Secondary Gain Concept

Definition Problems and Its Abuse in Medical Practice

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Secondary gain is claimed to be important to the generation and maintenance of disease or illness behavior. This concept is of major interest to the clinician dealing with the chronic pain patient, as these clinicians often encounter patients with whom secondary gain factors are suspected or inferred, or both. The author begins a critical examination of the concept of secondary gain. Primary, secondary, and tertiary gains and secondary losses are defined and described. Difficulties with and abuses of the secondary gain concept in chronic pain treatment are presented. **Key words:** *primary gain, secondary gain, tertiary gain, reinforcers, secondary losses, abuse of the secondary gain concept*

The purpose of this focus article is to generate a scientific and meaningful dialogue about a troubling concept: secondary gain. This concept is thought to be important to pain medicine and to medicine in general as it appears to have infiltrated the nomenclature of every medical specialty. For example, in preparing this article, the author was able to find and review 163 articles in which secondary gain, primary gain, and tertiary gain were mentioned in some way. These articles were categorized according to the medical specialty of origin and where possible by topic. In addition, any articles that were studied on secondary gain, whether controlled or not, were segregated as a group. The reports are categorized as follows: 15.3% from medicine, surgery, ophthalmology, ear, nose, and throat, dentistry, and neurology; 43.6% from psychiatry; 13.5% from psychology with pain as a topic; 6.7% from sociology, with pain as a topic in some articles; and 4.3% on the topic of Münchausen's syndrome but from various medical specialties. Of the 163 articles utilizing the secondary gain concept in some way, 16.6% were actual studies of some aspect of secondary gain (Fishbain et al., unpublished paper, August 1994). Thus, secondary gain appears to have infiltrated the medical nomenclature, even of specialties other than psychiatry and psychology.

This author believes that the basis for the secondary gain concept has not been subject to close scrutiny, so I will delineate the definitions around this concept. This is necessary because the present literature shows that this concept is poorly defined. Difficulties in definitions have led to different interpretations of the concept by clinicians. This in turn has led to abuse of the concept especially in its application to the concept of malingering. Here, the problem revolves around whether the observed behavior is consciously or unconsciously motivated. The definition problems have also led to difficulties in appropriately investigating the secondary gain concept. Finally, this article will suggest some new definitions for this concept, some of which the author believes could be investigated operationally.

DEFINITIONS

Gain is a psychoanalytic concept first noted and defined by Freud.[18] He described two types of gains from illness: primary and secondary. To Freud primary gain was a decrease in anxiety brought about through a defensive operation that had resulted in the production of the symptom of the illness. Primary gain was therefore an intrapsychic phenomenon. An example of primary gain would be the patient who

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shoots his wife using his right hand. He is guilty and conflicted over this action. The right arm then becomes paralyzed via a conversion mechanism. He is therefore punished. This results in decreased guilt and a reduction in intrapsychic conflict and decreased anxiety, i.e., primary gain. Freud went on to define secondary gain as an interpersonal or social advantage attained by the patient as a consequence of the illness.

Since Freud's time, the psychiatric definitions for primary and secondary gain have remained essentially the same. Barsky[2] defined primary gain as "a reduction in intrapsychic conflict and the partial gratification accomplished by the defensive operation." He defined secondary gain as "acceptable or legitimate interpersonal advantages that result when one has the symptom of a physical disease." The DSM-III-R[1] defined primary gain, as the gain achieved from generating a conversion symptom that results in keeping an internal conflict or need out of awareness. The generated symptom has symbolic value to the underlying conflict. Secondary gain was defined as the gain achieved from the conversion symptom in avoiding a particular activity that was noxious to the patient or enabled the patient to get support from the environment that might not otherwise be forthcoming, or both. It should be noted that the Freud and Barsky definitions relate to illness in general, while the DSM-III-R definitions relate specifically to conversion disorder. However, secondary gain is not a diagnosis in the DSM-III-R.[1] A large number of secondary gains have been described in the literature. These secondary gains are as follows:

1. Gratification of preexisting unresolved dependent strivings[39]
2. Gratification of preexisting unresolved revengeful strivings (e.g., getting paid for not working in a setting where the employee felt unappreciated or was engaged in a risky job, revenge at insurance carriers or adjustors who gave patient a hard time)[33,39]
3. Attachment behavior, an attempt to elicit caretaking[5,23]
4. Oversolicitousness and overprotectiveness by significant others[5,9,33]
5. Family antagonism (anger) because of disability, may increase patient resentment and determination to get his or her due to prove entitlement[30,33]
6. Preferential or less hazardous work conditions[14] or means of avoiding work[9]
7. Sympathy and concern of family and friends[14]
8. Ability to withdraw from an unpleasant or unsatisfactory life role or activity[10,14]
9. Sick role allows the patient to communicate and relate to others in a new, socially sanctioned manner[13]
10. Financial rewards associated with disability[5,14,26]
11. Drugs[9,26]
12. Holding the spouse in a marriage[5]
13. Maintenance of status in family[30]
14. Maintenance of family love[30]
15. Domination of family[9,30]
16. Being freed from the socioemotional role[10]
17. Means of contraception[10]

