Chronic failure in the treatment of chronic pain? The silent influence of the personality and its disorders

João Paulo Consentino Solano[1]

ABSTRACT

Patients with non-oncologic chronic pain conditions commonly present with psychiatric symptoms and disorders. In a sample of non-oncologic chronic pain patients referred for psychiatric consultation, personality disorders were found more frequently than any other diagnosis, including major depression. Borderline and narcissistic personality disorders were the most common psychiatric diagnoses in the group. This paper debates such findings along with a literature review carried out using the keywords chronic pain, borderline personality disorder, and narcissistic personality disorder. Diagnostic criteria for the personality disorders are shown, as well as some "soft signs" that may indicate the disorder. Two vignettes exemplify each of the personality disorders; finally, some recommendations are offered to ease the clinical management of such patients by multi-professional teams for chronic pain patients.

Keywords: Chronic Pain, Personality Disorders, Borderline Personality Disorder, Narcissism

[1] Psychiatrist, Preventive Medicine Department - FMUSP.

Mailing address:
Divisão de Anestesia do Instituto Central do Hospital das Clínicas FMUSP/Equipe de Controle de Dor
João Paulo Consentino Solano
Av. Dr. Enéas de Carvalho Aguiar, 155 - 8º andar - Bloco C
São Paulo - SP
CEP 01246-903
E-mail: joaopaulocsolano@uol.com.br

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INTRODUCTION

For a long time now the medical literature has reported that the treatment of chronic pain patients is difficult due to the presence of psychiatric comorbidities.[1-3] Reports from a variety of professionals indicate that, while dealing with chronic pain patients, especially chronic non-oncologic pain (CNOP), the occurrence of patients with depression, anxiety, substance abuse, hypochondria, and personality disorders is very frequent.[4,5]

When the older medical literature is compared with the most recent, one can see the rise in diagnosed depression. Most studies investigating psychiatric comorbidities among patients with CNOP indicate that depression is the most frequent affliction among these patients.[6,7] It is very common that patients with CNOP be referred to a psychiatrist with the diagnosis for which they receive treatment by pain management teams (fibromyalgia, for example) already labeled by the word "depression" with a question mark.

This article shows the experience of a psychiatrist working on a team that monitors patients with chronic pain, in whom personality disorders were present as the most prevalent psychiatric diagnosis. In addition, many patients had been wrongly diagnosed as having depression. Fictitious clinical vignettes exemplifying the most frequent personality disorders in the group and the criteria used to reach the diagnosis will be shown. The text is interwoven by the results of a literature review on the subject. At the end, a few recommendations are suggested to the health professionals who deal with CNOP in order to improve their clinical diagnosis and handling.

METHOD

A literature review of the last ten years in the LILACS, MedLine, and Cochrane Library databases was made. The borderline personality disorder and narcissistic personality disorder descriptors were combined individually with the term chronic pain. Articles in English, Spanish, and Portuguese were included. The reference lists of the articles were verified, as well as the books and book chapters pertinent to the subject.

Chronic pain and borderline personality disorder

While monitoring patients referred for psychiatric evaluation, the borderline personality disorder was the most frequent clinical-psychiatric diagnosis. The clinical-psychiatric diagnosis referred to here is what resulted from the classic anamnesis procedure, supported by the fourth edition criteria of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV).[8] Chart 1 shows the diagnosis criteria of the DSM-IV for the borderline personality disorder and shows a clinical vignette of a patient with CNOP to whom such diagnosis would be given.

The prevalence of borderline personality disorders in population studies varies from 1.6 to 5.9%.[9] Among psychiatric outpatients, its prevalence is estimated at around 10% and, in samples of chronic pain patients, it reaches 30%.[10] McWilliams & Higgins[11] identified borderline traces in four samples of patients with CNOP, including osteoarthritis, frequent cephalea, and chronic low back pain. Keuroghlian et al.[12] observed that the most serious borderline patients coincided with those individuals in the primary network who had less chance of recovering from more complex medical conditions (such as osteoarthritis and obesity), had the worst life habits, and overused health services. Frankenburg & Zanarini[13] pointed to the borderline cases as being patients capable of presenting "any syndrome" (including chronic fatigue, fibromyalgia, and painful temporomandibular joint syndromes), in addition to obesity, osteoarthritis, low back pain, and the excessive use of analgesics. For Sansone et al.[14] chronic pain must be considered as a symptom that is part of the borderline personality. In our CNOP group under psychiatric care, 40% of the patients were diagnosed as having a borderline personality disorder (12 in 30 patients).

