



Perspectives on understanding motivations of patients exhibiting functional overlay and effectively dealing with the confounding behavioral aspects.

Taxonomy of **PAIN PATIENT BEHAVIOR**

by Ron Lechnyr, PhD, DSW and Henry H. Holmes, MD

Physicians frequently encounter patients whose emotional issues, coping style, and psycho-social factors complicate the clinical picture. Though all types of physical illnesses and problems have psychological issues that need to be considered in the delivery of services, there are some patients whose response style may confound the diagnostic picture. When this happens, such patients are often given the label “hystronic,” “neurotic,” or as having a “functional overlay” to their pain or medical problems. Others involved in the case, from physicians, nurses, psychologists, clinical social workers, case managers, and insurers, may start to wonder whether the patient has “psychological problems” as the main cause of their difficulties. This results in the patient feeling that caregivers are no longer listening to them and so patient tries to “work harder” to “get others to listen.” This results in a stalemate for all concerned. In fact the difficulties, encountered by the physician employing traditional medical approaches in this population, are often due to the inability to deal effectively with functional syndromes, rather than due to the intractability of the organic pathology itself.

Functional Overlay Syndrome Definition

The term “functional overlay” is no more precise than the term “heart disease,” “GI disorder,” or “endocrine imbalance.” However, precision is demanded if our treatment is to be appropriate and specific. A breakdown of some of the commonly seen

functional overlays makes it apparent that the physician can often successfully address these issues partially or in full. The physician needs to be the key professional in developing an effective treatment approach and coordinating resources for this syndrome.

Since functional overlay syndrome do exist and are common in patients, they will either be managed, mismanaged, or neglected. Doing nothing can have as severe, and iatrogenic, an effect as reacting inappropriately. All physicians require an understanding of diagnostic categories and respective treatment approaches. For practical purposes, functional overlay can be defined as whatever else the patient brings along with their organic (real) pathology. These elements include psychological, emotional, coping, and interactional styles, basically, “the human factor.”^{1,2,3}

This definition assumes that there are both positive and negative functional overlays. In practice, however, use of the term usually carries a sense of, at a minimum, mild frustration and impatience since the process of diagnosis and treatment are made more difficult. It is important to understand that the patient’s response and coping style, which results in this overlay, is only an attempt to handle the fear and anxiety of the changes impacting their life and physical functioning. Further, the patient is thrust into an “alien” medical and psychological system that they do not fully understand; professional jargon confuses them and the required procedures unsettle them.^{2,3}

Involving a psychologist or clinical social worker having a specialty in pain management is critical to mediating treatment and maintaining continuity of care. The involvement of a mental health professional should not be seen as a way of dismissing the patient's complaints or problems, but rather as an adjunct to successful treatment. However, psychological intervention must be focused on the development of active self-care pain management skills if it is to be fully effective since 'insight therapy' alone is not as helpful to patients with chronic medical problems. The continued role of the physician as team leader is critical for several reasons: (1) many patients may avoid psychological intervention for financial, insurance, or personal reasons, fears, or the stigma of seeing a mental health professional, (2) the medical aspects of their condition can only be treated by the physician in a combined approach, and (3) assure evaluators, insurers, legal systems, and others of the validity of the underlying pathology and the proper way of realistically assisting the patient.^{4,5}

The following sections provide a discussion on the significant and varied aspects of patients exhibiting functional overlay, including perspectives on understanding motivations, varied ways of assessing, treating, and viewing such patients to improve outcomes. The taxonomy of eleven patient types was amassed over years of success and failure, and trial and error. It is meant to be practical rather than exhaustive, yet should provide utility to practicing physicians, psychologists, evaluators, legal representatives, insurers, and others in addressing this patient population.³

I. The Frightened Patient

Either directly or indirectly, the message is "I'm scared" and it may be conveyed in language noting a high physiologic arousal (fear) or in protective posturing (an attempt to avoid any further damage). Examples are the person who fears paralysis or further nerve damage; that their "arthritis" is progressive and will be disabling; that their symptom means cancer; or that surgery or painful treatment is needed (particularly if there have been personally traumatic medical episodes, or injury, in the past). The patient's internal images of what their symptom means are perceived in catastrophic terms. As a result, the patient may talk too much, ask

too many questions, be overly-dramatic, emotional, and have a sense of on-going panic and reactivity that makes exposure to this patient somewhat overwhelming.