Finally, both primary and secondary gain are thought to occur by unconscious mechanisms.[2,9,40]

Tertiary gains were first described and defined by Dansak.[11] These were gains sought or attained from a patient's illness by someone other than the patient, usually a family member. Since then, this type of gain has been noted in chronic pain patients[5] and cancer cases.[45] The types of tertiary gains described in the literature are as follows:

1. Collusion on the part of the significant other, to maintain focus on partner's somatic complaints, in order to divert attention from existential issues (cancer/death), thus providing attainable medical goals[46]
2. Significant other may enjoy changes in roles that result from the illness or chronic pain, i.e., family role conflicts are solved[5,30,33,38]
3. Financial gain[5,11,30,38]
4. Sympathy from social network over the family member with pain[5]
5. Decrease family tension and keep family together[20,30,38]
6. Resolve marital difficulties[20]

Authors have not commented on whether the wish for these gains by the family members occurs at a conscious or unconscious level. However, there is no reason to believe that this psychic operation should be different than for secondary gain.

RELATIONSHIP BETWEEN REINFORCERS AND SECONDARY GAIN

An operant is a response that operates on the environment. For pain, operants are the observable phenomena of pain: changing posture, pain expressions, requesting pain medications, decreasing activity, lying down, requesting attention, etc.[15,16,28] The operant conditioning model states that these responses or operants are influenced by their consequences that can reinforce the operant or response.[15,16,28] Thus, reinforcers can then be thought

of as rewards for operant behaviors. Reinforcers have been utilized by behavior theorists such as Fordyce[16] to explain the maintenance of pain behavior. Some alleged reinforcers for pain behavior are listed as follows:

1. Rest
2. Relief from pain
3. Change in mood after medication
4. Avoiding responsibility
5. Money (compensation)
6. Avoiding sexual demands
7. Attention and concern of others, e.g., spouse
8. Avoiding situations that expose inadequacies
9. PRN pain medication schedules
10. Exercise to tolerance levels
11. Approval from doctor
12. Pending litigation
13. Hostility toward or dependency on other family members
14. Prestige at being the sick family member
15. Little job satisfaction before injury
16. Stressful job before injury
17. Poor relationship with employer before injury

These alleged reinforcers are derived from the reinforcement literature.[15,25,28] However, it is arguable whether avoiding situations that expose inadequacies or little job satisfaction before injury, or both, are reinforcers.

The relationship between the secondary gain concept and reinforcers has never been clearly spelled out in the literature. When comparing the types of reinforcers (above) to the secondary gains (above) and tertiary gains (above), it appears that operationally some gains could be akin to reinforcers. However, Fordyce has made it clear that he believes that although reinforcers can maintain pain behavior, they have not necessarily produced that behavior.[16] Fordyce further states that reinforcers have nothing to do with whether pain is real or not real and believes that labels such as secondary gain reflect the application of the medical and disease model and refer to presumed underlying psychic processes for the generation of pain.[16] In this belief, Fordyce has stressed the fundamental difference between operant behavior theory and psychodynamic formulations. For operant theory, the observed behavior of the organism is simply a response to reinforcers. By contrast, in psychodynamic theory, the observed behavior has unconscious meaning and is the result of unconscious motivation. However, Cameron,[6] a psychoanalytic writer, has claimed that secondary gain is the result of a neurotic process and not its cause. Such a conceptualization of secondary gain would then again blur the distinction between it and reinforcers. Presently, there is some confusion about the exact relationship of secondary gain to reinforcers.

ABNORMAL ILLNESS-AFFIRMING STATES

The conscious-unconscious dichotomy has to some extent been utilized in the psychiatric nomenclature of the abnormal illness-affirming states. These states are presented in Table 1, which is compiled from a number of authors.[12,21,34,35] The abnormal illness-affirming states are presented in three major categories: somatoform disorders, factitious disorders, and malingering. As noted in Table 1, only within the somatoform disorders can the symptomatology be thought of as truly unconscious. The factitious disorders are partially conscious, while all aspects of malingering are within the conscious sphere. Only the

Table 1. Abnormal illness-affirming states[12,21,34,35]

States	*Illness Production (Signs and Symptoms)*	*Motivation for Production*	*Aware of Motivation*	*Aware of Intentional Faking*	*Control Over Symptoms*	*Primary Source Motivation*	*External Motivation*	*Presumed Personality*
Somatoform disorders (conversion disorder, hypochondriasis somatization disorder, somatoform pain disorder)	Unconscious	Unconscious	No	No	Involuntary	Internal	Absent	Varied
Factitious disorders, including Münchausen's syndrome	Conscious	Unconscious	No	Yes	Involuntary	Internal	NA	Borderline
Malingering	Conscious	Conscious	Yes	Yes	Voluntary	External	Present	Antisocial

somatoform disorders would then be concordant with the central concept of secondary gain, i.e., secondary gain mechanisms operate at an unconscious level. However, some psychodynamic theorists (and clinicians) do not believe the DSM-III-R position that categories of volitional behavior and thinking, such as that found in malingering or factitious disorders, or both, are not associated with unconscious processes. These theorists believe that these categories of behavior are also amenable to defensive operations as any other behavior.