According to the introductory paragraph of the DSM-IV for the diagnosis criteria of borderline personality disorder, the main symptom core of these patients is made up of instability in relationships, in affectivity, in self-image, and in impulsiveness (Chart 1). It is understood that it is much more difficult to reach a diagnosis in the first anamnesis with the patient, since the interpersonal and

Chart 1. DSM-IV criteria for diagnosis of Borderline Personality Disorder and clinical vignette

A pattern of instability in interpersonal relationships, self-image, and affections, and increased impulsiveness are indicated by having at least five of the following criteria:

a) frantic efforts to prevent a real or imagined abandonment;

b) unstable and intense interpersonal relationships, characterized by the alternation between extremes of idealization and devaluation;

c) identity disturbance: accentuated instability of self-image or of the feeling of self;

d) impulsiveness in at least two areas potentially harmful to the person (for example, impulse buying, sexual practices, substance abuse, imprudent/reckless driving, compulsive eating;

e) recurrence of suicidal behavior, gestures, or threats, or of self-mutilating behavior;

f) emotional instability due to heightened reactivity of moods (for example, intense irritability or anxiety episodes lasting from a few hours to a few days;

g) chronic feelings of emptiness;

h) inappropriate and intense anger or difficulty in controlling anger;

i) transitory and stress-related paranoid ideation or severe dissociative symptoms.

Clinical vignette

Miss A, 33 years old, single, monitored by the pain management team for fibromyalgia, chronic low back pain, carpal tunnel syndrome, and bursitis. She was also being monitored by a neurologist (cephalea), a gynecologist (endometriosis), a gastroenterologist (irritable bowel syndrome), a nutritionist (obesity), and a cardiologist (hypertension). She claimed to have also a confirmed diagnosis of obstructive sleep apnea. Recently, she had had a disagreement with the physician who monitored her and had changed doctors in the pain management team. A psychiatric evaluation was requested for the possibility of depression. In the psychiatric consultation, she reported feeling pain in "her whole body, for as long as she could remember". Since adolescence, she had been to emergency care many times due to fainting, without epileptic characteristics, always after some argument, either with her parents, neighbors, or boyfriends. She reported that, in some of those crises, before fainting, she would be beside herself, "not recognizing herself", and would attack the people who were around her (not only the one she was arguing with). She said she had been "dismissed" in a triage in a psychiatric outpatient clinic because she had not tried to commit suicide and did not have signs of self-mutilation. In her second psychiatric consultation, however, she said she always had wished to die, since childhood, because of an "empty abyss inside", and that, in her adolescence, she had had many boyfriends and abused some drugs to try to forget the "emptiness". Also in her second consultation she told the psychiatrist: "I love you, Dr. ...! as well as all the other gorgeous doctors in this hospital". In the objective anamnesis, her father denied previous circumscribed crises of depression or mood exaltation. He said that the patient had forced him to retire earlier, so he could help take her to many doctors. He also said the family felt exhausted because the patient had "something new every single day", which was generally a new health problem. And that the patient, since adolescence, had shown a whirlwind of contradictory emotions every day and nothing could satisfy her.

affective instability and impulsiveness may be only revealed by an objective anamnesis (with the patient's family members) or as the relationship with the physician is established. During an initial subjective anamnesis, the patient may present a depressive pathoplasty (a facade), which favors diagnostic error. This appears to be the rule and not the exception.

Further difficulty in the identification of the pathology is given by the fact that there are borderline personalities of "low performance" and of "high performance".[15-17] Unfortunately, this variation is not described by the DSM-IV. In the low performance borderline personality, the patient's social functioning is so compromised that the patient ends up being included in a mental health treatment program. In this group, the noisy signs of disease are frequent, such as suicide attempts and parasuicidal impulsiveness (self-mutilation). Many of these patients have an unproductive work history and serious difficulties in socializing that may have led them to superficial, ambivalent, or frankly aggressive relationships. Many of these patients actively seek treatment, either for their chronic psychological suffering or for depression, eating disorders, or problems with substance abuse. High performance borderline personalities are usually not noticed socially. They rarely recognize their psychological problems. They may not have made any suicide or parasuicide attempts nor received any mental health treatment in their lives. Many of these patients are only recognized by emotional instability crises and/or impulsiveness that are restricted to their most intimate relationships (generally directed toward family members in frequent scenes of verbal, physical, or sexual abuse). Generally, these individuals are productive at work and form apparently functional families. To diagnose a patient with chronic pain and a subjacent high performance borderline personality disorder is one of the most difficult clinical challenges, for it requires attentive listening not only for the DSM-IV criteria, but also for the subtle signs of the disease.

