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PROVIDING USEFUL DIAGNOSTIC FEEDBACK TO PATIENTS WITH FUNCTIONAL MEDICAL DISORDERS AND MAKING REFERRALS FOR PSYCHOLOGICAL TREATMENT

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Providing diagnostic feedback to patients with functional medical disorders is especially challenging to clinicians for several reasons, some pertaining to the disorders themselves and some pertaining to the attitudes and beliefs of the clinician. First of all, symptoms are by definition somatically focused, with patients frequently showing significant resistance to psychological interpretations and treatment modalities. This in itself can make providing feedback that is both honest and therapeutic an uncomfortable endeavor. Secondly, clinicians operating from traditional assumptions of mind-body dualism may lack appreciation of the complex interactions that occur in functional disorders. As such, they may carry the false assumption that the mere act of diagnosis is a punitive action, thereby rendering the provision of feedback an aversive task. Similarly, clinicians may be unaware of options for treatment, resulting in the belief that the diagnosis constitutes a "dead end," leaving patients without options and thereby making feedback moot at best. The preconceptions of clinicians regarding somatoform disorders may also lead them to lose feelings of empathy and therapeutic alliance toward patients. If so, clinicians may have difficulty putting themselves in the appropriate emotional stance for feedback. They may even avoid making an appropriate diagnosis and minimize or avoid interactions with patients themselves,

potentially thwarting treatment. Notably, a clinician's motivation for such avoidance may itself be unconscious or may involve little reflection.

Although challenging, providing feedback to patients with somatoform and other functional medical disorders may be quite beneficial if it is integrated with an appropriate treatment program. Owing to the frequent presence of entrenched defense mechanisms, one-time feedback is unlikely to be useful unless it is followed by treatment, especially in the context of a chronic course. Ideally, feedback is offered as part of an interdisciplinary evaluation and treatment program, which includes education about psychological contributions, the effects of stress on physical function, and other aspects of a biopsychosocial conceptualization of health and illness. Since such programs may not be available to the patient, feedback at minimum should be followed with appropriate referrals for psychological treatment, if the patient is open to such.

Given the typical resistance that patients show toward psychological treatment, a primary goal of diagnostic feedback is to maximize the likelihood that patients will become involved in appropriate treatment. Of course, providing feedback is more of an art than a science, and the way that it is presented may differ substantially depending on the patient's level of sophistication, the type of somatoform disorder, its particular presentation, and other concomitant psychological and personality factors. Feedback should also be tailored to the modality of the treatment that is offered. The general approach of the feedback method presented here is broadly psychoeducational, with the goal of increasing patient's understanding of the interactive nature of psychophysiological factors influencing health and disease.

Further explication of the treatment role of a psychologist in addressing psychophysiological interactions may help set the stage for an explanation of the more limited role of a clinician providing feedback to patients prior to the onset of treatment. Psychologists with experience in pain management may be helpful to patients, especially when pain constitutes the primary symptom manifestation. More generally, psychologists specializing in pain management are accustomed to speaking of psychophysiological patterns in ways that are palatable to patients. Appropriately trained psychologists may be capable of going into considerable detail on the nature of psychophysiological interaction, incorporating both biofeedback and standard psychophysiological techniques. By literally using the patient's own body as a laboratory, biofeedback techniques are particularly powerful in their ability to empirically demonstrate the effects of stress on physiologic arousal. Psychoeducational techniques may focus on explanation of type I and type II stress responses and physiologic channel arousal, with instruction on types of physiologic stress responses illustrated by diagrams of heart rate, blood pressure, muscle arousal, breathing, EEG desynchronization, and other physiologic measurements. Knowledge about stress responses then may be woven into a diathesis-stress conceptualization of health and disease, addressing the interactions among patient vulnerabilities (e.g., genetic factors, prior injuries, other environmental factors) and sensitized physiologic stress responses. With many patients, it is beneficial to provide them with deeper understanding of the many interactive factors that influence their own psychophysiological functions as an important initial phase of treatment. Further treatment may then focus on the development of new coping skills, ensuring that these are in place before any remaining inadequate coping defenses related to somatoform disorder are addressed.