The author believes that these differences of opinion between the psychodynamic theorists and the nomenclaturists can and have led to difficulties in the litigation process. The litigation process is often oriented toward the assignment of responsibility. As such, because the nomenclaturist have thought of malingering behavior as purely consciously motivated, the patients demonstrating these behaviors have historically been assigned greater responsibility for that behavior than the other abnormal illness-affirming states. Consequently, the difference in opinion between the psychodynamic theorists and the nomenclaturists needs to be resolved if the secondary gain concept is to be effectively utilized within current psychiatric nomenclature.

SECONDARY LOSSES

Biernoff[4] was the first to point out that if a patient allegedly responds to secondary gains, the consequences of this behavior generally result in secondary losses. These are losses occurring from disabilities related to secondary gain.[27] The secondary losses previously described in the literature are as follows:

1. Economic loss[3,24,44]
2. Loss of meaningfully relating to society through work,[24] i.e. loss of those social relationships
3. Family life[3,44]
4. Recreational activities[44]
5. New role not comfortable and not well defined[3,24]
6. Loss of respect and attention from those in the helping roles e.g. physicians[3,27]
7. Loss of community approval[27]
8. Social Stigma of being chronically disabled[27]
9. Guilt over disability[22,27]
10. Communications of distress are now unclear[3]
11. Negative sanctions from family[3]
12. Loss of support social network[17]

There has been one study specific to the concept of secondary losses.[17] In this study, Freeman demonstrated that chronic pain patients were consciously aware of the loss of support from different segments of their social network. The loss of support occurred at different times for each segment of the social network (earliest from employer) as the illness continued.[17]

This author has also clinically noted that generally, the chronic pain patient incurs a large number of secondary losses as a result of allegedly seeking secondary gain and that the patient appears to act in spite of these potential secondary losses.

Case Report 1

Mrs. Y, a 57½-year-old woman, was admitted to our pain center for the treatment of low back pain and neck pain. Her back pain began at 37 and was made worse by a fall at 44. She then developed neck pain at 51. At 54, both the neck pain and back pain increased in severity. She did not have surgery for her pain and had been given a diagnosis of fibromyalgia. Psychiatric history included a serious depression at 46 as a consequence to her pain, which was treated by counseling, and a nervous breakdown at 51, which required psychiatric hospitalization. The nervous breakdown was precipitated by the stress of trying to function at work with pain and problems with changes in job functions. She claimed that she could not tolerate the stress of her job any longer, and at 57 went on a leave of absence. At 57½, she received her Social Security Disability, and on entering our pain center was receiving $650.00 in monthly benefits. She claimed that she had no other sources of income. She was very anxious about her financial status because she believed that she could not live on the Social Security Disability income. During the psychiatric interview it was determined that if she worked for 2 more years she would become vested in her retirement fund. This potential financial incentive for maintaining her job function was suggested to the patient. The patient responded by saying that under no circumstances could she go back to her job because too much stress was associated with it.

The above case clearly demonstrates the secondary gain, i.e., elimination of job stress and a curious problem that Bayer[3] terms the *economy of gains and losses*. In Mrs. Y's case there is a financial incentive to maintain function for a short period, but the patient makes a conscious decision to incur a secondary loss and to pursue disability. It appears that the secondary gain of no job stress in the patient's mind far outweighs the potential secondary gain of increased disability income. Consequently, the patient is willing to incur a secondary loss. Bayer[3] has pointed out that this economy of gains and losses is difficult to understand and has been oversimplified

in the past. In addition, Bayer[3] has claimed that the economy problem makes it difficult to discern how, when balanced against secondary losses, secondary gains can reinforce the continuation of complaints. This issue presents a theoretic problem for understanding the role of reinforcement in the etiology of chronic pain. The fact that in a simplistic sense we do not understand the curious economy of gains and losses would argue toward the existence of some unconscious motivation for the resultant behavior. However, the author has not been able to find any psychoanalytic writings that have addressed or expanded on the interrelationship of secondary losses to secondary gains. Consequently, this area requires further exploration.

