Waddell's definition of "illness behaviour" is:

"observable and potentially measurable actions and conduct which express and communicate the individual's own perception of disturbed health".

Of course, a certain degree of illness behaviour is to be expected and should be regarded as "normal".

However, some patients are being labelled as having developed "abnormal illness behaviour" which is defined as

"maladaptive overt illness related behaviour which is out of proportion to the underlying physical disease and more readily attributable to associated cognitive and affective disturbances than to the objective physical disease..."

As Dr. Kelly Patrick Flannigan points out in an Internet article:

"IT IS EXTREMELY IMPORTANT THAT SIGNS OF ABNORMAL ILLNESS BEHAVIOUR ARE NOT INTERPRETED AS "MALINGERING" (A CONSCIOUS ATTEMPT TO MISLEAD THE EXAMINER). TRUE MALINGERING IS RARE. ABNORMAL ILLNESS BEHAVIOUR IS RELATIVELY COMMON, AND SHOULD BE INTERPRETED BY THE PHYSICIAN AS AN INDICATION THAT THE BIOMEDICAL MODEL MAY BE INADEQUATE TO DEAL WITH THE PATIENT'S INJURY OR ILLNESS EXPERIENCE." (1)

Flannigan rightly remarks that abnormal illness behaviour is a manifestation of psychosocial distress.

Robert W Teasell MD FRCPC, in his article, "The denial of chronic pain", writes:

"There is a current disconcerting trend towards dealing with chronic pain and its subsequent disability by denying its reality. The reason for this has primarily been cost containment and cost reduction...

Models of chronic pain management through denial are based on the proposition that chronic pain occurs as a consequence of compensation and inappropriate treatment.

Moreover, they emphasize the outmoded concept that soft tissue injuries heal after six weeks, and they cling to increasingly irrelevant behavioural models of chronic pain...

To justify such an approach, psychosocial factors are often implicated as causative.

However, a wave of recent research has demonstrated that psychological factors are more secondary to pain than causative...

The evidence that chronic pain has an organic etiology is growing and has become increasingly compelling."

The concept of "normal" and "abnormal" illness behaviour is illustrated in the following table:

Physical Disease,

"Normal" Illness Behaviour Abnormal or inappropriate Illness Behaviour

Pain Adjectives:	sensory	affective, evaluative
Symptoms:		
Pain:	localized	whole leg pain, tailbone pain
Numbness:	dermatomal	whole leg numbness
Weakness:	myotomal	whole leg giving way
Time Pattern:	varies with time	never free of pain
Response to		
Treatment:	variable benefit	intolerance of treatments, ER visits
Signs:		
Tenderness:	localized	superficial, non-anatomic
Straight Leg Raise:	limited even when distracted	improves with distraction
Axial Loading:	no lumbar pain	lumbar pain
Sensory:	dermatomal	regional,
Motor:	myotomal	regional, jerky, "giving way"
General Response to		
Examination:	appropriate pain	over-reaction

It may be helpful to bear in mind the following definitions:

The manual DSM-IV provides diagnostic classification.

Pain Disorders fall within Somatoform Disorders; with 3 subtypes (and being either acute - less than 6 months- or chronic):

307.8 Pain Disorder Associated with Psychological Factors

Psychological factors are judged to have the major role in the onset, severity, exacerbation, or maintenance of the pain.

In this condition, general medical conditions play either no role or minimal role in pain onset or maintenance.

307.89 Pain Disorder Associated with Both Psychological Factors and a General Medical Condition

Both psychological factors and a general medical condition are judged to have important roles in the onset, severity, exacerbation, or maintenance of the pain.

Pain Disorder Associated with a General Medical Condition

This is not considered a mental disorder. Pain results from a medical condition, and psychological factors are judged to play either no or minimal role in pain onset or maintenance.

If one considers the definition of chronic pain by the American Medical Association:

"Chronic Pain is a self-sustaining, self-reinforcing, and self-regenerating process. It is not a symptom of an underlying acute somatic injury but rather, a destructive illness in its own right.

It is an illness of the whole person and not a disease caused by the pathological state of an organ system.

Chronic pain is persistent, long-lived, and progressive.

Pain perception is markedly enhanced. Pain related behaviour becomes maladaptive and grossly disproportional to any underlying noxious stimulus, which usually has healed and no longer serves as an underlying pain generator..."

