CURRENT THERAPY OF PAIN

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CHRONIC PAIN PATIENT VERSUS THE MALINGERING PATIENT

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There is a great deal of confusion about the categories of histrionic personality disorders, conversion hysteria, and malingering. It is important to differentiate among these disorders, especially if the patient complains of chronic pain. Although patients with chronic pain often are diagnosed as "malingering," the occurrence of this deviant behavior is far less than was previously thought.

Keiser offers some very useful guidelines for determining if a patient is malingering or not: a meticulous physical examination, freedom from bias on the part of the examiner, and an understanding atmosphere "in which the patient feels free to discuss all of his fears associated with the accident and his treatment."

In an effort to provide a consistent method of assessing patients with chronic pain, one must bear in mind that a patient with a severe personality disorder can also have organic illness. In fact, it would be prudent to think of these two types of disorders as existing on two separate and distinct axes (Fig. 1). Complicating this is the psychological response to chronic pain, which changes over time. This has been termed by Hendler "the four stages of chronic pain." Essentially, a previously well adjusted individual, with good premorbid adjustment and a definable organic lesion that does not improve with treatment, goes through four stages (remarkably similar to the five stages described by Kübler-Ross in her book *On Death and Dying)*. The first stage is from 0 to 2 months, during which time the patient expects to get well. In the second stage, the patient begins to experience anxiety and hypochondriacal concerns, with abnormalities beginning to appear for the first time on psychological testing. The third stage is the chronic stage, when depression clearly appears in association with the other concerns. This stage usually begins 6 months after the injury and may last as long as 8 years. The final stage is the adjustment, which may occur from 3 to 12 years after the onset of the pain. During this stage depression resolves, but somatic concerns

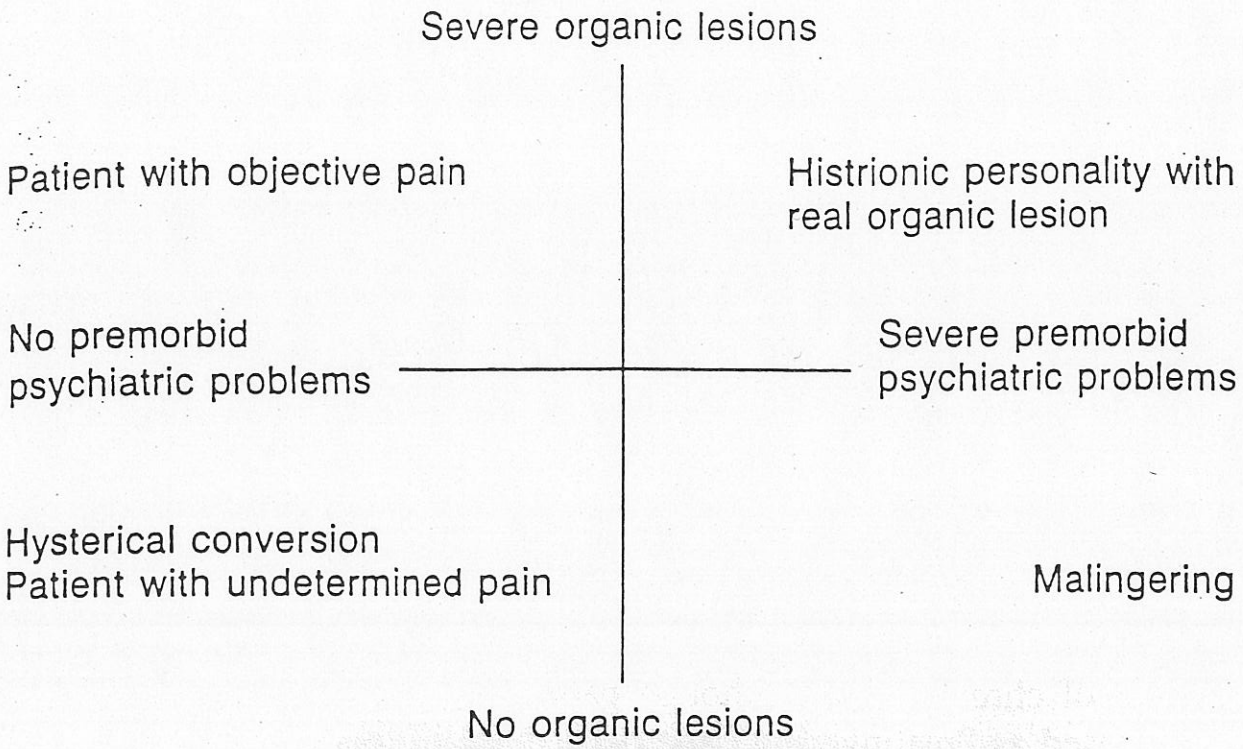

Figure 1 Premorbid psychological problems.

persist, resulting in psychological changes in a previously well-adjusted individual (Fig. 2). Therefore, one must not only consider the premorbid psychological adjustment of a chronic pain patient, but also the stage of their chronic pain, in order to determine the appropriateness of their psychological response to pain.