DIFFICULTIES WITH, AND ABUSE OF, THE SECONDARY GAIN CONCEPT IN CHRONIC PAIN TREATMENT

A number of authors have noted difficulties with, and abuse of, the secondary gain concept. These difficulties and abuses occur in all areas of medicine, including pain treatment, and often relate to the treating and legal professional. I concur with most of the following observations. First, the presence of secondary gain factors is usually equated with malingering.[14,27,36,44] This is incorrect and a basic misunderstanding of the secondary gain concept. As outlined in Table 1, only within the somatoform disorders are the symptoms entirely unconsciously produced and maintained. Consequently, according to the current secondary gain definition, the presence of unconscious secondary gain should lead one to suspect somatoform disorder and not malingering, although as pointed out earlier some psychiatrists believe that there may even be some unconscious motivation within malingering. Second, in the chronic pain and rehabilitation literature, secondary gain, as a term, "has developed increasing use and has generally referred to the financial rewards associated with disability".[14] The presence of potential financial rewards is then usually equated with malingering.[14] Consequently, the mere presence of litigation or disability benefits, or both, is recognized as a secondary gain issue[41] that in turn is translated into the malingering paradigm. Third, because the presence of secondary gain is usually equated with malingering, the resultant suspicion of the chronic pain patient interferes with treatment and development of empathy.[32,44] The secondary gain issues are then often used as an excuse for treatment failure.[27,31,44] This mechanism can be thought of as a secondary gain belief acting for the treating professional. The treating professional has a contractual and financial wish to heal the patient. Failure of treatment may lead to self-esteem difficulties or financial consequences, or both. As a result the secondary gain malingering paradigm is utilized in order to explain lack of treatment success, i.e., professional secondary gain. Professional and institutional secondary gain has been investigated and there appears to be some evidence for this concept (Fishbain et al., unpublished paper, August 1994). Fourth, little has been written about secondary losses and treating professionals appear to ignore the concept of secondary loss and only focus on secondary gain. These observations lend further support for the potential utility of the secondary gain belief to the treating professional. If one admits that secondary losses far outweigh the observed secondary gains,[44] then such an admission puts into question a framework that has utility in explaining treatment failure. Fifth, some authors[6] have defined secondary gain differently than originally described. Cameron defined secondary gain as "whatever advantages the patient gets out of being neurotic, once his neurosis has been established."[6] This definition has the implication that the secondary gain is the result of a neurosis and not, as many people suppose, its source.[6] This conceptualization of secondary gain appears to agree with the apparent discrepancy in the economy of gains and losses. If this last conceptualization is correct, then etiologically, clinicians, including those working in the chronic pain area, routinely make an error in attributing etiologic significance to secondary gain factors for the genesis of disease. Sixth, secondary gain is a sick role concept. The chronic pain patient is only sick for a short period of time after which the patient develops an impairment and a disability, i.e., attains a disability role. Some authors[24] believe that the sick role differs from the disability role and that it may be inappropriate to apply sick role concepts (i.e., secondary gain) to the disability role. In addition, it should be pointed out that the retreat into the disability role may be much more adaptive than being overwhelmed by the illness and loosing total loss of meaning in any aspect of life.[44] Therefore, the disability role may be the best option for the chronic pain patient's situation rather than a maladaptive response. Seventh, Bayer[3] has correctly pointed out that if all patients in a medical facility or all chronic pain patients, or both, were examined for alleged secondary gains, most would be noted to have one or more secondary gains. I am not aware of any studies that have been performed to support this statement (Fishbain et al., unpublished paper, August 1994) but, the numbers of alleged secondary

gains (above) make it likely that few patients would escape such a label in an unbiased study. Bayer[3] believes that secondary gain presents a diagnostic problem. In support of this statement secondary gain has recently been shown not to have any validity as a sign for the diagnosis of conversion disorder.[19] Finally, the identification of an alleged secondary gain does not necessarily mean that secondary gain has had an etiological or reinforcing affect on the chronic pain. The solicitousness of the spouse to the apparent pain of his or her mate may be a natural reaction of a caring partner. The solicitousness may or may not be enjoyed by the chronic pain patient and even if enjoyed by the chronic pain patient, it may or may not reinforce the pain behavior. Overinference is the process by which a conclusion is reached that a secondary gain factor merely by its presence, is reinforcing behavior or has had an etiological affect. Overinference is often present in case reports.[8] The following case is reproduced exactly from a series of pain case reports and will be used to demonstrate this concept.

Case Report 2

A middle-aged woman was referred for evaluation and treatment of headaches and medication detoxification. No organic etiology was uncovered for her headaches, and detoxification proceeded uneventfully until the patient became suicidal after a few weeks. The patient's husband had confessed to having an extramarital affair. Once the affair was revealed in couples' counseling pieces of the puzzle began fitting together for the patient: how her husband's seemingly solicitous attitude and encouragement to seek medical help and take medications had led her to be either asleep most of the time or toxic enough to be socially inappropriate. This allowed the husband the opportunity to pursue his affair, and obtain sympathy from the couple's social network, thus, tertiary gain. One could speculate that the original headache symptoms were an attempt to hold the husband in the marriage, i.e., attempts at secondary gain. With these factors identified and addressed in therapy, the headaches and suicidal features subsided and the patient and her husband were able to work on their marriage.

