

Chapter 1

The Nature of the Problem

Introduction

More than 100 somatic disorders are capable of mimicking psychological conditions. This reality presents every therapist with an important clinical challenge—to unmask psychological signs and symptoms that are being caused by medical disorders. When you are seeing a patient who appears to have a psychological problem, how might you assess whether that individual could have an underlying, discrete medical condition that is actually causing or complicating the presentation? And how might such an evaluation be accomplished during an interview? This book addresses these questions.

In our work as therapists, we have learned to be attuned to the subtleties of our patients' emotional lives, but we are often ill prepared to detect clues that mark the presence of covert organic illness. Yet, an important part of our job is to unmask any physical condition a patient might have. This is a vital undertaking, because fully effective mental health treatment is only possible once contributing medical disorders have been accurately diagnosed.

This book facilitates an expansion of your observational and listening skills. Using clinical stories, it introduces a variety of medical disorders and shows how these conditions are often camouflaged in people's lives. Discussions are included on how to approach somatic complaints, which particular mental status findings point to organic dysfunction, and how to conduct a thorough assessment.

This book is about well-described somatic disorders that may not look like they are physical because they initially or primarily affect the individual's mental and behavioral life. Many widespread and familiar maladies can masquerade as mental disorders: thyroid disorders, diabetes, Alzheimer's disease and other dementias, sleep apnea and other sleep disorders, temporal lobe epilepsy, HIV, the long-term consequences of head trauma, Lyme disease, and the side effects of medications, to name only a few. These and other physical conditions are common in patients who are

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seen by mental health practitioners; these medical conditions are also often the very source of the presenting clinical picture.

The goal of this book is to help clinicians learn to identify when there is evidence for an underlying organic condition so as to be able to effectively refer patients for a medical workup. It is crucial for mental health practitioners to initiate a medical consultation when signs, symptoms, and patterns of behavior have led to a concern that a patient might have an underlying medical disorder. A therapist may not know exactly what somatic condition a patient has, but it is possible to learn how to identify the evidence that some condition is likely to exist. Identifying the evidence will facilitate a medical evaluation that is targeted for the patient's particular symptom constellation and maximize the likelihood of unmasking any covert illness.

Unfortunately, there are no simple questionnaires, no "acid tests" that signal with certainty that a patient has an underlying physical condition. Making a diagnostic assessment is both a science and an art. As with being an accomplished therapist, the task is personally challenging and thoroughly engaging. It involves utilizing not only a body of information but also a library of experience. It calls for reasoned thinking as well as creativity and seasoned intuition. It requires using one's interpersonal and observational skills and maintaining one's clinical curiosity. While these skills are integral to being an excellent clinician and healer in any field, they are central to the sometimes lifesaving work of making a diagnostic assessment.

Learning skills that will help you to unmask psychological symptoms is a vitally important undertaking. Here is what Drs. Barbara L. Yates and Lorrin M. Koran concluded after thoroughly reviewing the modern research studies on the topic of their chapter, "Epidemiology and Recognition of Neuropsychiatric Disorders in Mental Health Settings."

Overwhelming evidence shows that undiagnosed physical illness is prevalent in patients with psychiatric disorders. Medical conditions in this population are overlooked for many reasons, but in some cases these conditions directly cause the patients' psychiatric symptoms. Public mental health programs, especially programs for the seriously mentally ill, may be the patient's primary source of health care. Even with patients who have a primary care physician, the possibility of undetected, important physical disease remains substantial. (Yates & Koran, 1999, p. 41)

This Is a Common Problem

Everyone has had a firsthand experience with the effects of physical conditions on the mind. A night without sleep will make it more difficult to concentrate at work and easier for a someone to lose his or her temper at home. Too much coffee leaves people anxious and unable to fall asleep.

A few drinks at a party may bring out one's sense of humor, lend an unfamiliar measure of social confidence, or imperil good judgment and make a person argumentative. A high fever, the side effects of particular medications, and, certainly, psychoactive drugs may not only have an impact on alertness, mood, level of anxiety, mental agility, and attention but may also cause hallucinations, paranoia, or delusions, altering the very experience of reality.

In all of these situations, the mental effects are time-limited and their cause is apparent. You know that when your fever comes down, when the new medication wears off, when you sober up, or manage to get a good night's sleep, your mind will return to its usual state. This is comforting. But imagine what it would be like to experience these same changes in the workings of your mind with no obvious physical cause and no surety that you would ever be your old self again. That is akin to the experience of having a covert somatic disease that produces mental symptoms. Under these circumstances, patients are likely to believe erroneously that there is something troubling them psychologically or that they are going crazy.