The need is for in-depth education directed at changing the patient's perception of the problem to one which is less threatening and more under personal control. Since the patient is frightened, this may need repetition several times, most effectively in the presence of a significant other whom the patient trusts. The medical world is alien to most people and has its own language which is not easily understood by the average person. Terms and procedures that are common to health physicians are not so common

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or understood by patients. They often misinterpret what is said and have selective attention to what they hear. They need to have things patiently explained over and over again until they feel comfortable that someone is helping them with what seems to be changing their world view of life.^{6,7}

II. The “Please Hear Me” Patient

This patient complains either verbally or non-verbally that no one cares or takes the time to listen and understand. This patient values relationship above technical information and, before developing confidence in any treatment, will need to be treated as an individual. Otherwise, very

technically competent medical attention may be discounted. The relationship with the physician helps the patient feel safe.

The physician needs to listen carefully, examine carefully, and take the time to develop a relationship. These patients can be very grateful and loyal if handled appropriately. They need time to digest the information communicated to them so that they can be assured that others hear their concerns and understand them. A patient who seems depressed may, in actuality, just be a patient wanting to be heard.⁷

III. The “I Hurt Everywhere You Touch” Patient (Low Pain Tolerance)

This patient is difficult to examine; light palpation and examination procedures cause greater than expected pain and resistance. The patient exhibits a poor discrimination for the severity of their felt sensations. The physician finds exact diagnosis is often difficult or impossible.

The problem is one of lowered pain tolerance. Close questioning usually discloses the symptoms of endogenous depression with exhaustion, sleep disorder, mood and concentration difficulties. These patients often expect a great deal of themselves and may exhibit embarrassment, a fear of having a psychological problem, or a sense of inadequacy. Further, new research has led to the understanding that some patients may be genetically programmed to feel things more intensely. This does not reduce the reality of the organic problem. It just requires a different approach and understanding of how such patients react, especially when they feel exhausted and overwhelmed.

The physician should express concern that the patient's pain or medical problem has been so severe that they have become exhausted. An explanation to the effect that this is common and related to depletion of brain chemistry which in turn causes the lowered pain tolerance, sleep problems, etc. is generally much more acceptable than using the word "depression" or using psychological terms. Antidepressants should be prescribed in appropriate dosage with adequate explanation to ensure compliance. The physician should reassure the patient that as their sleep and natural resistance to pain improves, treatment will continue towards resolving the pathology. Giving them permission to "back off" the usual

demands they make on themselves and encouraging them to see a psychologist who has special expertise in dealing with chronic pain and illness issues may also help them to cope more successfully with their condition.^{8,4}

IV. The “Overwhelmed” Patient

This patient may present similarly to the low pain tolerance patient. The difference is that the stressors are more external — marital, financial, children’s behavioral problems, death in the family, etc. — and have grown to a crisis proportion with the patient becoming overwhelmed. The emotional energy behind their complaints is a “cry for help.”

In this situation, the crisis intervention model is most appropriate. The physician must explain the medical problem in relationship to their severe, understandable stress; treat the medical condition, but explain that it will not resolve without simultaneously treating the “cause.” Connecting the patient with resources for support and problem-solving to regain control and stability of their situation is the focus. Generally, this may be beyond the scope of the physician’s role, time and skills, and psychological resources must be enlisted. The physician must not allow the medical problem to become the sole source of attention or else the underlying causal factor, or “dis-ease,” will remain unresolved.

V. The Angry/Blaming Patient

This patient expresses anger either directly or indirectly which, in turn, interferes with establishing or maintaining an adequate doctor-patient relationship. It is important to note that anger is usually a “smoke screen” covering other human emotions and concerns. Anger is a communication that calls for understanding at a deeper level. Unfortunately, being human, many physicians take the anger personally and allow it to poison the doctor-patient relationship. It is critical that the physician learn confrontational skills so that the patient can be assisted to understand his/her own emotions and concerns.