The authors do not present any evidence whatsoever of the husband's alleged tertiary gain or the patient's secondary gain, or both. It appears that all these mechanisms are inferred and probably overinferred. To prove that the husband was feeding the patient pills in order to have an affair, one would have to have the husband in long-term psychotherapy where this tertiary gain theory was explored. Trial interpretations would need to be made and evidence would need to be gathered in this fashion. In this case report, there is no indication that this was done. In general, if one closely examines the secondary and tertiary gain literature most of the case reports appear to overinfer the conclusions presented. This also is partially true of the reinforcement literature.

CONSCIOUS–UNCONSCIOUS PROBLEM

Perhaps the most significant problem with the concept of secondary gain is that of the conscious-unconscious dichotomy. This dichotomy is important because if it can be shown that secondary gain issues affect patients' behavior in a conscious fashion, then, according to the abnormal illness-affirming states (Table 1), these patients would no longer fit under the rubric of the somatoform diagnoses.

By definition, secondary gain cannot be a conscious mechanism. Yet, clinicians inherently link the presence of secondary gain with conscious mechanisms. For example, Weissman[45] claims that "protracted litigation creates conditions that promote mnemonic and attitudinal distortions, as well as conscious and unconscious motivation for secondary gain." Can it be that secondary gain mechanisms operate on both a conscious and unconscious level or, are clinicians confused about the definition of secondary gain? The real case report that follows demonstrates that secondary gain factors may affect the patients' conscious behavior.

Case Report 3

A 39-year-old heavy equipment field mechanic (Mr. X) was referred to our pain center for evaluation by his workers' compensation carrier. He had been injured in a motor vehicle accident 1 year earlier with resultant neck pain, right shoulder pain, headaches, low back pain, and temporal mandibular joint dysfunction. Psychiatric examination revealed the following information. Mr. X was very angry at being at the center and did not wish to be there, but could not refuse to comply with the wishes of his carrier for fear of losing his benefits. He was in the process of settlement with his carrier, but needed to be at Maximum Medical Improvement (MMI) to proceed with this settlement. As he was injured in a motor vehicle accident his plans were to proceed with a third party suit once settlement with the workers' compensation carrier had concluded. He believed that this was his last stop before settlement. He did

not plan to go back to work after his workers' compensation settlement. Mr. X had been psychiatrically hospitalized for 2 weeks and discharged 5 days before admission to our center. Reason for admission was severe depression with suicidal ideation secondary to uncontrollable pain and feeling hopeless. During that admission, Mr. X had required Demerol (Winthrop Pharmaceuticals, New York) intramuscularly, 100 mgs every 3 hours to control his pain. Mr. X had been told that he had reflex sympathetic dystrophy but believed he had a pinched nerve in his neck and required surgery. Two stellate blocks had only increased his pain. On the second day of his 3 day evaluation, Mr. X claimed that his pain had now miraculously disappeared. He attributed the disappearance of his pain to a shoulder injection that he received on the day he transferred to our center. At his case conference, Mr. X claimed that since his pain had disappeared and he was now cured, he did not require treatment at our center. The corollary to that was that Mr. X was now at MMI. The psychiatric consultant (DAF) was skeptical of the cure claim and believed that the patient was lying to avoid the center because he wanted to proceed with his settlement. Two years later the psychiatric consultant was called to a deposition in reference to Mr. X. At the deposition it was learned that Mr. X had settled with his workers' compensation carrier but was now litigating to have surgery for his pain. The carrier was denying surgery based on the documented pain cure claim at our center. Mr. X now claimed his pain had not entirely disappeared during his 3-day stay at our center.

Mr. X's case demonstrates a number of interesting problems in reference to secondary gain. Mr. X appears to have some secondary gain issues. He admits that he wants to proceed with settlement (workers' compensation benefits), but his real interest is the third-party suit. He wants to be at MMI to proceed with this suit and does not wish to be at our center, as that would potentially lower his impairment rating through our attempts at rehabilitation. These secondary gain issues appear to affect Mr. X's behavior. He appears to lie to be discharged from the pain center. Thus, Mr. X appears to act in a conscious fashion in response to these secondary gain issues. These actions made Mr. X look like a malingerer, and if he had little pathology such an impression would have been, or was, entertained. However, Mr. X was not cured by the settlement verdict[29] and continued to have pain and continued to seek surgery, even at the expense of appearing as if he had lied for secondary gain reasons. In Mr. X's case the secondary gain issue not only affected his behavior, he appeared to have conscious control of his response to this secondary gain issue. Although the evidence presented in this case appears to link secondary gain agendas with observed behavior, the interpretation of this case could still be subject to overinference.[8]

