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Taxonomy of Pain Patient Behavior

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

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

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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.

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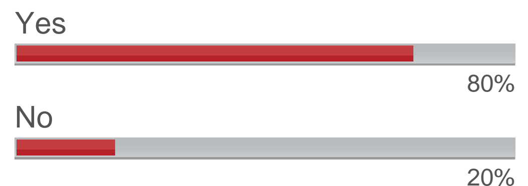

Others involved in the case, from physicians, nurses, psychologists, clinical social workers, case managers, and insurers, may start to wonder whether the patient has “psychological problems” as the main cause of their difficulties. This results in the patient feeling that caregivers are no longer listening 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.

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Functional Overlay Syndrome

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 it's own language which is not easily understood by the average person.

Terms and procedures that are common to health physicians are not so common 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]

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