The physician should allow the anger to be expressed (without taking it personally!). If the angry tone of the interaction continues, the physician should comment on and validate the anger, while at the same time insisting on a desire to be of help and have a good doctor-patient

relationship. Questioning and listening to the patient to determine what the anger is about and asking what the patient wants can help diffuse anger. Anger can be a defense and you may learn what the patient fears and wants (instead of what he/she may have gotten previously that did not meet expectations). Giving a sense of control to the patient and changing approaches to match expectations, if possible, can help the patient feel empowered. Allow time, perhaps over several office visits, for a relationship to develop. Handled appropriately, angry patients often become cooperative patients who see their physician as a partner in the treatment process. Often the anger of a new

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patient is the result of feeling that they were not heard or taken seriously by other physicians.

VI. The Somatizer

This patient type describes a condition that is emotional (“dis-ease”) expressed physically or somatically. The intensity of the focus on symptoms reflects the intensity of the emotional disturbance. Unfortunately, the patient is searching for relief “in all the wrong places” without conscious awareness of the emotional basis of symptoms or because considering the emotional side appears impossible or overwhelming. Frequently, such patients have had poor childhood emotional

training or have sustained significant trauma and abuse. What is important here is that the patient is actively asking for help, even though the help needed may be very different than what the patient believes. There is a spectrum of somatization from simple to complex conversion disorders such as hysterical paralysis or hemianesthesia.

The physician should intersperse medical and psycho-social questions while taking history—weighing each equally. Listening carefully to the imagery of the patient’s symptom description for clues (most somatizers are not difficult to spot!) and emanating acceptance and a non-judgmental attitude towards the person and their condition is very helpful in this situation. Sometimes it may be necessary to do some unnecessary workup to demonstrate serious attention to the patient’s perceived symptoms, yet offer structure and limits to diagnostic and therapeutic forays. Remember that the symptoms the patient offers are not what needs to be “cured,” but instead are clues to their personal mystery — sifting for such clues will ultimately determine what the patient really needs from treatment. The myth that this patient type is untreatable is presumed by most physicians and insurers but, in reality, can successfully respond to a pain management psychological approach to treatment.

When a relationship has been built, the physician may take risks and lead the patient to the real “pay dirt” in the emotional arena. Getting the patient to accept psychological intervention is tricky but can be done if the patient feels accepted and sees the referral as part of a coordinated approach to their care. To ensure acceptance of this approach, maintain regular, but brief, office visits until the patient is capable of less dependence on these visits.

VII. The Passive Patient

This patient does little to actively participate in their own care. Many varieties of behavior may be involved including failing to follow through with treatment — even when agreed to — appearing helpless, overwhelmed, incapable of acting on their own behalf, or offering numerous excuses usually based on being controlled by others or by circumstances.

The patient is asking the physician to validate, either in word or behavior, that she/he has no control over health or cir-

cumstances. It is very flattering to “be needed,” but this can become a trap to the unsuspecting physician who ends up validating the patient’s helplessness.

The physician’s attitude must be one of respect and firm expectation that the patient learn to manage their own problems. This includes withholding attention, prescriptions, or passive treatments until the patient has fulfilled his/her obligations. The agreement, simply stated is: “I’ll provide these medical services, provided you follow through with the recommendations which only you can do for yourself: I’ll take one step for each step of yours, but no more.” This attitude defines the treatment relationship as adult to adult rather than adult to child. The physician will often reap the reward of having believed in the patient or of being “a tough guy” (but respected). This helps the patient reach out for behavioral pain management therapy in appropriate, active, self-caring ways.³

VIII. “Secondary Gain”/Malingering

Disease and disability are, from one perspective, learning opportunities. For some it may become more comfortable to remain ill than to recover or adjust. Illness may “gain” the patient attention and care they don’t otherwise receive, or it may relieve them of responsibilities that were burdensome or overwhelming. For some patients, continued pain and illness may be the only means of securing access to drugs in dependency states. Illness can be a retaliation on others or even a protection from further physical abuse.

The basic principal is that continued illness “makes sense” to the patient’s “private logic” from a holistic point of view. True malingering is rare, while secondary gain factors are common and will remain so as long as people lack viable options or the confidence to successfully make changes in their lives.

