" from "sick". *Transcult Psychiatry* 2008; **45**: 198–229.

8 Cremers T, Zoulfi Khatiri M, van Maren K, Ring D, Teunis T, Fatehi A. Moderators and mediators of activity intolerance related to pain. *J Bone Joint Surg Am* 2021; **103**: 205–12.

9 Fischerauer SF, Talaei-Khoei M, Vissers FL, Chen N, Vranceanu AM. Pain anxiety differentially mediates the association of pain intensity with function depending on level of intolerance of uncertainty. *J Psychiatr Res* 2018; **97**: 30–7.

10 Teixeira M, Tehrany R, Jaggi A, Ahmed R, Dove L, Ramanuj P. Collaborative care model versus usual care for people with musculoskeletal and co-existing symptoms of anxiety and depression: protocol for a feasibility mixed-methods randomised controlled trial. *BJPsych Open* 2023; **9**(4): e109.

11 Becker SJE, Briet JP, Hageman MGJS, Ring D. Death, taxes, and trapeziometacarpal arthrosis. *Clin Orthop Relat Res* 2013; **471**: 3738–44.

12 Teunis T, Lubberts B, Reilly BT, Ring D. A systematic review and pooled analysis of the prevalence of rotator cuff disease with increasing age. *J Shoulder Elbow Surg* 2014; **23**: 1913–21.

13 Crijns TJ, Ring D, Valencia V. Factors associated with the cost of care for the most common atraumatic painful upper extremity conditions. *J Hand Surg Am* 2019; **44**(11): 989.e1–e18.

14 Vranceanu AM, Bakhshaie J, Reichman M, Ring D. A call for interdisciplinary collaboration to promote musculoskeletal health: the creation of the International Musculoskeletal Mental and Social Health Consortium (I-MESH). *J Clin Psychol Med Settings* 2022; **29**: 709–75.

15 Rohrback M, Ramtin S, Abdelaziz A, Matkin L, Ring D, Crijns TJ, et al. Rotator cuff tendinopathy: magnitude of incapability is associated with greater symptoms of depression rather than pathology severity. *J Shoulder Elbow Surg* 2022; **31**: 2134–9.

16 Coronado RA, Brintz CE, McKernan LC, Master H, Motzny N, Silva FM, et al. Psychologically informed physical therapy for musculoskeletal pain: current approaches, implications, and future directions from recent randomized trials. *Pain Rep* 2020; **5**(5): e847.

17 O'Sullivan PB, Caneiro JP, O'Keeffe M, Smith A, Dankaerts W, Fersum K, et al. Cognitive functional therapy: an integrated behavioral approach for the targeted management of disabling low back pain. *Phys Ther* 2018; **98**: 408–23.

https://doi.org/10.1192/bjo.2023.524 Published online by Cambridge University Press