In a further effort to clarify the psychological profile of patients with chronic pain, Hendler has described four categories, which delineate the psychological components most often seen in association with chronic pain. The first category is defined as the patient with objective pain, who has a good prepain adjustment and a definable organic lesion. This individual, if he does not receive successful treatment, goes through the four stages of chronic pain described above.

The second category of patients with chronic pain are the patients who exaggerate chronic pain. These patients have a poor premorbid adjustment, with preexisting personality disorders, previous attempts at suicide, or previous history of depression. Very often, these individuals also have a history of alcohol and drug abuse, marital difficulties, and a history of physical, sexual, or psychological abuse in their own childhood. They also have a definable organic lesion, but their response to

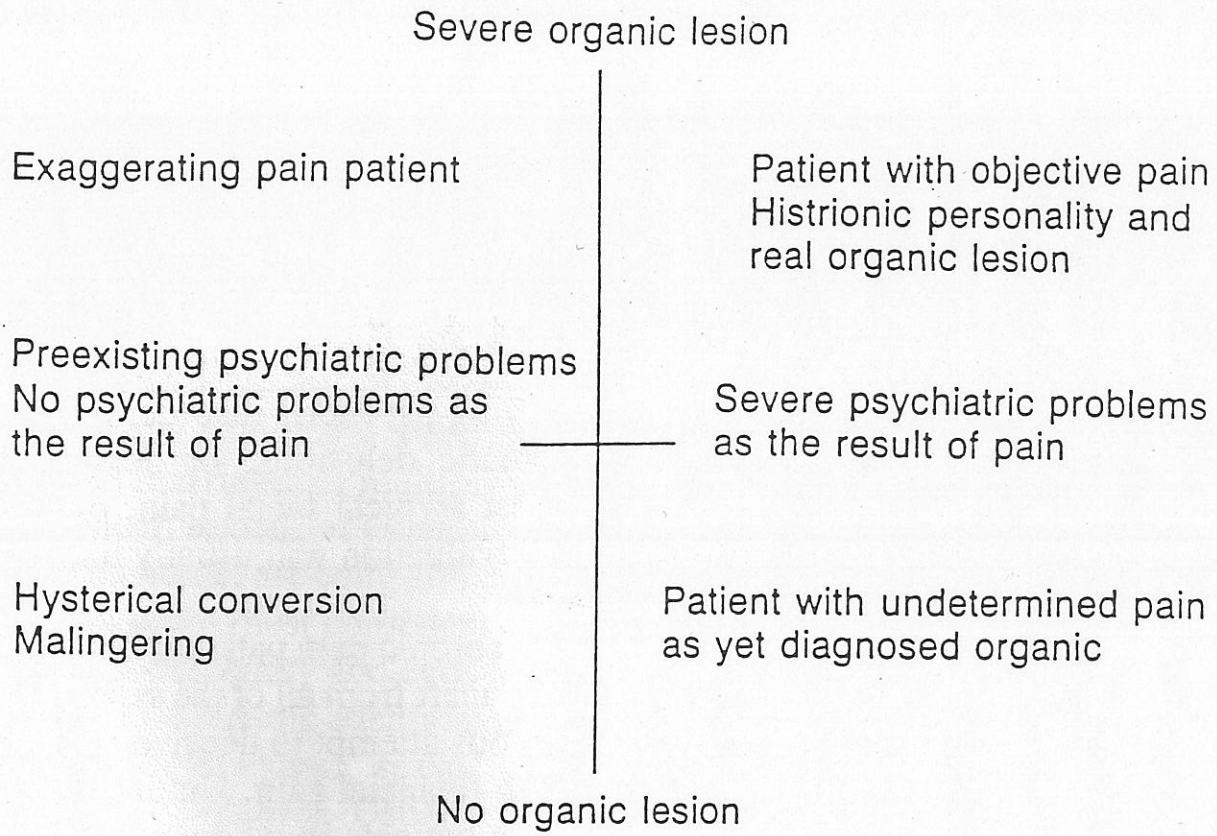

Figure 2 Psychological problems resulting from chronic pain.

this organic pathology is far in excess of what one might expect from a patient with objective pain. They do not have hysterical conversion, they are not malingering, but they surely are difficult to manage. The more severe the underlying organic pathology, the more difficult a management problem they become, especially as this is compounded with their difficult personalities.