For Sansone & Sansone[18] the borderline patient with chronic pain is paradoxically less and more sensitive to pain. Less sensitive in times of self-mutilation (for those who fulfill this criterion, see item e, in Chart 1), but more sensitive during the treatment, in which the pain complaints (and other complaints) seem to be hyperbolized. For those authors, and also for Mason & Kreger,[15] Kreger,[16] and Kreisman & Straus,[17] such a paradox may be explained by the fact that, in the act of self-mutilation, the patient can exercise control over the misfortunes he or she experiences. Such exercise of control, however, cannot always be achieved along the entire life of the patient. Actually, this is the case for everybody. The borderline personality does not accept that his experiences of pleasure or discomfort are outside of his anticipatory control. Therefore, the possibility of feeling pain (discomfort, indisposition, suffering) makes the borderline personality react with exaggeration, habitually with catastrophic thinking, in an attempt to retake control or elicit care (or protection) from somebody else.[11,19] This somebody else is interchangeable: a family member, a physician, a physiotherapist etc. For Sansone & Sansone,[18] the borderline personality is consolidated in a family scenario that "reinforces interpersonal communications in which the expression of symptoms invokes care that comes from outside". There has been an increase in recent years in the number of articles about the importance of hyperbolization phenomena in the borderline patient[20,21] and about catastrophic thinking in patients with chronic pain.[22-25] Their reading shows that the authors could not always detect a borderline condition in their samples - either by not looking for them with the appropriate instruments or by not having access to the interviews with psychiatrists There may be a lack of translational reading of the findings that would make it clearer that the emotional hyperbolization of borderline patients and the catastrophic thinking of patients with chronic pain may be two very close constructs, subject to overlapping. The compulsive need for control against possible discomforts, hyperbolic reactivity, and catastrophic thinking are subtle signs that can guide the clinician to the diagnosis of borderline personality disorders.

In order to obtain perennial care and protection, the borderline personality learns early on to present himself or herself as a victim. The role of aggressor is initially given to a family member, and, after a few years, to a physician or to other health professionals, to the hospital, to the health system, to the social security system (and to all "unfair" society). For a long time medicine has known the turbulence of patients who seem to be adhered to the role of victim. The victim-aggressor dual model was, however, refined to a triangular model by authors who noticed that the borderline personality is addicted, since childhood, to a dramatic script performed to exhaustion with three characters: a victim, an aggressor, and a savior.[15,16] The patient alternately occupies the roles either of victim (depressive facade, with weakness, pain, physical debilitation, self-commiseration, remorse, regret) or of aggressor (aggressive facade, in moments of incoercible complaints, litigious intransigence or explosions of rage, where the other is blamed for the misfortunes of the borderline personality). The role of savior, also since childhood, is usually occupied either by another family member (who takes position against the aggressor and comes to help the patient), or by a neighbor or acquaintance. This triangular dynamic became known as the "Karpman triangle", as a homage to the physician who identified it.[26] Although it is also found in functional families, it is observed that, in families with one or more members with borderline personality disorder, the exaggerated acting of the three roles of the triangle has the power to perpetuate a derailed environment, frankly chaotic. The doctors who deal with these patients are easily given the role of saviors (generally in the first consultations), only to being banned later to the role of persecutor (with the evolution of a treatment that generally fails). This dynamic is included in the DSM-IV criteria (item b, alternating between excessive idealizations and devaluations of the other). The continuous - many times lifelong - adhesion of the patient to the role of victim is also in the DSM-IV (criterion a), for being sick all the time guarantees one will not be abandoned (to be left behind). The viscous adhesion to the role of sick/victim and the speed with which the patient feels offended, either in the dual or triangular model, also function as subtle signs of a borderline pathology, by which the clinician may be guided. The problem is that, many times, the less experienced professional or one who works under time pressure may not notice the correspondence between the DSM-IV criteria and the subtleties of communication with his patient.

