Most of these myths are perpetuated by medical and allied personnel. They can significantly increase the degree of suffering experienced by the patient.

1.Pain is only subjective: by which may be inferred that subjective = imaginary. This is, of course, a fundamental inaccuracy and could perhaps be refuted by using the following argument:

Q: Doctor- do you love your wife? A- Yes, of course.

Q- can you demonstrate that with a test? A-No Q- then how do we know objectively that you love your wife: presumably we have to take your word for it? A-Yes.

Q-How is that different from Mr. Bloggs' pain; surely we also have to take his word for it? A-well, I guess so.

2.There is psychological overlay: (aka compensation neurosis, malingering, symptom magnification, subjective complaints etc.) there are a number of buzzwords favoured by medical professionals and these are most often brought to bear in situations where the physical source of the patient's problems is not clear-cut.

However, inexact and inappropriate ?labelling' is decidedly unhelpful. It can be useful to challenge the physician to define the terms formally, because quite often he/she will be unable to do so satisfactorily.

Pain generated in the mind (psychogenic) is rare but is over diagnosed.

Conditions such as malingering are in fact psychiatric diagnoses (about 5% of chronic pain patients are thought to be malingerers for a variety of reasons).

Subconscious symptom production, somatisation (translation of psychological distress into physical symptoms) and psychological problems such as depression are *not* malingering, because none of them involve intention.

3.There is no evidence on medical tests: so there cannot be a problem: a common point of view.

Modern day technology is deemed all-powerful and its limitations overlooked.

Added to which, the correct tests must be applied, because if the wrong questions are asked, then it is unsurprising that the answers are skewed.

4.There is a physical problem but not severe enough to account for the problems, which must therefore be psychological.

NOTE: psychiatric diagnoses by physicians not trained in the specialty: "sidewalk diagnoses". One of the common problems is the use of pejorative terminology such as ?hysterical conversion'

5.Compensation neurosis: actually, the concept of this, also known as ?greenback poultice' in America, arose after the Second World War, when disability benefits in Germany were blamed for fostering neurotic dependency in Germans.

In reality, there is little concrete evidence that people ?take up their beds and walk' once their claim is settled; the vast majority remain ill as before.

Of course, there are cases in which individuals have made entirely fraudulent claims; it seems that the taint of the greed of the few spreads so that suspicion falls upon the genuine majority.

6.Secondary gain influences the patient's progress: this unpleasant term refers to a 1945 description ?certain uses the patient can make of his illness' (
[1]
)

One must always bear in mind that looking at secondary gain must be balanced out by looking at secondary loss: so respite from unpleasant or stressful situations (e.g. work) is offset by loss of status, financial security etc.

Should the issue of secondary gain be raised, simply cataloguing the numerous losses occasioned by chronic illness can easily deflect it: which of course, we shall in due course be looking at in further detail.

We should also consider the concept of tertiary gain, which may affect third parties such as doctors, rehab counsellors and lawyers, who may find it difficult to maintain objectivity.

For instance, doctors may fail to care appropriately for the patient and thereby enhance the problems, especially frustration, anxiety and despair.

The patients may respond by ?turning up the volume': increasing their demands, and probably relating their story more emotionally; they may even embellish it in order to make themselves heard: which in turn raises the risks of being labelled as emotionally liable and disturbed.

7.The patient does badly on tests such as Functional capacity evaluation, so must be a

malingerer: Waddell signs and psychological testing are often trotted out by insurance companies and medical professionals as ?evidence' that the patient's illness is not entirely ?bona fide'.

In 1980, Waddell and colleagues developed a standardised assessment of behavioural responses to examination: features such as illness behaviour and distress were emphasised.

However, in identifying these ?nonorganic' physical signs, their goal has been misinterpreted and misused both clinically and medico legally.

Gelman and Brazin ([2]) note:

"The authors rejected the notion that their testing identifies malingerers or exaggerators. Among patients with more non-organic signs were patients with conservative treatment failure, which sometimes results in multiple surgeries.

Furthermore, non-organic signs were equally common among litigants and non-litigants.

In one group of ten patients with spinal infection or tumors, two had non-organic signs.

The authors caution:

" It is safer to assume that all patients complaining of back pain have a physical source of pain in their back. Equally, all patients with pain show some emotional and behavioral reaction."

One of the principal points is that of individual interpretation of results by the examiner, who may, of course, be biased.

Note that these tests are more art than science, are subjective and involve such variables as: test taker inexperience, examiner inexperience, sleep deprivation, anxiety, anger, fear, depression, etc. as well as the current pain level.

Use of ?averaging' the scores of multiple validity tests (e.g. pain score to heart rate ratio, rapid exchange grip, pain behaviour etc.) is use of poor mathematics.

One final note: one of Waddell's ?signs' is emergency room admission for simple low back pain: which might be construed as inappropriate medical practice rather than patient behaviour!

Psychologist Mark Grant outlines his

"Eight Most Unhelpful Myths About Chronic Pain" on his website ([3]):

- "Pain always means there's something wrong"
- "If the cause for your pain can't be found, it must be ?in your head'"
- "Pain is good for your character": he stresses, "Unrelieved chronic pain is soul-destroying, not character-building."
- "Showing pain or complaining is a sign of weakness"
- "Some people don't want to get better because they benefit from being in pain"
- "The best patient doesn't ask too many questions of the doctor"
- "Chronic pain is generally well-managed medically"
- "You'll just have to learn to live with it"

He concludes: "Do not become discouraged, keep asking and looking for

information."

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[1] Fenichel, O. *The Psychoanalytic Theory of Neurosis,* Norton, New York, 1945

[2] The Use of ?Waddell' in Workers' Compensation Claims http://www.gelmans.com/Articles/Waddell9/html .

[3] http://www.overcomingpain.com/8myths.html