It is important to understand that secondary gain factors are ones the patient is not aware of on a conscious level, yet may strongly motivate a patient towards specific goals of an unconscious psychological nature. Primary gain factors, by comparison, are those the patient is very aware of trying to obtain, such as increased, or continuing, compensation. This latter behavior is not as frequent as one might think in patients with disability and illness.

The physician must take an adequate

psycho-social history, probing gently for the presence of primary and secondary gains. Except in the case of drug dependency, it may not be therapeutic to directly confront the patient unless there is a strong therapeutic alliance. However, basing treatment extent and duration on objective findings, rather than subjective complaints, will avoid most pitfalls. Mobilizing resources, particularly referring the patient to a pain psychologist, or a pain center program, can provide the patient with more options and choices for coping more effectively. This

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is preferable to the “good swift kick” approach which will often simply land the patient in another physician’s office schedule without any awareness or resolution of the problem.

IX. Hysterical Personality/Over-Dramatization

These patients simply express themselves with greater vigor, color, and flamboyance. This is often a learned behavior, and it can be cultural. The patient believes that this is what is required to get their physician’s attention and proper

treatment. This is not personal. They present these same behaviors in most aspects of their lives. They tend to be colorful in language and have a strong need to describe symptoms in extensive and dramatic terms.

It helps to have seen the patient over a period of time so that the stability of the style is apparent. The task is to simply accept (and perhaps even enjoy!) this manner of self-expression. Importantly, the extent of evaluation and treatment should reflect objective findings and not the level of the patient’s emotionality or drama. The patient needs to be educated as to why their manner of approach may get them less of a positive response from physicians. Developing a structured way of relating and establishing a therapeutic “holding environment” which can help the patient contain, manage and focus their feelings in a more productive manner, can be very helpful. However, this can be a difficult task for the patient, psychologist and physician. It is important to remember that the patient’s manner of responding only means that they are trying, through their “colorful dramatics,” to insure that others pay attention to their symptoms. The physician needs to complete the medical evaluation even in the presence of the “dramatics” in order to treat any organic problem that “co-exist” with the psychological issues. It is important to remember that real physical problems can exist even with dramatic presentation of symptoms.

X. Major Psychiatric Disorders

Patients with major psychiatric problems develop medical illness and complaints even more frequently than the population at large. Unfortunately, many define their psychiatric problems in physical medical terms. This can create a significant obstacle to engaging in appropriate mental health care. Obviously, such patients should have a combined medical and psychiatric/psychologic approach both for their own benefit and the physician’s comfort.

The goal is to bring the patient into psychiatric or psychological management while simultaneously providing appropriate medical care. It helps for the physician to state the concerns as follows: “I am worried that your medical condition has been so severe and difficult that it has taken a toll on you physically and emotionally. I see the signs of strain. I believe



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¹ Cherkin, D.C., Eisenberg, D., et.al. Randomized Trial Comparing Traditional Chinese Medical Acupuncture, Therapeutic Massage, and Self-care Education for Chronic Low Back Pain. Arch Intern Med. 161(8):1081-8; Apr 23, 2001.

² Ferrell-Torry, A.T. and Glick, O.J. The Use of Therapeutic Massage as a Nursing Intervention to Modify Anxiety and the Perception of Cancer Pain. Cancer Nurse. 16(2): 93-101; Apr 1993.

³ Kaard, B., Tostinbo, O. Increase of Plasma Beta Endorphins in a Connective Tissue Massage. Gen. Pharm. 20(4): 487-89; 1989.

⁴ Jensen, O.K., Neilsen, F.F., Vosmar, L. An Open Study Comparing Manual Therapy with the Use of Cold Packs in the Treatment of Post-traumatic Headache. Cephalalgia (Norway). 10(5): 241-50; Oct 1990.

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you need support to help you through until we can get your medical condition under better control. I would like you to see [name of mental health professional] while I continue to see you for medical treatment and we will coordinate closely.” This explanation rarely engenders resistance and avoids the frequent patient interpretation that “the doctor thinks it’s all in my head,” which can lead to an unproductive change of physicians. Instead, the mental health professional receives a better-prepared and more receptive client.