In addition to guilt, the borderline patient also usually causes feelings of obligation and fear in the partner.[15,16] It could be proposed, also among the subtle signs, that the physician raise the possibility of borderline pathology when he notices a chronic tendency to feeling guilty for the therapeutic failures, or "obliged" to make his patient improve quickly, or persistently afraid of the patient's demands.

It is common to consider the borderline patient as someone who manipulates the other to satisfy his or her demands, either silently or rudely. These demands seem insatiable - that is, the borderline personality appears to have an insatiable voracity. If a physician or therapist allows the patient to speak freely (which is recommended in the first consultation and periodically), there may be a robust

discharge of a torrent of intense emotions and new physical complaints. This vociferous flow of emotions and complaints corresponds to the criteria (f) and (h) of the Chart 1. Kreisman & Straus[17] call this posture of the borderline personality towards life and towards others an emotional hemophilia, for the sick person seems unable to contain the pulsating effervescence of his or her emotional life. The need of the sick person to ostensibly communicate the extremes of colors and pains of his emotional life to the other person leaves the physician mesmerized for a few minutes, not knowing what to do with the patient. In our meetings to discuss cases, we have called this a "the physician's overload sign". Unfortunately, we see that many professionals in these moments of paralysis choose the easiest and quickest way out - they look at the paper and ask for new exams or consultations with specialists from other departments. In fact, many physicians and therapists who examine many of these patients in one day, feel emotionally massacred and drained of their energy. Kreger & Mason[15] point out that the hyper demanding and manipulating profile of these patients is not intentional, but secondary to the chronic experiences of psychological pain, despair, and loneliness - putting into evidence the criteria (c) and (g) of the DSM-IV.

It is good to remember that these patients, in order to feel less hurt by life, need to find frustration in the other (outside, in the outside world). Therefore, frustrating the other (a caregiver or a physician, for example) fulfills an economic function for these patients: "if the frustration is there (in the other), there is less chance that it is inside me" - this would be the perpetual and unconscious drive of the borderline personality. While monitoring such patients in the CNOP team, we are used to being periodically frustrated with therapeutic strategies that seem perfect, even heroic, but that ultimately fail. We consider this tendency to systematically produce frustration in the other (generally by non-verbal communication) as another subtle sign of borderline pathology.

Many borderline personalities do not make evident suicide or self-mutilation attempts along their lives. They perform them silently. Sabotaging their own treatment or having an eternally ineffective treatment may be silent symptoms that are equivalent to the self-aggressions that the borderline personalities inflict on themselves throughout their lives. Many times, we have the impression that these patients fail to take their medication as prescribed, fail to come to the consultations, fail to prepare themselves for scheduled procedures - as if their healing was not in their own interest, or as if they could be exempt from the responsibility for their own treatment (since outside there is the other who cares for them). With that behavior, it is seen that the question of control over what happens to oneself remains in the hands of the patient: he can dose how much pain he will allow himself to feel in advance. In this perverse dynamic, the result is that the patient is able to put his caregiver, the physician, in a "no-win situation".[15,16] Nobody wins. The physician needs to be aware not to act on a vindictive counter-transference and also not to feel disillusioned with the medical profession or have professional burnout. Placing your caregiver in a no-win situation is also a subtle sign of a borderline personality disorder as well as of a narcissistic disorder, with the latter more prevalent in our sample of CNOP.

Chronic pain and narcissistic personality disorder

The prevalence of narcissistic personality disorder in the population is quite variable, possibly reaching 6%.[9] In clinical samples, the prevalence is between 1.5 and 17%.[27] In samples of chronic pain patients, it varies from 2 to 23%.[4] Among the patients with CNOP who receive psychiatric care in our outpatient clinic, 30% show criteria for the narcissistic personality disorder. Chart 2 shows the criteria for the diagnosis of the disorder and a clinical vignette to illustrate.