Of course, feedback on the need for psychological treatment may be counterproductive if presented in a brief, dismissive, or overly casual manner. If symptoms

are explained as simply and directly attributable to psychological processes, patients are likely to receive such feedback defensively. Likewise, clinicians are advised not to speak in terms of simple "either/or" conceptualizations of functional versus organic disorders. If at all possible, the provision of feedback should take place in a discussion format and in a setting that is private and free of distractions. Depending on the nature and extent of their defenses, two patients with somatoform disorder may respond differently to the same comment aimed at exploring psychophysiological interactions. Accordingly, providing diagnostic feedback involves constant monitoring of the way patients are receiving the information. Clinicians may wish to pay particular attention to nonverbal signals such as a loss of eye contact or dysthymic affect as cues to alter the presentation. It may also be helpful to "check in" with patients occasionally, assessing their emotional state as revealed by their speech and perhaps asking them what they think about the feedback given to that point. The level of detail appropriate in the feedback session may vary greatly depending on the patient's sophistication, interest, and emotional reactivity. An apt metaphor for the feedback process itself is that of tuning a radio transmitter to find the frequency that transmits through a patient's particular defenses. Clinicians may also picture the process as one of carefully negotiating a branching path, which may include some twists and turns but leads to the goal of increasing a patient's understanding. By keeping these metaphors in mind while giving feedback, clinicians may be more mindful of the process rather than the goal, thereby experiencing less frustration when the goal is not immediately reached.

Although the path may seem tortuous, most patients with somatoform and functional disorders are amenable to some form of psychophysiological explanation. Initially, rapport may be developed by a review of a patient's reported symptoms, providing assurance that symptoms are acknowledged and understood. Depending on the context and the time available for feedback, the connection between physical symptoms and psychological factors can be introduced in general terms, then explained in a manner that is germane to the patient's particular circumstances. Use of the term "stress" may often open the door to consideration of psychophysiological interactions, emphasizing that all people experience stress but may manifest it in a variety of ways. Subsequently, explanation of the effect of stress and emotions on autonomic and endocrine functions may be helpful, working toward specific reference to a patient's particular symptoms. If patients will have future exposure to biofeedback or other psychophysiological measurement techniques, these may be briefly explained in the feedback session. In general, including details on the treatment modality may serve to enhance patients' interest in assenting to treatment.

As a detailed example of feedback related to pain, a tension myalgia explanation modified from that offered by John Sarno may be received very positively.³ Such a model can explain how pain induces physiologic and sympathetic arousal in muscles, with reactive stress and hypervigilance for symptoms. Patients may be told that frustration over pain and anger over ensuing life disruptions commonly exacerbate the reaction, preventing parasympathetic recovery necessary for healing and resulting in a hyperaroused muscle pattern that blocks blood flow and leads to low-grade ischemia and atrophy in muscles. Patients can then see this as an interactive psychophysiological process that blocks healing and may contribute to continued reinjury during normal activities, following an exacerbating course if left untreated. An associated model for rehabilitation can prescribe graduated increases in activity combined with decreased generalized emotional reactivity and distress and decrease in somatic vigilance (e.g., Martelli, 1999; 2000²). The rehabilitation model for

conversion disorders offered by Teasell and Shapiro (this volume) suggests that feedback for conversion disorders should correspond to subsequent treatment by being less psychoeducational and more behavioral in focus, laying the foundation for the particular behavioral techniques that are part of the program.⁴ In their "strategic-behavioral" approach, used to treat chronic conversion disorder, the treatment strategy hinges on a "double-bind" intervention, which involves a measure of pretext on the part of clinicians. As such, treatment contains a paradoxical component, and in-depth explanations of psychophysiological interactions are not as prominent. Knowledge of the treatment modality to be employed is crucial in ensuring that feedback does not later serve as a detriment to treatment. Whatever treatment modalities are employed, all include the often-cited prerequisites for psychotherapeutic improvement, consisting of a credible rationale and a believable ritual.¹

The feedback session ends with an eye toward treatment options, allowing the patient time for questions or comments. Some patients with somatoform disorders may be very sensitive to being dismissed or instructed without being given an opportunity to speak or ask questions. An open, non-confrontational attitude by the clinician, with appropriate empathy reflected in nonverbal cues, will help inoculate patients against possible negative emotional reactions to feedback. In the end, feedback is usually meant to instill in patients a greater appreciation of psychophysiological interactions, sowing seeds for the extension of such themes in the context of ongoing psychological treatment.