I believe that patient's behavior can be changed by the presence of secondary gain agendas. In addition, I believe that sometimes patients can and will act in a conscious manner in response to the secondary gain agenda. There are two studies that directly[37,43] and indirectly[7,42] support this viewpoint. The first two studies by Stout[43] and Radley[37] demonstrated that patients suffering from medical illness can consciously identify the secondary gains they receive from that illness[43] but that few patients actually admit to secondary gains.[37,43] The second two studies are by Chapman[7] and our group.[42] Chapman claimed that he had identified a group of chronic pain patients who had consciously failed to provide accurate self reports to the treatment staff. All these patients had a pending or current disability status and most were referred by the insurance carriers and, as hinted at by Chapman, did not wish to be at that treatment facility. They were much like Mr. X. Although there are methodological issues with this study specifically relating to how a decision was reached in reference to conscious intent, the data indicates that there are groups of chronic pain patients who may provide false reports in a conscious fashion. In our study[42] the author psychiatrically evaluated 218 consecutive chronic pain patients with emphasis on a past history and current history of illicit drug use. All patients submitted their urine for toxicology study. Nine chronic pain patients (4.1%) were found by urine toxicology to have lied about current drug use during their psychiatric examination. All nine patients were workers' compensation patients.[42] These studies do not prove that chronic pain patients act in a conscious manner to fake their symptoms but indicate that chronic pain patients do at times provide false information in a conscious fashion. It is unclear if such behavior would or would not be present if secondary gain or other agendas, or both were not operational.

The studies described are the reason why clinicians are confused about whether secondary gain issues are conscious or unconscious phenomena. Consequently, some clinicians view the presence of potential monetary secondary gain as an agenda influencing the patient's behavior in a conscious fashion. Others, who are aware of the definition of secondary gain, as an unconscious mechanism, are perplexed when patients' behavior appears as if it is consciously motivated by secondary gain.

This conscious-unconscious dichotomy dilemma is important to understanding the behavior of secondary gain and is also often important to the litigation arena. If patients respond to secondary gain issues in a conscious manner, then according to abnormal illness-affirming states this behavior approaches the behavior in Münchausens' syndrome or malingering, or both (Table 1). As we all know, the litigation arena is intensely sensitive to and interested in this issue. The decision, or diagnostic problem, about a behavior is consciously or unconsciously motivated is fraught with difficulty and is almost impossible to make with certainty.[3] Consequently, I believe that because secondary gain has been defined as an unconscious mechanism, the application of this concept to chronic pain and other medical conditions has created major conceptual difficulties and problems.

CONCLUSIONS AND RECOMMENDATIONS

This focus article has outlined some major problems with the concept of secondary gain. The problems are the following: definitional, the relationship between the defined secondary gain concept and reinforcers, the economy of secondary losses and the problem that this creates for psychoanalytic theory and operant theory, the unconscious-conscious dichotomy and its application to the secondary gain concept, and the relationship of these problems to the abuse of the secondary gain concept. These problems are not the opinion of the author but are obvious within the literature and have also been presented by other authors cited in the text. The author believes that these problems relate to the fact that the secondary gain concept was formulated when psychologic concepts were not held to the same scientific standards as were concepts in the natural sciences. As such, these concepts entered the literature and over time have undergone transformations from their original technical status to operational notions available to third-party carriers, nonpsychologically sophisticated clinicians, the legal system, etc.

At issue is whether the secondary gain concept should be entirely abandoned. Such a decision should relate to whether there is objective scientific study data that supports the importance of the secondary gain concept to behavior. I have concluded that secondary gain factors could be important to the maintenance of pain or disability status, or both, and in influencing behavior in general (Fishbain et al., unpublished paper, August 1994). The research supporting this conclusion is, however, spotty and weak. In spite of this I believe that there is enough evidence to conclude that the secondary gain concept should not be discarded, at least until it is adequately investigated in a scientific fashion.

In reference to the definition problems, because conscious and unconscious motivation can rarely be demonstrated with certainty,[3] I would recommend that this part of the concept be split from the definition. I offer the following definitions. The first definition would encompass the old concept of secondary gain and follows any behavior that results in acceptable or legitimate interpersonal advantage that can be shown to have an unconscious motivation. I believe that this type of definition can never be adequately investigated, a definition that is easily operationalized should be available. I would call this category secondary gain behaviors or perception and would define these as: patient and nonpatient behaviors or perceptions that appear as if the individual is seeking some form of gain. Operationally, numbers 2, 4, 6, 7, 8, 10, 11–14, and 16 from the list of secondary gains could be thought of as secondary gain behaviors or perceptions that would be obvious to the examiner. Some of these behaviors for example numbers 12–15 could be obvious secondary gain behaviors or perceptions but may, or may not, be the actual unconscious motivation or the secondary gain.