If the borderline personality presents nuclear symptoms of instability and impulsiveness, the narcissistic personality presenting the superlative experience of one's own grandiosity is also nuclear.[28] This is about the patient who systematically lets his doctor know that he or she does not feel treated yet to the level of his merits (or sufferings), or has an expectation of special treatment, our feels too important (self-entitlement), or has arrogant or haughty behavior, either in his relating with acquaintances or with the professionals who care for him.[27]

Obviously, the patient does not tell the physician that he feels grandiose, worthy, better than his peers, nor is it likely that he would show himself in this way in self-applicable diagnostic scales. Many times, to present oneself as very humble, actually, is part of a special, grandiose character that, silently, the patient attributes to himself. The diagnosis will be made, then, by the observation of the patient's behavior either in his relationship with the health professionals or through the reports obtained with his family members. Sometimes, however, listening carefully will allow the patient's report (even if in a humble tone) to betray itself and the physician to see the grandiosity, the self-entitlement, or arrogance in the non-verbal implications of his discourse.

The DSM-IV concentrates all of its criteria for narcissistic personality disorder around the inadequate sense of the patient's own grandiosity (criteria a-i in Chart 2). However, as a patient who seeks medical help (with chronic pain, for example) he must present himself as someone who needs another's help, it is many times with the subtle signs that the physician will be able to raise the possibility of narcissistic personality disorder. Generally, such signs are not present in the first appointment, which makes it difficult to diagnose.

Among the subtle signs, Westen & Shedler[29] suggested that, besides what is listed in the DSM-IV, narcissistic patients are typically controllers and competitive, and they tend to get involved in power disputes. In our midst, we have seen many narcissists who simply cannot allow their pains to improve because they are already in legal disputes with their former employers (and do not want to lose the case).

The DSM-IV criteria do not clarify the existence of two "subtypes" of narcissists, as recognized by most authors: the grandiose-exhibitionistic narcissist and the reserved-sensitive narcissist.[27,30,31] The former, also called "overt" narcissists, easily meet the DSM-IV criteria, due to their arrogance, search for attention, sensation that they deserve privileges and exceptions, and their relative absence of anxiety. The latter, also called "covert", are inhibited narcissists, hypersensitive to criticism, anguished, and apparently humble. For Kernberg, this overt/covert polarity among narcissists represents a *continuum*, and there is no need to create subtypes for the disorder.[28] In our clinic, we have been able to confirm this view: in general, in the first consultations the patients hide their narcissistic arrogance; and then, when they feel more secure of the physician's attention, or feel as if they are "friends with the physician", their pathology becomes evident.

Still, among the subtle signs of narcissistic disorder, whether overt or covert, the physician must be aware of the patient-impermeable-to-any-guidance and of the patient-who-never-gets-better. In both cases, it seems that an impenetrable constitution of self is behind the behavior.

Chart 2. DSM-IV criteria for the diagnosis of Narcissistic Personality Disorder and clinical vignette

A pattern of grandiosity (either in fantasy or behavior), a need for admiration, and a lack of empathy are indicated by having at least five of the following criteria:

a) a grandiose feeling of his or her own importance;

b) a concern with fantasies of unlimited success, power, intelligence, beauty, or ideal love;

c) a belief in being a "special" and unique being, and who can only be understood by or must be associated with other people (or institutions) who are also special;

d) an excessive demand for admiration;

e) a feeling of entitlement, that is, irrational expectations of receiving a especially favorable or obedient treatment;

f) exploits his or her interpersonal relationships, that is, takes advantage of others to achieve his or her own objectives;

g) lack of empathy: avoids recognizing or identifying with the feelings and needs of others;

h) frequently envies other people or believes others envy them;

i) arrogant and insolent behavior and attitudes.

Clinical vignette

Mr. B, 47 years old, construction worker, had been on sick leave for 10 years, following a block of cement falling on his thorax. Referred to the pain management team after six months of being treated in the orthopedics department, where the diagnosis of chondrocostal contusion had been given and the use of analgesics and anti-inflammatories had not eliminated his pains. Radiography and ultrasound of the region eliminated other diagnoses. He reported incapacitating pain on the middle and lower third of the right hemithorax, which worsened when he lifted any weight. In the fourth psychiatric consultation, he arrived one hour before the opening of the outpatient clinic. When the other patients arrived, he asked the doctor to be seen first (he had an event right after that). He became deeply irritated when told that the patients who had appointments before him would be seen first. He claimed that in his previous consultation, the psychiatrist had seen a patient who felt ill in the waiting room before him - which was true. His irritation did not diminish, even when it was explained that that had been an emergency. After this incident, B abandoned the treatment. In the objective anamnesis, his wife had said that B had always cared for his athletic body, but after the accident, he could not carry the bags from the market (the wife and an 11 year-old son would carry them, although B was always with them): "sometimes he gets home screaming with pain, throws himself on the sofa and stays for hours without moving; I need to bring him food and, afterwards, a small bowl to brush his teeth". The wife also said that B had had many fights with his construction bosses, because he thought he was always right (he was known as "argumentative"). At home he was hard-headed, the type who never bows down to the wishes of this wife or son. When there were arguments, it was frequent that B would spend days "sulking, sad, not leaving the bedroom, until they apologized to him". According to his wife, B did not take the medication as the doctors had prescribed, for he said that "nobody understood what he felt better than he did".

