

Detecting and Assessing Somatoform Disorders

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Case Study

- “Lanna” is a successful, 33 year old entrepreneur who owns three businesses with her boyfriend, “Mark.”
- Recently one of their businesses has been struggling and she and Mark have been getting into frequent arguments
- While driving to work one day, she is rear-ended by a truck and her head strikes the airbag
- She develops from this numerous cognitive and physical symptoms including:

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Case Study

- Headache
- Vertigo
- Dizziness
- Neck pain
- Back pain
- Light sensitivity
- Sound sensitivity
- Right leg numbness
- Shooting and tingling her thighs
- Poor sleep
- Poor appetite
- Reduced sex drive
- Depression
- Hypertension
- Memory loss
- Word-finding problems
- Attentional problems
- Inability to work
- Inability to socialize

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Case Study

- She presents to the office limping on a cane and wearing sunglasses
- She informs the examiner that this will be “very unpleasant” for her
- Shades are drawn, lights are dimmed
- The interview takes 2.5 hours
- After two tests she requests a break
- After two more tests she needs to end testing for the day
- Testing is completed over 3 sessions

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Questions:

- Is this from a brain injury?
- Is this a psychological reaction to her injury?
- Is this related to a preexisting psychological condition?
- Is this a somatoform disorder?
- Is this malingering?

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Definition of a Somatoform Disorder

- Somatoform conditions are conditions in which psychological distress manifests in the form of physical/cognitive complaints
 - “Non-psychologically minded” patients
 - The distress “has to go somewhere”
 - Ease of attributing psychological distress to other sources of distress

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DSM-5 Terminology

- Somatic Symptom Disorder
 - Disproportionate and persistent thoughts and/or anxiety and/or excessive time and energy devoted to at least one somatic symptom
 - There is an absence of medical explanation
 - The state of being symptomatic is persistent (at least 6 months)
 - May be specified as with or without predominant pain
 - Severity can be mild, moderate, severe

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DSM-5 Terminology

- Illness Anxiety Disorder
 - AKA "hypochondriasis"
 - The symptom are not present or mild
 - However, *anxiety* about a perceived disorder and/or health is excessive
- Conversion Disorder
 - Symptoms involve voluntary or sensory function
 - There is incompatibility between symptoms and known neurological/medical conditions

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DSM-5 Terminology

- Psychological Factors Affecting Other Medical Conditions
 - A medical symptom or condition is present
 - However, psychological/behavioral factors adversely affect the condition (delayed recovery, exacerbation of disease, interferences with treatment)
- Factitious Disorder
 - Falsification of physical or psychological signs or symptoms or induction of disease or disease associated with the deception
 - The individual presents as ill, impaired, injured to others
 - The deceptive behavior is evident *in the absence of obvious external rewards*
 - Not better explained by psychosis, etc.
 - NOT an actual somatoform condition!

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ICD-10 Terminology

- Somatization Disorder: multiple, recurrent, frequently changing physical symptoms at least two years in duration
- Hypochondriacal Disorder: persistent preoccupation with the possibility of having one or more serious and progressive physical disorders
- Somatoform Autonomic Dysfunction: symptoms are claimed to represent a physical disorder of a system/organ that is mostly autonomic in nature such as cardiovascular, GI, respiratory, urogenital, although symptoms do not reflect actual dysfunction in that system

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ICD-10 Terminology

- Persistent Somatoform Pain Disorder: persistent and severe pain which occurs in association with emotional conflict or psychosocial problems that are sufficient to allow the conclusion that they are the main causative influences
- Dissociative Disorders: these capture conversion disorders and other forms of disassociation (e.g. fugue, amnesia)

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DSM-IV-TR Terminology

- Somatization Disorder: A history of many physical complaints beginning before age 30 years that occur over a period of several years and result in treatment being sought or significant impairment in social, occupational, or other important areas of functioning.
 - Four pain symptoms, two GI symptoms, one sexual symptom, one pseudoneurological symptom
- Given the stringent criteria, undifferentiated somatization disorder or somatization disorder NOS are often used

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Risk Factors

- Lowered “resilience”
- Unusual or complicated illnesses in childhood
- Poor attachment
- Sexual and physical abuse (especially in childhood)
- Family history/modeling of symptoms
- Cultural factors

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Self-Deception

- Somatoform conditions are forms of self-deception
- The individual has “tricked” himself into believing the symptoms are present
- Contrast with malingering/factitious presentations which involve intentional deception of others
- Animals feign to survive – why not the human animal?

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Neurocognitive Deficits

- True “neurocognitive” deficits secondary to a somatoform condition are rare
- Subjective cognitive difficulties are quite common!
- Deficits on testing are likely secondary to transitory struggles in attention and concentration
 - Inconsistent test scores
 - Struggles on measures of the frontal/executive systems
 - Very slow, effortful, and/or exaggerated performance
 - “Stoic” versus “Expressive” traits

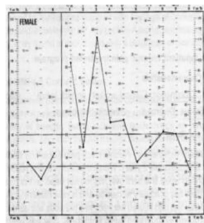
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Psychological Disturbance

- MMPI-2 has items designed to pick up somatoform characteristics
 - Scale 1: Hypochondriasis HIGH
 - Scale 2: Depression LOW
 - Scale 3: Hysteria HIGH
- Individuals with profiles like this often try to present themselves as normal and resent psychological interpretations of their discomfort.
- They lack insight into the source of their difficulties and are likely to attribute psychological disturbance to physical illnesses
- They endorse a disproportionate number of symptoms compared to individuals with known medical conditions

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Conversion V Pattern



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Somatoform Disorders and PPCS

- Persistent Postconcussive Syndrome resembles somatic symptom disorders
- Does PPCS arise from a somatic symptom disorder?
- Multiple Sclerosis argument
- A combination of performance on effort measures, neuropsychological measures, and the MMPI-2 can answer this question

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Somatoform vs Other Psych vs Neurological

- These conditions all include:
 - Post-concussive symptoms
 - Subjective cognitive complaints
 - Personality/mood changes
 - Struggles in frontal/executive systems
 - Often present in medical-legal environments!