The development of the two previous definitions would also enable the researcher to make a clear distinction between secondary gain, secondary gain behaviors or perceptions, and reinforcers. Reinforcers would then be the rewards for secondary gain behaviors or perceptions. Examples of this would be the solicitousness of the spouse for the pain behavior of the chronic pain patient.

Finally, this author believes that if we are to escape the secondary gain quagmire, an operational diagnosis for secondary gain should be developed and tested. As such a diagnosis is not currently available in the DSM-III-R.[1] I do not believe that a secondary gain diagnosis is necessary, but unless such a diagnosis is developed, the secondary gain concept will never be operationally tested and the concept will remain clouded. If such a diagnosis is developed, it could contain the three definitions discussed previously: secondary gain (presence of unconscious motivation), secondary gain behaviors or perceptions, and reinforcers (rewards for secondary gain behaviors or perceptions). These definitions are utilized as diagnostic criteria for this diagnosis and are presented in Table 2. Within the diagnosis presented in Table 2, each of the diagnostic criteria A, B, and C could be investigated separately or in combination with each other (e.g., B and C together, etc.).

Table 2. Secondary gain diagnosis

A Unconscious Motivation Clear-cut evidence of unconscious motivation for the observed secondary gain behaviors or perceptions.
B Secondary Gain Behaviors or Perceptions Observed secondary gain behaviors or perceptions (e.g., wish to be out of an unpleasant job, etc.). List as many as apply.
C Reinforcers Observed reinforcers (rewards for secondary gain behaviors or perceptions). List as many as apply.

Diagnostic criteria A is problematic as the unconscious area is difficult if not impossible to investigate.[3] Typically psychoanalysis investigate this area through postulating a dynamic formulation that is then investigated through dream analysis and trial interpretations. Such a procedure is slow, time-consuming, and is also open to overinference. Therefore, it is the opinion of this author that because there is such great difficulty in deciding on the presence of criteria A, criteria A should not be included in the operational diagnosis and should be investigated separately from elements B and C. In support of this last recommendation the author was not able to find any research that addressed the unconscious motivation issue except case reports (Fishbain et al., unpublished paper, August 1994). Therefore, diagnostic criteria A requires immediate investigation or the unconscious motivation aspect of the secondary gain concept should be abandoned.

Developing and testing a secondary gain diagnosis does not help the general clinicians and pain specialists deal with the secondary gain problem now, especially when the clinician or pain specialist, or both, are asked to testify in court or in deposition about the secondary gain issues of his or her chronic pain patient. Thus, the author would recommend the following practical approaches to dealing with alleged secondary gains. First, the clinician must decide whether he or she wishes to use the secondary gain concept in his or her pain practice based on the information presented. Some clinicians may wish to avoid this controversial area in their clinical practices, while others may believe that addressing secondary gain agendas increases the efficacies of their programs. Second, if the clinician is currently utilizing this concept or wishes to utilize it, he or she must avoid the abuses associated with the utilization of this concept, especially equating the presence of secondary gains with malingering. Finally, the clinician should avoid treating the patient with alleged secondary gains differently unless he or she believes that these issues should be addressed to improve program efficacy. Failure of treatment with such a patient should not automatically be attributed to an alleged secondary gain agenda.

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References

1. American Psychiatric Association: Diagnostic and statistical manual of mental disorders. p. 257. 3rd ed. American Psychiatric Association, Washington, 1987
2. Barsky AJ, Klerman GL: Overview: hypochondriasis bodily complaints and somatic styles. Am J Psychiatry 140(3):273–282, 1983
3. Bayer TL: Weaving a tangled web: the psychology of deception and self-deception in psychogenic pain. Soc Sci Med 20(5):517–527, 1985
4. Bienoff J: Traumatic neurosis of industry. Industr Med Surg 15:109–112, 1946
5. Bokan JA, Ries RK, Katon WJ: Tertiary gain and chronic pain. Pain 10:331–335, 1981
6. Cameron N: Personality development and psychopathology. pp. 273–274. Houghton Miffin, Boston, 1963
7. Chapman SL, Brena SF: Patterns of conscious failure to provide accurate self-report data in low back pain. Clin J Pain 6:178–190, 1990
8. Coffman JA, Desaver SC, Smeltzer DJ, O'Donnell V, Olson SC: Sample bias and overinference: two sources of error in interpreting case report data. J Clin Psychiatry 50(3):105, 1989
9. Colbach EM: Hysteria again and again and again. Int J Offender Ther Comp Criminology 31(1):41–48, 1987
10. Connors DD: Women's "sickness": a case of secondary gains or primary losses. Adv Nurs Sci 7(3):1–17, 1985
11. Dansak D: On the tertiary gain of illness. Compr Psychiatry 14:523–534, 1973
12. Eisendrath SJ: Factitious illness: a clarification. Psychosomatics 25(2):110–117, 1984
13. Engel G: Conversion symptoms. p. 653. In MacBryde CM, Blacklow RS (eds): Signs and symptoms. J. B. Lippincott, Philadelphia, 1970
14. Finneson BE: Modulating effect of secondary gain on the low back pain syndrome. Adv Pain Res Ther 1: 949–952, 1976
15. Fordyce WE: Behavioral methods for chronic pain and illness. CV Mosby, St. Louis, 1976
16. Fordyce WE, Fowler RS, Lehmann JF, DeLateur BJ: Some implications of learning in problems of chronic pain. J Chron Dis 21:179–190, 1968
17. Freeman DW: Sick rule dynamics and chronic back pain in the injured worker. Seventh World Congress on Pain, Paris, France. Abstract 315:109, 1993
18. Freud S: Introductory lectures on psychoanalysis (1917). pp. 378–391. Vol. 16. Hogarth Press, London, 1959
19. Gould R, Miller BL, Goldberg MA, Benson DF: The validity of hysterical signs and symptoms. J Nerv Ment Dis 174(10):593–597, 1986