The impermeable-to-any-guidance patient usually does not follow the prescriptions of the physician. Medication is self-administrated erratically; missing consultations is common; procedures need to be negotiated in advance, in repeated and tedious crises of hesitation in which the patient seems to doubt that the physician wants his well-being. The physician may feel depreciated by the patient, or feel that he needs to apply periodic maneuvers to revalidate his authority as a doctor in the relation with the patient.

The never-gets-better patient, from within his narcissistic armor, is communicating his triumph over that which all others are afraid of: pain and suffering. Silently, his strength and grandiosity are being exhibited. It is as if the patient could say daily to his peers, in self-aggrandizement, "everybody needs health; for me, this is not an issue". The never-gets-better patient, aside from seeing himself as someone special, sees his problem as special. Therefore, it does not sound good to him that his physician say that his problem is easy to solve. After all, to remain at the top of his strength (or resistance), the narcissist is only interested that his illness is extremely difficult to handle. Having an illness that can be eliminated is akin to eliminating oneself, which is what happens when one of these patients receives a clean bill of health: he feels that, unfortunately, being surrounded by the dedicated physicians and by the promising benefits of medicine has come to an end (that is, he will stop being the deserving recipient of special treatment, planned by exhausted physicians who live "burning the midnight oil" researching and thinking about a solution for his case).

For Kernberg, the grandiosity of these patients is shown in an "invasive" arrogance that contaminates and degenerates the physician-patient relationship: these patients obtain an unconscious secondary gain from the illness when they systematically demonstrate the incompetence and incapacity of the health professionals to alleviate their symptoms. They become specialists in the field of their own suffering, research diligently on the Internet, verify the qualification of therapists, compare their merits and deficiencies, come to treatment as if to "give a chance to the physician" - but obtain a consistent degree of unconscious satisfaction in defeating the clinical help that is offered to them.[28]

The narcissist defends the impenetrability of his own self. This is to say that he defends the limits of his physical self and to say that he is continuously worried about his body. Minimal physical sensations are over-analyzed. Some patients report symptoms that are unique, bizarre, never felt by anybody before. The physician, many times amazed, has the impression of witnessing the first appearance of that symptom in human history. It is a special symptom afflicting an equally special patient, who is mysteriously strong and capable of tolerating it. For the narcissist, to tolerate diseases and pain is, many times, a question of bravery.

We observe one of the main subtle signs of this disorder when we see a narcissist trapped in the "dialectics of submission". Their relationship with the other can be summarized as "either I subjugate the other or he will subjugate me". His mind is continuously (although not consciously) occupied with the question: "who dominates whom here?" Because of this pernicious dialectic, the narcissist does not conform to social limitations and always choses antagonism. In general, there is a life history that shows limited capacity for regular work (with a specific time to start and finish), little aptitude for teamwork, and little respect for hierarchy. It is a life whose trajectory collides with that of his superiors and/or leads to frequent job changes. In some cases, a completely unproductive work life is the observable result of an attentive anamnesis. Because the narcissist needs to feel "free", independent of social rules, there is often a noticeable non-conformity to any sleep routine. Spouses of narcissists generally complain that their husbands or wives want to sleep during the day, and spend the night wandering around the house or at the computer. Sometimes, narcissists are also inflexible about following the rules of eating habits. Periods of hyperphagia can result in physical problems related to being overweight and in referrals to other specialists, including a referral not always needed for bariatric surgery. In short, the narcissistic patient has enormous difficulties to establish and maintain commitments because, in the dialectics of submission, to become attached to commitments would "diminish" his or her importance.