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Neurological

- Mild and Major Neurocognitive Disorders
- Neurocognitive profiles that fit site of injury
- Neurocognitive domains “hang” together with preservation in areas that would be spared
- The mechanism and severity of injury results in a dose-response outcome in cognition, emotional functioning, and behavior

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Psychological

- Self-report and behavioral observations of depression/anxiety are quite apparent
- Neuropsychological scores are more variable, with domains that do not “hang together”
- Cognitive profiles known to be more specific to psychological conditions emerge (e.g. preserved encoding with poor recall)
- The patient’s day-to-day functioning is variable with odd patterns of symptom change (e.g. memory is worsening over time)

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Somatoform

- Similar to psychological conditions, although self-reported signs of depression and anxiety are usually less severe
- MMPI-2 Conversion V profile emerges
- The patient's symptoms are disproportionate or simply incongruent with the injury in question

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Malingering

- Malingering requires intentional feigning for external incentives
- Measures are designed to measure feigned psychiatric symptoms, feigned cognitive symptoms, and feigned physical symptoms
- The MMPI-2 is useful in separating feigned psychiatric and physical symptoms from genuinely experienced symptoms
- Performance validity measures can separate feigned cognitive symptoms from genuinely experienced symptoms

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Detecting Malingering:

- Neurological signs
 - Broad deep tenderness over the back
 - "Giving away" weakness
 - Diminished sensations
 - Shooting pains that do not follow the nervous system
 - Low-back pain reported when pressure is applied to the head while standing
- Neuropsychological signs
 - Failed force-choice measures (below chance)
 - Exaggerated cognitive struggles on items
 - Discrepancy between data and observed behavior
- Psychological signs:
 - Exaggerated self-report measures
 - Describes extreme symptoms that are incongruent with affect
 - Bizarre symptoms (little green men syndrome)
 - Symptoms come and go

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Slick Criteria (1999; 2012)

- Definite Malingering:
 - Presence of substantial external incentive to exaggerate/fabricate symptoms
 - One or more strong indicators of exaggeration/fabrication of neuropsychological problems or deficits
 - Behaviors are not substantially accounted for by psychiatric, neurological, or developmental factors
- Probable malingering:
 - Presence of substantial external incentive for exaggeration/fabrication of symptoms
 - Three or more indicators of possible exaggeration/fabrication

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- Strong Indicators (1 or more needed for definite)
 - Below chance performance on one or more forced-choice measures
 - High probability (.95 or greater) that performance on a validated index is below actual ability levels
 - Self-reported symptoms are unambiguously incompatible with or directly contradicted by observed behavior and/or test performance
- Possible Indicators (3 or more needed for probable)
 - Marked and implausible discrepancy between self-report and cognitive scores/behavior/self and collateral reports/expected performance

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Effort Measures

- Measures designed to pick up simulated "poor effort"
- Patients who fail multiple effort measures do not provide a neuropsychological profile that can be interpreted for clinical purposes
- Conversely, patients who pass multiple effort measures are likely exerting legitimate effort throughout the evaluation and their scores can be interpreted

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What Encompasses Effort Measures?

- Short answer: Everything!
- Longer answer: Standalone and embedded measures
- Standalone measures are specifically designed to detect poor effort
 - Strong research foundation
 - Failure of even one may raise questions about the examination
 - If the patient picks up on it, they can “pass” this one
- Embedded measures are usually derived from existing measures
 - Failure of several will raise questions about the examination
 - Easily hidden within real neuropsychological measures
 - Research foundation not as powerful as standalone measures

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How many are appropriate?

- Too many effort measures is essentially “deep sea trawling”
- Research shows that individuals with genuine cognitive disturbance (and even the normal population) can fail measures if enough are administered
- Too few effort measures may be insufficient to pick up variable or subtle signs of poor effort
- Rule of thumb: 2-4 standalone measures and 2-4 embedded measures is typical amongst neuropsychologists

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Somatoform in Medical-Legal Settings

- Important to determine if the patient’s struggles are linked to a genuine neurological/neurocognitive disorder, a psychological disorder, a somatoform disorder, or malingering
 - Issues of causation, compensation, and treatment hinge on this determination
- A somatoform disorder results in preoccupation with dysfunction and symptom magnification of physical symptoms that is largely at an unconscious level
- Are neuropsychologists qualified to rule out the physical causes?

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Ruling out Physical Complaints

- Neuropsychologists are well-aware of the residual physical and cognitive symptoms that emerge from neurological conditions
- We are also well-aware of the various manifestations of psychological illness
- If a patient has symptoms that are incongruent with a neurological condition and evidences signs of a somatoform disorder on testing (and not malingering), then the likelihood is that a somatoform disorder is at play

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Issues of Causation

- What came first? The injury or the somatoform disorder?
- Many premorbid factors increase the likelihood of developing a somatoform disorder
- “Fragile egg” syndrome
- The somatoform disorder “came at the right time”
- Personality traits tends to be stable before and after accident
- Pre-accident records and a thorough interview are key in making a determination

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Treatments

- Psychoeducation
- CBT therapy
- Interpersonal therapy
- Mood stabilizing medications
- “Rehabilitation” efforts?

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Questions/Comments