If such a patient decides to seek help, he or she will most likely consult with a mental health professional. We all know that therapy would not stop the anxiety that comes from drinking too much coffee, the difficulty in concentrating that results from sleep deprivation, or the visual hallucinations that are produced by LSD. The same is true of the anxiety that is produced by an overactive thyroid, the difficulty with concentrating that results from disordered breathing during sleep as occurs with sleep apnea, or the visual hallucinations that may be produced by temporal lobe epilepsy, an extremely common type of seizure disorder that can occur without any loss of consciousness. Psychotherapy will have little to no impact on these very common medical diseases, but other treatment approaches might be effective.

Sometimes these physical illnesses are capable of persisting for years without worsening dramatically and without evolving into a crisis that would make it clear that an underlying organic disease is present. Yet without the correct somatic diagnosis, years of unnecessary suffering for the patient and frustration for the therapist are often inevitable. With medical treatment that is targeted at the patient's actual organic diagnosis, it is possible for the patient's symptoms to improve and, in many cases, completely resolve.

An Illustrative Clinical Vignette

Within the pages of this book, you will meet adult patients of all ages and be introduced to many different physical afflictions. This first clinical

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vignette is about an elderly gentleman with an important medical condition.

Joan was a social worker who had been seeing me in psychotherapy to work on her troubled marriage. In that context, she began to express concern about her elderly father's declining mental state. Joan's mother and father were both retired physicians who now lived in Chicago, many miles from their daughter.

Joan felt especially close to her father, Dr. Joe. She loved to hear him reminisce about having lived through that era of medical history when there wasn't much a doctor could do to help people who were sick; a physician could only make a diagnosis, provide emotional comfort, and prescribe medication that usually had little effect. In that time of mostly futile treatment, a diagnosis was virtually all there was, and back then it was a lot. A diagnosis represented not only the thoughtful engagement of the mind of an educated and respected clinician, focused squarely on the patient's condition, but it also foretold the future. Could you pass this disease on to others? Would you recover? How long might that take? Could you be left impaired? Would you die?

Joan's parents were retired from medical practice now, but they had hardly slowed down in this ninth decade of their lives. Their social and cultural calendar was astounding; their excitement about cutting-edge movies and trends in the art world was inspirational. This made it especially poignant to Joan when she noticed a change in her father's energy level. Dr. Joe began to move slowly and was increasingly unsteady on his feet. He ceased to be engaged by the activities that had animated him over a lifetime: He sat silently and still for long stretches of time; he no longer played the piano or even listened to music; he stopped reading the book review; and he had no further interest in the daily crossword puzzle. "*It's finito la commedia!*" he would say to his daughter.

Joan's mother Sarah was not unsophisticated in her diagnostic assessment. To Dr. Sarah the signs of depression were obvious: loss of interest in daily activities, absent zest for life, slowed physical and mental activity. Dr. Sarah also had noticed that her husband was having trouble with his memory, and she believed that he had the beginnings of Alzheimer's disease. With years of clinical experience under her belt, Dr. Sarah formulated that her husband was having a depressive reaction to early Alzheimer's disease, and she could readily envision the inevitable downhill course his mind would take, dragging the quality of their lives down with it.

Joan discussed with me how sad it was to think of her father having Alzheimer's disease. As therapists sometimes do, I became the hidden, long-distance consultant in the case. On my suggestion, Joan recommended to her parents that they consult with their geriatric primary care

physician rather than simply assuming that these changes in Dr. Joe were the beginnings of an untreatable dementia. The primary care physician took a careful history, conducted a standard physical examination, and ordered some screening blood tests and a chest x-ray. A mini-mental status exam, which included screening tests of memory, was administered and, surprisingly, it was essentially normal for someone in his 80's. Joan's father did not appear to have a clear dementia like Alzheimer's disease. In fact, the doctor could find no obvious cause for Dr. Joe's decline.

It sounded as though Dr. Joe simply had a late-life depression. Clearly, he looked depressed, and he had reasons to be depressed. His physical capacities had declined; he could no longer play tennis or walk with a quick step; he still insisted on opening the door for the ladies, but really, it had become easier for the ladies to hold open the door for him. His self-esteem suffered. He had lived through the inevitable succession of deaths of good friends, colleagues, and relatives. Sarah and Joe going out with friends had come to mean Sarah and Joe going out with an assortment of widowed women. The men who had been dinner, concert, theatre, and museum companions for years were either deceased or in nursing homes. Joe said that he felt like the last one standing, but barely, and now with a cane.