The third group of patients are the patients with undetermined pain. These are patients who have personality traits remarkably similar to the objective pain patient, and their response to chronic pain is appropriate. However, in these individuals, no clear-cut organic lesion can be found. At this stage, the physician is obliged to keep looking, and must not assign the diagnosis of hysterical conversion or malingering. Eventually, an organic lesion is found, as was reported in Slater's classic paper, "The Diagnosis of Hysteria." Slater did a 9-year follow-up on 85 patients originally diagnosed as having "hysteria" at Queens Square Hospital in London. On follow-up, 28 patients were found to have an organic basis for their complaints, including trigeminal neuralgia, thoracic inlet syn-

drome, Takayasu's syndrome, undetected dementia, epilepsy, vestibular lesions, and total block of the spinal cord. Three had undetected neoplasms, and two others had atypical myopathy and disseminated sclerosis. Of the 85 patients with the original diagnosis of "hysteria" (meaning conversion symptoms), only seven were found to have an acute psychogenic reaction resulting in the formation of conversion symptoms.

The fourth category of chronic pain patients is the affective or associative group, i.e. people with underlying psychotic disorders, or severe depression, who either have somatic delusions, or depressive equivalents. These patients may manifest atypical facial pain, or pain all over their body. A formal pychiatric evaluation will usually uncover the underlying thought disorder.

To refine the psychiatric diagnosis of chronic pain patients, one must recognize that *malingering* is separate and apart from all of the syndromes described above. *Malingering* is a conscious attempt to deceive the physician, and it is frequently associated with financial gain. Unfortunately, the term is often assigned to chronic pain patients in whom a clear-cut diagnosis has not been established. Therefore, it is prudent to review the characteristics of the difficult personality types one encounters in diagnosing and treating chronic pain, comparing and contrasting them with one another.

PATIENT WITH CHRONIC PAIN OF KNOWN CAUSE

The patient with chronic pain of known cause is an individual with a good prepain (premorbid) adjustment who usually has only been married once or maybe twice, who has held a steady job with progressive promotions and salary increases, who does not have a history of drug or alcohol abuse nor a prior history of depression or suicide, and in whom a definite organic basis for the pain can be determined. In response to a chronic, persistent pain that is not treatable, this individual may exhibit the four psychological stages, described above. Thus, a previously well-adjusted individual may exhibit psychiatric problems that are the direct result of chronic pain. This may be viewed as a normal response to persistent pain, and should be contrasted with the other types described below.

CHRONIC PAIN PATIENT WITH A HISTRIONIC PERSONALITY

A patient with a histrionic personality disorder may also have a definable organic basis for the complaint of pain; these are not mutually exclusive events. Approximately 98 percent of the patients with histrionic personality disorders are female; 2 percent are males. They have difficulty establishing interpersonal relationships, which are usually based on a mutual pathologic weakness of the partner. Therefore, a history of multiple marriages or multiple broken engagements, as well as a history of physical, sexual, or psychological abuse as a child, or of coming from a broken home, are compatible with the diagnosis of histrionic personality. The seven most consistent characteristics of a histrionic personality disorder are: vanity and egocentricity, lability and excitability but shallow affect, dramatic attention-seeking and histrionic behavior, exaggeration and falsification, sexual seductiveness, frigidity, and dependent, demanding behavior. Usually these patients have elevated scales 1 and 3 (hypochondriasis and hysteria) on the Minnesota Multiphasic Personality Inventory (MMPI).

CONVERSION REACTION

Conversion reaction is a very rare disorder. It occurs in approximately 2 percent of psychiatrically hospitalized patients, and is equally divided between people with preexisting histrionic personality disorder, depression, or passive-dependent personality disorder. As mentioned above, one must be very cautious about assigning the diagnosis of conversion reaction to any patient, because early forms of many neurologic diseases, with variable presentations, can defy diagnosis. *Conversion* is an unconscious defense mechanism that protects an individual from overwhelming and unacceptable psychological stress. It must be distinguished from malingering, which is a conscious effort to deceive. The onset of the symptomatology is usually sudden and is associated with either a life-threatening event or an event that was so psychologically repugnant to the patient that he could not tolerate the psychological trauma.