When the dialectics of submission invades the field of his relationships with health professionals, the narcissist needs to defeat

the entire team around him. Which is to say he cannot tell the doctor that the treatment is good. Moreover, to prevail over the other is equated to having an impenetrable body, with signs and symptoms that persist, despite any medical effort and good will. Sometimes some symptoms may disappear, as if by magic, but other symptoms soon appear to replace them. This is how the "treatment" of patients with varied somatizations evolves - all kinds of hypochondria and persistent somatoform pain disorders - which, as a rule, have a narcissistic personality subjacent to the expression of their complaints. In the dialectics of submission, to acquiesce and improve through the physicians' strategies is to be defeated, whereas to resist, entrenched in the disease, is to defeat the physicians and all of medicine.

FINAL CONSIDERATIONS

Authors report a high prevalence of personality disorders in patients with CNOP, between 31 and 59%.[4,32] If the personality disorders are not diagnosed, the patients will not be treated appropriately. Kernberg & Yeomans affirm that of the patients referred to psychiatric hospitalization at the McLean Hospital, from Cornell University, diagnosed with depression or bipolar mood disorder, half of them had neither diagnosis, but did have serious personality disorders.[33] In a study of 1,300 patients with incapacitating columnar problems, depression was found in 56% of the patients, while 70% showed personality disorders.[34] In an epidemiologically-based sample, personality disorders appeared as a risk factor for various medical conditions, including chronic pain, even with the control of depression.[35] In our group, of the 30 patients referred for evaluation and psychiatric monitoring, only two were diagnosed with depression.

The elected treatment for personality disorders is psychotherapy and there are various modalities, with their main recommendations.[10] On the one hand, the behavioral cognitive therapy and the techniques derived from it, such as dialectical behavioral therapy and the mentalization-based therapy are the most popular;[36] on the other hand, psychoanalysts are more inclined to use techniques more focused on analyzing transference.[37] The conjunction of psychotherapy and pharmacotherapy will be the best option, especially when there is comorbid anxiety or depression, intense emotional instability, suicidal or parasuicidal behavior, or impulsiveness. However, it is important to keep in mind that the strict pharmacotherapy treatment, as is offered many times to depressive patients, is doomed to failure. It is possible that the current tendency to treat personality problems simply as depression is responsible for part of the therapeutic failure observed with CNOP patients.[38-40]

There is considerable comorbidity between the borderline and narcissistic personality disorders. For Kernberg, both belong to the same nosological region (the borderline organization of personality) that shelters persons organized in a frontier region between adaptive functioning on the one hand and psychotic gravity on the other.[37,41,42] In both disorders, the patients externalize anxiety in a dramatic manner, abrasive to the relationship with the other. The overlapping between the two may be explained in these terms: the borderline personality demands care because it feels it has fragilities and diseases, whereas the narcissistic personality demands care because it is certain of deserving it. In both, it can be seen a viscous, perpetual, inertial adhesion to the privileges of childhood.

Old and new texts deal with the personality profile of patients with refractory pains or symptoms, who seemed to remain chronically mired in the role of victim or sick person.[4,43,44] Some have named the phenomenon also as "illness behavior".[45-47] All of them gave importance to the so-called "secondary gain of illness". In this article, we would like to emphasize something less debated, which is the tertiary gain, in which who wins is not the patient, but the physician and the health institution. Pawl[48] points out that physicians can refer patients to treatments that have already been proven ineffective, only because they will receive financial gain for these procedures. Unfortunately, aside from this conduct being ethically deplorable, it conveys a lie to the patient that a physical cause for his maladies will continue to be investigated by medicine. In teaching hospitals, we have also seen another type of tertiary gain, equally pernicious: the team gains experience with interventional procedures, which is welcome by the youngest physicians in search of new skills.