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APPENDIX A. Survey of Indicators Suggestive of Non-organic Presentations and Somatic, Psychological, and Cognitive Response Biases

Pain Assessment Measures with Built In Response Bias Indicators

- Pain Assessment Battery (PAB)—Research Edition: Proposed clinical hypothesis procedure for evaluating response bias
- I. Symptom Magnification Frequency (SMF) > 40%
 - II. Extreme Beliefs Frequency (EBF) > 35%
 - III. Four other "validity" indicators (i.e., alienation, rating percent of max, % extreme ratings (2 scales) Elevations on 3 validity scales Scores of 21-31 (Exaggerating) Scores > 31 (Primary psychological influence)
- Milieu Behavioral Health Inventory (MBHI) Hensler (i.e., Mensana Clinic) Back Pain Test

Medical Indicators

- Hoover's test
Test for malingered lower extremity weakness associated with normal crossed extensor response "Drunk type" gait with near-falls but no actual falls to ground
Patchy sensory loss, midline sensory loss, large scotoma in visual field, tunnel vision
Long tract involvement results in promotor type drift
Proximal shoulder girdle weakness and malingering typically present with downward drift while in supination
- Stenger's test
Test for malingered hearing loss during audiologic evaluation
If organic, should be consistent regardless of whether observed or not
Gait for a patient with hemiparesis should present similarly in all directions; malingers do not as a rule practice a feigned gait in all directions
Malingered finger sensory loss is difficult to maintain in this perceptually confusing, intertwined hand/finger position
Due to the fact that both sensory modalities run in the spinothalamic tract, they should be found to be commensurately impaired contralateral to the side of the CNS lesion
Lack of atrophy in a paralyzed/paretic limb suggests the limb is being used or is getting regular electrical stimulation to maintain mass
All these observations are most consistent with non-organic presentations including consideration of malingering or conversion disorder
Lack of any static imaging findings on brain CT or MRI in the presence of a dense motor or sensory deficit suggests non-organicity
An aware patient malingering profound alteration in consciousness or significant arm paresis will not let their own hand when held over their head, drop onto their face
An examinee claiming severe right brain damage who claims right eye blindness and right-sided weakness and sensory loss
- Non-organic sensory loss
Non-organic upper extremity drift
- Gait discrepancies when observed versus not observed
Gait discrepancies relative to direction of requested ambulation
Forearm pronation, hand clapping and forearm supination test for digit/finger sensory loss
Pain versus temperature discrepancies
- Lack of atrophy in a chronically paretic/paralytic limb
Diminishes under influence of sodium amylal, hypnosis or lack of observation
Incongruence between neuroanatomical imaging and neurologic examination
- Arm drop test
Presence of ipsilateral findings when implied neuroanatomy would dictate contralateral findings

Tell me "when I'm not touching" responses

Lack of shoe wear in presence of gait disturbance

Calluses on hands in "totally disabled" examinee

Assistive device "wear and tear" signs

Mankopf's maneuver

Lack of atrophy in a limb that is claimed to be significantly impaired

Sudden motor give-away or ratchitiness on manual strength testing
Weakness on manual muscle testing without commensurate asymmetry of DTRs or muscle bulk

The test for simulated low back pain

Magnuson's test

Delayed response sign

Wrist drop test

Object drop test

Hip adductor test

Disparity between tested range of motion and observed range of motion of any joint

Straight leg raise (SLR) disparities dependent on examinee positioning

Grip strength testing via dynamometer

Sensory "flip" test

An examinee with claimed sensory loss who endorses that he does not feel you touch him when you ask him to tell you "if you do not feel this"

An examinee with claimed longer term gait deviation due to orthopedic or neurologic causes should demonstrate commensurate wear on shoes (if worn with any frequency)

An examinee who is unable to work should not present with signs of ongoing evidence of physical labor

In any examinee using assistive devices for any period of time, e.g., cane, crutches, there should be commensurate wear on the device consistent with their claimed impairment and disability

Increase in heart rate commensurate with nociceptive stimulation during exam (there is some controversy on whether this always occurs)

If side to side measurements and/or inspection do not bear out atrophy, consider other causes aside from one being claimed

Considered to normally be a sign of incomplete effort or symptom exaggeration

Suggests simulated muscle weakness if longstanding

Flexion of hip and knee with movement only of toes should not produce an increase in low back pain

Have examinee point to area several times over period of examination; inconsistencies suggest increased potential for non-organicity

Pain reaction temporally delayed relative to application of perceived nociceptive stimulus

In an examinee with claimed wrist extensor loss, have them pronate forearm, extend elbow and flex shoulder...if on making a fist in this position they also extend wrist, non-organicity should be suspected

Examinee claims inability to bend down yet does so to pick up a light object "inadvertently" dropped by examiner

Test for claimed paralysis of lower extremity, similar to Hoover's test yet looks for crossed adductor response

When ROM under testing is significantly disparate (e.g., less) from observed, spontaneous ROM suspect functional contributors

Differences in SLR between sitting, standing, and/or bending may suggest a functional overlay to low back complaints

Three repetitions at any given setting should not vary more than 20% and/or bell-shaped curve should be generated if all 5 positions are tested

Sensory findings should be the same if testing upper extremity in supination or pronation or lower extremity in internal versus external rotation. Differences may suggest a functional overlay

