CHAPTER EIGHT

Pain Behavior

Barry grew up in a brutal environment. He was the youngest of thirteen children. He was beaten badly by his father and also his older brothers and sisters. Whether his epilepsy derived from head injury incurred in some of those beatings or whether it was a result of some genetic mischance is uncertain. He achieved a tenth-grade education, but his learning skills were limited and he is functionally illiterate. In spite of his handicaps, however, he found steady employment as a carpenter. He had a stable marriage of eighteen years and was the father of two sons.

His first back surgery for a ruptured disc was done at age thirty-eight. He recovered sufficiently to go back to work. The following year he became ill with an intestinal blockage that required several operations. During the course of this prolonged illness, he lost weight—from 245 pounds to 117. He became depressed and sleepless and remained so in spite of treatment with Effexor. His misfortune continued. He ruptured another disc and required surgery, but he failed to recover and entered a life of incessant painfulness. He began treatment with Hydrocodone and the muscle relaxant Soma. His pain spread all over his body into his shoulders, torso, hips, and legs. His doctors told him, he said, that his joints were “worn out from hard labor.”

He moved about with hesitation, limping badly, and holding on to any available piece of furniture to help support his weight. His movements were restricted by pain, and it took him forever to gather himself onto the examining table and lie down on his back. He grimaced and winced frequently and sometimes screamed when a movement was particularly difficult for him. Finally, with Barry supine on the table, I attempted to perform the time-honored straight leg raising test. In this maneuver, the physician slowly lifts the patient’s leg toward the ceiling, asking if and when
he has pain. If pain occurs before the movement can be completed, it is a sign that the large sciatic nerve is damaged, most commonly by a ruptured disc (the term sciatica refers to pain radiating down the leg). I was able to get Barry’s leg but a couple of inches off the table before he screamed in agony. I repeated the maneuver on the other leg, and the same thing happened. Almost any back-injured person, even with the worst sciatica, will tolerate their leg being lifted two inches without pain. Why couldn’t Barry?

It is time now to talk about pain behaviors, that is, the exhibition of physical suffering. We have all done it. I certainly have many times with back spasms, leg cramps, or an acutely swollen gouty knee. With these illnesses I grunt, I wince, I grimace, and I resist any movement that will worsen the pain. The migraineur does the same when she goes into a room and turns off the light and closes the door to lie quietly alone. These are all understandable actions, and they are in many regards self-protective. We avoid that which makes the pain worse. Pain behavior is a part of our lives, and it is a common, even predictable reaction to injury. It is rather uncommon, however, in those who suffer chronic pain. Only a few of the people I have described thus far exhibited any real pain behaviors during the course of my interview. The reason for this is, I believe, that pain behaviors are energy inefficient and energy wasteful. Sustaining them for weeks, months, or even years is exhausting and self-destructive. Nonetheless, it does happen occasionally, and I want to address this subject in some detail because my thinking of the matter has turned 180 degrees within the past few years.

When pain behavior persists beyond the time limits that the physician could reasonably expect from the injury, it invites suspicion. It suggests that the patient’s exhibition of suffering offers him some gain—be this sympathy, attention, more pain medicines, or financial reward from litigation. These benefits are identified in the lexicon as secondary gain. In other words, the victim, by virtue of his behavior, gets something more out of his illness than he deserves. This, I emphasize, represents a high order of presumption. We
don’t really know that the victim is seeking something extra. We only presume it. It is an easy trap to fall into, and we physicians do it a lot. We ascribe what appears to be an overreaction to pain in pejorative terms, using descriptors such as attention-seeking, non-physiologic (and Barry’s two inches off the table back pain was certainly non-physiologic), or symptom magnification. We compound what I believe is an erroneous judgment by frequently attributing it to some want of intellect or emotional strength. And Barry, we certainly know, had plenty of that. He was, after all, childhood abused, uneducated, illiterate, and epileptic.

I want to pause now and develop an idea that I think is quite important, perhaps one of the most important that I present in this book. There is a well-recognized psychiatric disorder known as conversion reaction. It is characterized by the loss of some neurologic function such as sensation, muscle strength, or vision that appears in reaction to stress and occurs in the absence of any identifiable abnormality of the brain. Conversion, certainly, is non-physiologic. For example, the victim of conversion reaction blindness says he cannot see, and yet his pupils constrict on exposure to light. Or he cannot move—he is paralyzed—but his reflexes are perfectly normal. We believe that conversion reaction is an act of the subconscious. It is not the product of will. That is to say, the victim does not knowingly create the symptoms. (If the symptom is created by an act of will, that is known as malingering).

Conversion reaction is one of several psychologic defense mechanisms, ways of coping, however maladaptively, to stress. I have already written at some length about denial as a defense mechanism and also, briefly, repression and transference. The defense mechanism of conversion, we have traditionally believed, usually befalls the less endowed, those who by dent of limited intellect and education lack the emotional resources to confront stress. They are not sophisticated enough to enter denial. They are forced to express their damaged emotions in a more vivid exhibition.

Now, back to Barry’s extravagant pain behaviors. Could they not be a form of conversion reaction? Psychiatrists would be very reluctant to say so. Traditionally they are disinclined to view pain and its companions, including pain behaviors, as a form of conversion, but I really don’t see
why. If we could but accept the possibility that they are, it would be an enormous conceptual advance.

If pain behavior is indeed a form of conversion, it is (so far as we know) the product of the subconscious and, therefore, quite independent of will. How then can we use terms such as attention-seeking and symptom magnification when the victim has no control at all over his symptoms? How could he possibly magnify that which is beyond his control? How do we know that the patient is seeking gain? Really, we don’t know that the patient is employing his symptoms for advantage. We only presume it, and that, I will suggest, may be as much a product of physician frustration as anything else because pain behavior is indeed difficult to put up with. It is distracting and time consuming, and most physicians have a lot of trouble with it.

Conceptualizing that pain behaviors can be a symptom of conversion has, I believe, made me a better physician and probably a better man because it has removed me from preconception and prejudice. I now view pain behavior/conversion as merely another symptom of chronic pain along with disordered sleep, mood, and all the rest. I have learned, and this is quite surprising to me still, that pain behavior is actually a very good prognostic sign. I suspect that very few physicians would agree with that, but I believe it to be true.

I completed, at glacial pace, my interview and examination. I prescribed Clonazepam and Imipramine, telling Barry to continue his Hydrocodone and Soma. He returned at the appointed time to report that his sleep was somewhat better, but his pain was absolutely unchanged. His wife commented to me, however, that she thought he was feeling better, and that his mood was certainly better. I enjoyed observing that he seemed to move about with a little less hesitation and a little less grunting. I scheduled him to return in three weeks, but it was three months before I saw him again. He was no longer encumbered. He moved about with ease, and I made a point to check his straight leg