As for the diagnostic question in medicine, many times the diagnosis of mental problems is made by exclusion. There are authors who disagree with this posture.[49,50] There are clinical presentations, such as personality disorders and somatization, in which physical symptoms are psychologically created and maintained. Such presentations also deserve to have diagnostic validity *per se*, instead of waiting that they be diagnosed and treated only after the exclusion of a myriad of physical organic causes marginally capable of giving rise to their symptoms.[40]

The high performance borderline and the covert narcissistic personalities are difficult to diagnose by the DSM criteria. In these cases, the attention to subtle signs is indispensable. Some authors suggest that the pain management teams search for the presence of dysfunctional personality traces by means of scales applied to all the patients already in their first appointment.[32,51] We think that such an approach may dissolve the confusion between depression and personality disorders in the CNOP services. Tragesser et al.[5] suggest that patients with CNOP frequently have depression as a symptom (as with hostility or anxiety), and this leads many physicians to erroneously diagnose them with depression as a disease. Zanarini et al.[44] points out that the self-victimizing dysphoria, typical of the borderline personality, increases the chances of the patient being seen as depressed. Kernberg & Yeomans[33] postulate that genuine depression should only be diagnosed when (at least) one depressive crisis is demarcated in the life history of the patient.

The two personality disorders dealt with here represent overloads for the physician-patient relationship. It is noteworthy that clinicians from diverse specialties call them "difficult patients".[40,52] Below, we give some recommendations that may be useful in the monitoring of these patients by the chronic pain management teams.[53]

An objective anamnesis is essential. Only the report of a family member or friend may bring to the physician true information on how the patient functions in his interpersonal relations in the family and at work. The objective anamnesis also serves to expand the therapeutic alliance to other family members/caregivers, in addition to elucidating unclear points in the life history of the patient, such as the context for suicide attempts, use of un-prescribed psychotropics, lawsuits against the work and social security systems, and capacity to adhere to treatment, etc.

Diagnostic scales in psychiatry are useful for the purpose of research; however, when used in the context of clinical monitoring of the patient with CNOP, they can cause side effects. For example, even if the patient does not confirm the existence of (almost) all the listed ailments, this list offers a repertoire of new symptoms that the patient may use *a posteriori.* Allowing the patient to describe his problems in his own words is the most trustworthy procedure in dealing with these patients.

It is important to establish clear limits from the beginning of the treatment and to remain aware not to make exceptions to what was previously agreed. The patient must consider himself as co-responsible for the results of his treatment. It is counterproductive that the patient come to the hospital at any day he needs, at any time he wants, that he collect prescriptions from professionals of various departments, that he be able to get all his medication for free (and many times, to expect home delivery). This could be part of a pre-established contract with the patient: maximum number of missed appointments tolerable; rescheduling appointments if the patient is late; maximum duration of the appointment; consultations at times other than those scheduled; number of prescriptions or pills to be supplied every month. In the waiting room, patients should not be allowed to exchange the order of appointments (the physician never knows the basis for such exchanges). The systematic transgression of the treatment prescribed must result in the elimination of the patient from the group-which must be previously agreed.

To recommend psychotherapy and monitor the adhesion of the patient. It must be part of the contract that the pharmacological treatment will only be maintained if the patient is coming to the psychotherapy sessions, either with professionals from the pain management team or from another department.

To identify and limit the secondary gains. Taking advantage of the sick condition to obtain attention/care from family members, to be exempt from responsibilities, or to avoid returning to work are the most common examples. We have also seen patients who try to be eternally linked to teaching hospitals as a way to guarantee their own access (and of family members) to treatments that may be necessary, including other departments, through the contact with an already known physician.

To combat any tertiary gain. It is not ethical to offer ineffective treatments to patients, either to obtain financial compensation or to acquire practical skills.

To monitor the feelings triggered by the relationship with the patient. Leaving any interest in the cure to the patient (the normal is that he be the main interested party). Not to accept any blame for medication or procedures that were ineffective. Not to react to the hostility of the patient with hostility (remember that we are in that relationship for anything except fighting with the patient). Feeling afraid of the patient, or feeling obliged to solve his problems must also be identified and handled, preferably with the help of other members of the team.

Reading of the medical history. Each physician must carefully read the medical history. This will allow them to see whether the patient is following what has been prescribed and prevent them from adopting unsuitable conduct. The patient cannot be expected to be co-responsible for his treatment if the medical team itself offers him a mismatch of prescriptions.

Analgesics and psychotropics must be prescribed by one professional only. This prevents a well-intentioned professional from testing combinations of, for example, an antidepressant, a mood stabilizer, and an analgesic on a patient who is already taking another medication (many times in the same class) in a therapeutic test initiated by another physician.

Team communication must be optimized. It is among the symptoms of these patients to spread hearsay that has the potential to create disputes, and may cause the destruction of the team. Case discussions and periodical meetings of the team members are highly recommended.

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