20. Hughes AM, Medley I, Turner GN, Bond MR: Psychogenic pain: a study of marital adjustment. Acta Psychiatr Scand 7(2):166–170, 1987
21. Hurwitz TA: Ideogenic neurological deficits: conscious mechanisms in conversion symptoms. Neuropsych Neuropsychol Behav Neurol 1(4):301–308, 1989
22. Katz S, Shurka E, Florian V: The relationship between physical disability, social perception and psychological stress. Sci J Rehab Med 10(3):109–113, 1978
23. Kolb LC: Attachment behavior and pain complaints. Psychosomatics 23(4):413–425, 1982
24. Larson DL, Spreitzer EA: The disabled role, affluence, and the meaning of work. J. Rehab 36:29–32, 1970
25. Lawlis GF, McCoy CE: Psychological evaluation: patients with chronic pain. Orthop Clin North Am 14(3): 527–538, 1983
26. Long CJ, Webb WL: Improving diagnostic strategies for pain patients. Neurosurgery 7(3):225–229, 1980
27. Martin RD: Secondary gain: everybody's rationalization. J Occup Med 16(12):800–801, 1974
28. McKee M: Behavioral techniques in pain modification. Clev Clin J Med 56(3):502–508, 1989
29. Mendelson G: Chronic pain and compensation: a review. J Pain Sympt Manag 1(3):135–144, 1986
30. Modlin HC: Compensation neurosis. Bull Am Acad Psychiatry Law 14(3):263–271, 1986
31. Munn JS, Baker WH: Recurrent sympathetic dystrophy: successful treatment by contralateral sympathectomy. Surgery 102(1):102–105, 1987
32. Naftulin DH: The psychological effects of litigation on the industrially injured patient: a research plea. Industrial Medicine 39(4):167–170, 1970
33. Nemiah JC: Psyhological complications in industrial injuries. Archives Environ Health 7:482–486, 1963
34. Overholser JC: Differential diagnosis of malingering and factitious disorder with physical symptoms. Behav Sci Law 8:55–65, 1990
35. Pilowsky I: The concept of abnormal illness behavior. Psychosomatics 31(2):207–213, 1990
36. Purcell TB: The somatic patient. Emerg Clin North Am 9(1):137–159, 1991
37. Radley A, Green R: Styles of adjustment to coronary graft surgery. Soc Sci Med 20(5):461–472, 1985
38. Rickarby GA: Compensation: neurosis and the psychosocial requirements of the family. Br J Med Psychol 52:333–338, 1979
39. Ross DW: Differentiating compensation factors from traumatic factors. p. 31. In Leedy JJ (ed): Compensation in psychiatric disability and rehabilitation. Charles C. Thomas, Springfield, 1982
40. Sarwer-Fonger GJ, Dancy TE: The psychodynamic basis of compensation: a contribution to the study of ego defenses. Can J Psychiatry 4(2):125–132, 1959
41. Sievers HR: Microsurgical versus standard lumbar discectomy. Neurosurgery 22(5):837–841, 1988
42. Steele-Rosomoff R, Fishbain DA, Goldberg M, Rosomoff H: Chronic pain patients who lie in their psychiatric examination about current drug/alcohol use. Pain 5S:299, 1990
43. Stout MA: A cognitive-behavioral study of self-reported factors in migraine. Psychopathology 17(5–6): 290–296, 1984
44. Thompson DL: Secondary gain, a second look: issues in counseling the industrially injured worker. NARPPS J News 6(2):59–63, 1991
45. Weissman HN: Distortions and deceptions in self-presentation: effects of protracted litigation in personal injury cases. Behav Sci Law 8:67–74, 1990
46. Wright MH, Nekemkis AM; Functional use of secondary cancer symptomatology. Int J Psychiatry Med 13(4):267–275, 1984