This implies the progression over time from the DSM-IV Pain Disorder Pain Disorder Associated with a General Medical Condition to one of the more malignant Pain Disorders 307.8 Pain Disorder Associated with Psychological Factors or 307.89 Pain Disorder Associated with Both Psychological Factors and a General Medical Condition.

It also makes the assumption that pre-existing psychological or subsequent environmental factors are necessary for sustained pain.

These are standard ways of looking at chronic pain patients. Note however, the following comments on the Law Med Web (Internet site) under Personal Injury Litigation: "Waddle Twaddle":

"Be prepared to examine non psychiatric medical experts about their special training in psychosomatic medicine. For the litigator, an expert medical report identifying Waddell signs should be a reminder to obtain psychiatric expert opinion on somatoform disorder and malingering."

In 1997, Isabella Mori at Simon Fraser University published a paper titled:

"Chronic Pain and the Doctor-Client Relationship: An Action Research Project."

The impetus for this study was "the observation of many clients' outrage, disbelief and hurt at being told by some doctors, either directly or indirectly, that their pain was "all in their head", that is, psychogenic".

The author hypothesised that clients and doctors draw different experiences from their

relationship and that neither are sufficiently aware of these differences; she also further hypothesised that increased awareness might result in improvements in the doctor-patient relationship and thus eventually in patients' well-being.

The paper acknowledges that both doctors and patients perceive there to be significant gaps in doctors' understanding of chronic pain, citing various papers to corroborate this.

It also suggests that patients' knowledge of the ?psychological complexities of pain' is as poor as that of the doctors. This makes for a rift between the two parties, which is not being bridged by shared information or established trust.

In this context, a psychogenic diagnosis being made by default is more likely.

Hendler et al (2) cite lack of knowledge as one of the reasons for this diagnosis. A doctor who is unfamiliar with psychological aspects of pain may misinterpret the patient's presentation.

Furthermore, doctors may be unfamiliar with a condition such as arachnoiditis, about which medical awareness is limited because it is considered rare.

The patient now feels not only uncertain and disappointed by the level of his/her doctor's knowledge, but also under threat because this diagnosis is perceived as a threat to his/her sanity.

Of course, it is important to differentiate between psychogenic illness and psychological aspects of chronic illness.

The former term implies that psychological issues cause the pain, whereas the latter deals with the mental and emotional impact of physical illness. Often describing conditions as psychogenic is a bit like putting the cart before the horse.

Many patients are so afraid of being ?accused' of ?making it all up' that they resolutely refuse to discuss psychological aspects at all.

This may ironically compound the impression they convey that there is a strong psychological element and might make the psychogenic diagnosis more likely.

Mori's paper referred to a gap between doctors' knowledge about depression and stress in chronic pain patients and the patients' experience.

Many patients are adamant that the pain causes depression and stress and NOT vice versa.

There is a strong degree of controversy over this in the medical literature and amongst medical practitioners.

Mori also raised the point that many doctors seem unable to manage the subjectivity of pain: ? " if he's laughing, it can't be that bad"' as well as the vital point that patients are unsure whether to minimise or maximise their reported pain.

Whilst health professionals tend to think that patients are overstating pain, there are some studies, which suggest the reverse may in fact be true.

Sometimes patients go through tremendous unseen struggles, a fact which doctors should always keep in mind:

"Emily vowed each night that she would get up in the morning...she tried to get up.

She would relax a little while, culling back what sleep there had been in the night, trying to make tranquil the tensions in her body, and then get out of bed and begin to dress.

She made herself do this at her former speed, not allowing the illness to grip and drag at her, thinking to cheat her body back to its former self by observing all that she had been."

Melvyn Bragg, "The Cumbrian Trilogy."

What is seen in a clinic setting is by no means fully representative of a patient's life.

[1] PAIN IS A BLIND GUIDE IN INJURY MANAGEMENT 1995, Kelly Patrick Flannigan, MD, FRCP(C) http://www.masmith.inspired.net.au/pain/flannigan.htm

[2] Hendler, N.H. & Kozikowski, J.G. *Psychosomatics,* (1993b); 34(6): 494-501Overlooked physical diagnoses in chronic pain patients involved in litigation.