In other words, it made sense that Joe was depressed. Joan and I pondered how to explain the atypical features of his presentation. Perhaps the mild, day-to-day difficulties her father was having with memory resulted from a depression that was affecting his ability to concentrate. As for the slight unsteadiness on his feet, perhaps this was orthopedic, the inescapable effects on bone and cartilage of a long life of stomping down hospital corridors and bounding across tennis courts, always going somewhere in a hurry.

No one knows for sure what would have happened if, at this juncture, Dr. Joe's doctor had referred him to a therapist. Likely, Joe would have been treated for the obvious diagnosis, depression. After all, he had essentially been medically cleared. In this case, the primary care doctor did not send Joe to a therapist. He sent him to consult with a neurologist. Joan was relieved to hear this, because she had learned from me that her father might have an early, treatable form of dementia called normal pressure hydrocephalus (NPH). This relatively uncommon condition occurs when the fluid-filled ventricles of the brain enlarge without an increase in spinal fluid pressure. As the ventricles gradually expand, adjacent nerve tracts in the brain are stretched and compressed. NPH presents with a triad of symptoms: apathy that can look like depression, a disturbance of gait, and, often, urinary incontinence.

But Joan's heart sank when her parents refused to see the neurologist. "What's the point?" asked Sarah. "The neurologist is only going to put

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your father through all kinds of tests and, in the end, there will be nothing they can do for him anyway!" "What's there to lose?" Joan spat back.

With encouragement from me, Joan persuaded her parents to give the neurologist a chance. NPH is treated by surgically installing a shunting tube that continuously drains small amounts of cerebrospinal fluid from the fluid-filled ventricles of the brain. A preliminary diagnosis is made by taking a history and performing a mental status examination. Only then does a physician conduct a physical exam and order brain-imaging studies. Often the diagnosis is confirmed by draining some fluid from the spinal column and noting whether gait or mental state improves.

It became clear that the diagnosis of NPH was correct when Joe called his daughter after the doctors had performed this test. Miraculously, it was Dad's familiar voice, animated and vital again. "Mom and I just had the most wonderful lunch!" he said, laughing. Joan cried—with joy. The diagnosis was everything!

This diagnosis of NPH told my patient a lot. It told her that her father had a covert physical problem that was likely generating many of the changes in his mental state as well as his unstable walk. It told her that a treatment could be targeted to this particular physical problem and that this treatment had a chance of being effective. It told her that there were risks, but also that there was the possibility of recovery, even at Dr. Joe's age. The diagnosis also gave her a glimpse into the future. She could imagine her father at the piano again, playing a little too loudly. She could picture him rejoining their traditional Thanksgiving game of charades. And that's what did happen. The correct diagnosis in this instance offered hope.

In the 1930s, a diagnosis was virtually all there was, whether it was hopeful or not. In the 21st century, a diagnosis is just the beginning. It still represents the thoughtful engagement of the mind of an educated and respected clinician, focused squarely on the patient's condition. It still tells the future. But now, once the diagnosis is known, in many situations the future can be altered. Effective treatment can begin.

Most readers have probably never heard of NPH, and many may worry, "What if Joe's doctor hadn't referred him to a neurologist but, instead, had sent him to see a therapist. And what if that therapist had been me?" Or "What if Joe had come to see me straightaway, without ever having seen his primary care doctor at all? Or, what about the possibility that this NPH might have emerged while I was seeing Joe for some other problem? It is very likely that I would have thought he was simply depressed. I would probably have missed the treatable diagnosis!"

At this point it is important to recall that Joe's primary care doctor did not send him to a therapist. He sent him to a neurologist, and he

must have done so for a reason. I too had recommended that he see a neurologist. What did I know? What did the primary care doctor know? What did he see or sense? And what if you could learn to see or sense or know those things as well? When medical illnesses masquerade as mental conditions, they usually don't do a perfect imitation. Generally, they leave clues to the fact that there is some physical condition in the picture. With some work, it will be possible to learn the signs, symptoms, and patterns of presentation that indicate the presence of some organic disorder, though one may not know precisely which disorder.

Looking more carefully at the case of Joe will give the reader an idea of this book's approach:

- What were the clues to the presence of a covert medical condition in Joe?
- How were these clues disguised or camouflaged within Joe's presentation?
- What kind of investigation led to the disease's unmasking?

Three important clues pointed to the possibility of an underlying organic condition. The first was Joe's difficulty with walking, a clear physical sign. This clue was easy to overlook for several reasons: It came on gradually; it's not unusual for the elderly to have trouble with mobility; and there is a tendency to explain this kind of problem as simply a result of the ravages of time. But time takes its toll by causing actual physical changes. A clinical detective would need to be vigilant, careful to not dismiss this physical sign as simply a result of old age. It turned out that keeping this physical sign in mind while leaving open the question of its cause was important in eventually making an accurate diagnosis.