Pinch test for low back pain

Personality Instruments with Built-in Response Bias Designs

Personality Assessment Inventory (PAI)

- Inconsistency (INC), Infrequency (INF), Positive Impression Management (PIM), and Negative Impression Management (NIM) scales
- 8 score patterns thought to comprise a "Malingering Index" (Morey, 1996)
- > 2 patterns malingering suspected
- > 4 patterns likely malingering

Minnesota Multiphasic Personality Inventory (MMPI-2)

- Validity indices (L, F, Fb, Fp, Ds, K, VRIN, TRIN), F-K (Gough, 1954)
- The Fake Bad Scale (Lees-Hailey, 1991)
- Compare subtle to obvious items
- Rogers et al (1994)—cutoff scores:
Liberal:

1. F-Scale raw score > 23
 2. F-Scale T-Score > 81
 3. F-K Index > 10
 4. Obvious—subtle score > 83
- Conservative:
1. F-scale raw > 30
 2. F-K index > 25
- Obvious—subtle score > 190

Other Domain Specific Measures with Built-in Response Bias Designs

Trauma Symptom Inventory (TSI)
3 Validity Scales (Response Level, Atypical, Inconsistent)

Qualitative Variables in Assessing Response Bias

Time/Response Latency Comparisons Across Similar Tasks
Inconsistencies across tasks

Performance on Easy Tasks Presented as Hard
Low scores or unusual errors

Remote Memory Report
Difficulties, especially if < recent memory, or severely impaired in absence of gross amnesia

Personal Information
Very poor personal information in absence of gross amnesia

Comparison Between Test Performance and Behavioral Observations
Discrepancies

Inconsistencies in History and/or Complaints, Performance
Inconsistencies across time, setting, interviewer, etc.

Comparisons for Inconsistencies Within Testing Session (Quantitative and Qualitative):

- A. Within Tasks (e.g., Easy vs. Hard Items)
- B. Between Tasks (e.g., Easy vs. Hard)
- C. Across Repetitions of same/parallel tasks (R/O fatigue)
- D. Across similar tasks under different motivational sets

Comparisons Across Testing Sessions (Qualitative, Quantitative)

Symptom Self Report: Complaints

Poorer/inconsistent performance on re-testing
High frequency, severity of complaints and higher frequency, severity versus significant other report or other collaborative report

Main and Spaniswick, 1995

- Failure to comply with reasonable treatment
- Report of severe pain with no associated psychological effects
- Marked inconsistencies in effects of pain on general activities

- Poor work record and history of persistent appeals against awards
 - Previous litigation
- Early symptoms reported late or acute symptoms reported as chronic

1. Failure to show any pain relief to at least one of the following: biofeedback, hypnosis, mild analgesics, psychotherapy, relaxation exercises, heat and ice, mild exercise

2. Failure to show any pain relief in response to TENS

Stress initiator minimized vs. emphasized; Blame self vs. other; Helpless vs. grandiose dreams; Deny vs. emphasize emotional impact; Reluctant vs. easy memory elicitation; Specific vs. general guilt; More vs. less stress associated environmental avoidance; Helpless vs. directed anger.

Assessment of Cognitive Effort: Performance Patterns on Existing Psychological/Neuropsychological Tests

Psychological/Neuropsychological Tests

Low (vs. expected, estimated, etc.)

"Near-miss" (Ganser errors)

Attention-Concentration Index Score < General

Memory Index (AC-GMI)

Unusually low w/o gross motor deficit

< 13

Atypical Recognition Errors (>=2); Recognition Failure Errors

See formulas

Poor or unusual performance

< 50% chance responding

< 50% chance level responding

Correct/incorrect responses; time on group vs. ungrouped

< 89% raises suspicion

Lezak (1983), < 3 complete sets, < 9 items

< 50% chance level responding

R < 9 or Inclusion < 15; poor or unusual performance

< 50% chance level responding or below cutoff

< 50% chance level responding or below cutoff

< 50% chance level responding or below cutoff

< 3 complete sets, < 9 items

Adapted from Marielli, Zasler, and Pickett, 2001,²⁴ with permission. Please write authors for comprehensive list of references.

Computer Assessment of Response Bias (CARRB)

Rey Memory for 15 Items Test (MFT)

Symptom Validity Testing (SVT)

Word Completion Memory Test (WCMT); Any implicit memory word stem priming task

Validity Indicator Profile

Portland Digit Recognition Test

Pritchard Tests of Neuropsychological Malingering

Rey Memory for 15 Items Test (MFT)

< 3 complete sets, < 9 items

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