Pain is a very poor conversion symptom, because even patients with a real organic basis for their complaints of pain have difficulty convincing others that there is a problem.

PATIENT WITH UNDIAGNOSED PAIN

A patient with undiagnosed pain has the same psychological profile as the patient with objective pain and responds in the same way because of the pain. The only distinction between the two is the absence of objective diagnostic tests confirming the etiology of the pain. In these patients, the physician should not rely on tests but on clinical acumen. Patients with slipped rib syndrome, aberrant Tietze's syndrome, cancer of the pancreas, multiple sclerosis, and a host of other medical diseases that defy early detection should not be labeled as having conversion reactions simply because no basis for their complaint has been found. This type of patient needs a careful diagnostic assessment.

MALINGERING

The malingerer may present with organically defined lesions, but he may attribute these organic ills to a minor injury from which he may derive compensation, such as an auto accident or an on-the-job injury. In fact, the injuries that he sustained and for which he has organic deficits may have occurred before the event to which he ascribed them, but he is trying to maximize the return that he might get from a compensable injury. Usually, the malingerer consciously simulates disease to avoid responsibility, to evade difficult or dangerous duties, or to receive financial rewards. The key word in defining malingering is deceit.

Because deceit plays a central role in malingering, one must be quite suspicious of patients with a prior arrest record, a history of illicit drug addiction, and multiple workmen's compensation claims; those who have had multiple accidents; and those in financial stress. Financial gain and self-preservation are the two great motivations for malingering.

Pain is an ideal symptom for a malingerer, because there is no objective way to measure pain. In contrast, a patient with a conversion reaction tries to pick the most visible form of symptomatology to convey their psychic distress. The hallmark of a malingerer is a reticence to participate in diagnostic studies. Unlike most patients with chronic pain who state that they will do almost anything to get rid of their pain, the malingerer tries to preserve it. On the F, K, and L scales of the MMPI, the malingerer may have higher scores than most chronic pain patients. Finally, under narcosynthesis, a malingerer maintains his symptomatology, whereas a patient with conversion reaction does not.

TABLE 1 Differential Between Patient with Chronic Pain and Malingering Patients

Diagnostic Factor	*Patient with a Histrionic Personality and a Real Organic Lesion*	*Hysterical Conversion*	*Patient with Undetermined Pain*	*Malingering*	*Patient with Objective Pain*
Conscious control of symptoms	No	No	No	Yes	No
Dramatic	Yes	No (unless in a histrionic personality)	No	Yes	No
Willing to participate in tests	Yes	Yes	Yes	No	Yes
Personality type	Histrionic 98% Female 2% Male	Passive dependent 33% Histrionic 33% Depressed 33%	No pathology	Sociopathic, passive–aggressive	No pathology
Sudden onset of symptoms	Variable	Yes	Variable	Variable	Variable
Response to psychotherapy	Fair	Good	Fair	Poor	Fair
Resolution with legal settlement	No	No	No	Yes	No

Visible symptoms	Not always	Always	Not always	Always	Not always
Concern with symptoms	Intense focus but easily distracted	Some concern	Some concern	Total focus, not distracted	Some concern
Litigation involved	Variable	Variable	Variable	Almost always	Variable
Temporary resolution of symptoms with amobarbital	No	Yes	No	No (usually won't take test)	No
Conscious attempt to deceive physician	No	No	No	Yes	No
Score on Mensana Clinic Screening Test	15–20 points	Variable—too small an experience to comment	17 points or less	21 points or more	17 points or less
Organic basis for complaints	Yes	No	Yes, but undiagnosed as yet	No, or a preexisting injury	Yes

Malingerers offer historical clues. Ask the patient to submit a written history, with detailed chronologic events, and then look for inconsistencies in the verbal history. The physician must be cautious to extend every effort to confirm diagnosis in a patient, regardless of the personality difficulties they may encounter. However, when inconsistencies and deceit appear, one may then suspect malingering (Table 1).

SUGGESTED READING

Hendler N. Diagnosis and nonsurgical management of chronic pain. New York: Raven Press, 1981. This book has several chapters on the difference between histrionic personality, hysterical conversion, and malingering.

Keiser L, ed. The traumatic neurosis. Philadelphia: JB Lippincott, 1968. A classic book to help the physician understand the psychodynamics of disability after an accident.

Slater E. Diagnosis of "hysteria." Br Med J 1965; 1:1395–1399. Although dated, the best paper on overlooked medical diagnoses, misdiagnosed as hysteria.