Clue number two was a marked change in Dr. Joe's behavior; this was noticeable to everyone. However, only careful and thoughtful inquiry ascertained that Joe was not precisely depressed. He was not happy about getting old, and he was not happy about having no energy, but he didn't actually feel depressed. What he was fundamentally experiencing was apathy, lack of motivation, and psychomotor retardation, which is a slowing in his physical and mental processes. This distinction between depression and apathy is difficult but important to make because apathy is more often associated with organic disease.

Clue number three was Dr. Sarah's observation that her husband had mild difficulty with memory in daily life. This symptom was frightening to Sarah. Given that her husband was elderly, she assumed that this was Alzheimer's disease. However, a simple mental status test performed by the geriatric primary care physician revealed that Joe's memory storage was not impaired. This implied that any difficulties with

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remembering were more likely because of problems with concentration or motivation.

In order to get to the right diagnosis, it was important to tolerate uncertainty about what was the matter. It was crucial to reject the easy idea that Joe was simply getting old. It was necessary to see that this was not a classic depression. One had to sweep aside the notion that Dr. Joe had Alzheimer's disease and open one's mind to other possibilities. Only then was it possible to see a pattern of signs and symptoms that pointed toward the actual diagnosis.

The geriatric primary care physician and I, as the background consultant in the picture, became aware that Joe's presenting problems could be part of that classical triad of signs and symptoms that comprise the presenting picture of NPH. Even without a history of urinary incontinence, it was still possible for Joe to have NPH, though I wondered whether Joan's father might have been uncomfortable sharing this potentially embarrassing symptom with his daughter. Untreated, NPH eventually leads to an irreversible dementia. If identified early on, this form of dementia is often treatable. In other words, NPH is one of those diagnoses you do not want to miss. This is why Joe's doctor sent him to a neurologist.

The story of Dr. Joe illustrates one further point—how difficult the road is to getting effective medical help. Even though Drs. Joe and Sarah were highly educated, motivated, and resourceful, and even with a trusted, caring, and competent family physician in the picture, they needed the support and encouragement of their daughter to make their way to the appropriate specialist. Their fear of Alzheimer's disease might have been paralyzing had it not been for their daughter's encouragement. For patients and families who are less educated, less motivated, less trusting, and less resourceful or financially able, the barriers to attaining top-quality health care are even more difficult to surmount. This is where an informed therapist, through support, encouragement, and active, informed referrals, can make a difference.

One of the many important obstacles to obtaining good health care that even blocks the best educated and brightest patients, families, and therapists is simply this: People do not know what they do not know! Joan and Drs. Joe and Sarah had never heard of NPH. The reason to consult with medical specialists is because they *do* know about conditions that others might never have heard of.

The goal of this book is to address needs that many therapists experience—to be more fully informed about physical diseases, to learn about how organic disorders masquerade as mental conditions and how to recognize when there is a need for a medical referral, and then to know how to work and collaborate with the patient, the family, and other health-care providers to see the referral through.

In attempting to achieve that goal, this book has been written to be readable. It is filled with numerous narrative examples from a therapist's point of view. The book avoids the use of medical jargon while still presenting sophisticated, scientific clinical knowledge. And because there is a large amount of information to absorb about the numerous somatic diseases that can masquerade as psychological disorders, the book introduces that information in manageable portions and circles back to look at it from a variety of perspectives.

What Is and Is Not Included

This book focuses on organic disorders that present in adulthood. It does not cover pediatric illnesses, though it does include some medical conditions that might first be recognized in adulthood even though they have been present since childhood (e.g., attention deficit hyperactivity disorder and the autism spectrum disorders). Also, this book is not about the secondary psychological reactions that individuals may have when they are afflicted with a medical illness. Nor is this book about psychosomatic conditions in which an underlying psychological disturbance such as a depression or an unresolved conflict manifests with physical complaints. Psychosomatic disease is exactly the opposite of what I am writing about. With a psychosomatic disorder, the psychological component is hidden; the physical component, on the other hand, is "worn on the patient's sleeve."

Although *Unmasking Psychological Symptoms* aims to introduce many of the medical conditions that can masquerade as psychological conditions, it does not claim to be encyclopedic in presenting every disorder that a patient might have. The book also cannot cover every sign or symptom of organic disease that patients might experience.

Disclaimers

This book cannot substitute for a formal consultation with a competent physician. The narrative cases in this book are based on the experiences of real patients and real clinicians. All identifying information has been changed, and often the narratives are composites of more than one clinical story. In all cases, the narratives strive to capture the complexity of actual practice and the essence of the therapist's clinical experience.

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