XI. The “Normal” Patient

Many normal patients, faced with an injury or illness, may react in uncharacteristic ways from their usual manner of relating in the absence of such stress or traumatic event. At these times it is easy to see the obvious pathology in regressed functioning that can interfere with appropriate recovery. When patients are in dependent positions they can regress in their functioning. It is tempting to assign the obvious psychopathology as the cause of the problem, yet it is important to remember that each of us, when under stress, can be “difficult” patients who react in immature ways in order to defend against “attack” and vulnerability.

The physician should explain the issues of crisis and trauma and its impact on the normal person, including the stages of grief and how we all react to illnesses.⁹ Helping family members to understand the issues, enlisting their support in the recovery process, and encouraging all members to understand their reactions as normal and will subside with time, can be very beneficial. The physician should be open to referring the patient for psychological consultation even if the patient is “normal.” Everyone needs support and help at times of crisis. Such psychological help and support can assist patients to recover more quickly and with less complications.^{10,11} The goal of psychological intervention, in this instance, should concentrate not so much on diagnosis as on assisting the patient to learn active self-care management skills.

Proper Role of Psychological Testing in Pain Patient Evaluation

The MMPI-2, which was first developed in 1939 and later updated and revised in the 1990’s, provides a tool in understanding psychopathology, behavioral issues, and

problems in functioning. The test’s numerous subscales allow for a more in-depth understanding of an individual’s functioning, motivation, prognosis, issues of chemical abuse potential, traumatic responding patterns, and an understanding of the psycho-social issues impacting the patient’s functioning. This can be useful in the context of understanding the stress a patient is under, identifying the issues that are blocking the patient’s progress in treatment interventions, and as a “guide” for treatment. Utilizing the MMPI-2 for other purposes, however, such as trying to discredit a finding of “permanent pathology” in a patient has no validation in re-

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search and misconstrues the purpose of this useful evaluative tool.

Some useful insights gained from the MMPI-2: (1) psychiatric disorders found in chronic pain patients show improvement with pain treatment,^{12,13} (2) lack of problem-solving pain management with sole focus on immediate relief creates further physical problems, reduced functioning and fosters anxiety about future pain problems,¹ (3) 40% of chronic pain patients suffer from depression as a result of living with chronic pain, rather than their

depression causing chronic pain,¹⁴ (4) cognitive behavioral therapy is superior at decreasing pain intensity and improving pain coping,¹⁴ (5) pre-surgical psychological evaluation can help improve surgical outcomes, especially if the focus is on assisting the patient in understanding how their present functioning may hinder any type of intervention,¹⁷ and (6) most importantly, understanding that the MMPI-2, or any other psychological test, should only be used as a guide for treatment interventions, rather than as a tool having as its sole focus psychopathology.^{15,16,17,18}

Conclusion

Rarely do these categories of functional overlay exist in pure form, the clinician usually encounters various combinations. Hopefully, however, this simple formulation of types and approaches is useful. It is apparent that some factors affecting functional overlays can best be dealt with by physicians who, in their role as team leaders, can assist in the coordination of other treatment approaches including psychological interventions. Issues facing physicians include the need for educating patients to dispel unreasonable fears, implementing a behavioral approach for passive patients, managing drug prescriptions (or commitments not to prescribe), and managing patient-physician interactions in which the physician’s personal reaction may contribute iatrogenically.

Physicians do enjoy complex and challenging problem-solving issues in working with patients. The expertise and creativity brought to difficult surgical and medical problems is exemplary. Functional overlay is just as challenging an area of medicine and psychology and deserves the same disciplined differential diagnosis and specific treatment approaches — as well as an acknowledgment of limitations. A patient with several interacting medical conditions needs treatment approaches that honor each. Functional overlay can be viewed simply as a second medical condition which requires that we modify our approach to the first and treat the combination. The challenge in managing these cases is quite often a physician’s personal reactions to these patients’ psychological response style. It is hoped that this article will provide the physician, psychologist, and others, with a guide to understand and respond therapeutically to these complex syndromes. ■

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