

**SYMPTOM MAGNIFICATION SYNDROME:
A MODERN TRAGEDY AND ITS TREATMENT**
Part One: Description and Definition

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Introduction

For many years I have worked as a clinical psychologist, rehabilitation counselor, and work capacity evaluator with individuals who are in the process of adjusting to a severe disability. Over the course of my involvement I have noted patterns of behavior that can impede progress and limit the utility of subsequent rehabilitation services. I have formulated a theory to account for these behavior patterns and I have developed strategies for intervention. I believe that this theory and the strategies can be considered within the context of a phenomenon that I have termed the "Symptom Magnification Syndrome".

Prevalence

The Symptom Magnification Syndrome (SMS) is a pervasive phenomenon that has tremendous impact on the ability of our health care system to deliver services. In a study (Matheson, 1988a) of 377 consecutive cases of chronically disabled individuals (mean = 2.1 years post injury) referred for evaluation and work hardening in an industrial rehabilitation center, 21 people (24%) suffered from the syndrome. The syndrome poses a drain on our society's financial resources for health care, restitution for lost earnings, and decreased productivity that cannot be sustained without seriously undermining our ability to compete in the world market.

Definition

Symptom magnification syndrome is defined as "a self-destructive, socially reinforced behavioral response pattern consisting of reports or displays of symptoms which function to control the life circumstances of the sufferer". This definition encompasses all of the important aspects of the syndrome. It is a self-destructive pattern of behavior which is learned and maintained through social reinforcement. This pattern of behavior is composed of reports and/or displays of symptoms, the effect of which is to control the life circumstances of the sufferer.

It is important to note that the symptom magnification syndrome does not constitute a psychiatric diagnosis although each of the SMS types has an analog in the psychiatric literature. Because SMS is considered in terms of a behavior

pattern rather than in terms of a psychiatric syndrome, identification and effective intervention can be undertaken by occupational therapists, physical therapists, and other non-psychiatric clinicians.

Three Types

We have been able to identify three primary types of symptom magnifier. The Type I, whom we will call the Refugee, the Type II, whom we will call the Game Player, and the Type III, whom we will call the Identified Patient. It is far easier to identify the general symptom magnification syndrome than to pinpoint type. Differentiation among the three symptom magnification syndrome types sets the stage for better understanding of techniques of identification and treatment. In many cases the symptom magnification syndrome type may be identified only during treatment.

Refugee

The Type I Refugee finds that the symptom behavior provides an escape from an apparently irresolvable conflict or life situation. The metaphor that I use to describe the Refugee is one in which the sufferer is looking back over his or her shoulder while attempting to escape from a difficult life situation. As a consequence, this person has little future orientation and goals are very difficult for this person to develop or embrace. The Refugee perceives the availability of effective role back-up as nonexistent. Behaviorally, the Refugee is in and out of the worker role and is often able to work part time on an occasional basis, but never in a sustained manner. The Refugee is unwilling to seek support under pressure, although he or she may appear to be helpless. The Refugee is willing to "grit his teeth" to endure conflict passively because this conflict actually appears (to him or to her) to be unable to be resolved without seeking outside assistance. The Refugee appears to be a martyr in relation to his or her symptoms and the attendant situation of his or her life. For example, this type of person would say, "The pain is terrible, but I will make it through somehow". The Refugee has a psychosocial history that includes placement in a family or community network that he or she perceives as being integral and irreplaceable to the family or to the community. The Refugee will often involve professional caregivers in what I call "yes, but" interchanges. These "yes, but" interchanges are a style of interaction that will negate or blunt the professional's attempts to provide assistance to the sufferer. To the Refugee, the symptoms themselves appear to provide an escape from the irresolvable conflict. As a consequence, the Refugee has little true motivation to follow through with treatment.

The analog to the Type I Refugee in the psychiatric literature is the person who suffers from a somatoform disorder. This is a group of disorders in which the symptoms suggest a physical disorder for which there are no findings or a non-physiologic mechanism and for which there is evidence that the symptoms are

linked to psychological factors or conflicts. I want to point out that the Refugee is not a person who suffers from a somatoform disorder. However the somatoform disordered person has a tremendous amount of similarity to the Refugee. Generally speaking, the Refugee will not meet all of our requirements that are put forth to qualify for diagnosis of somatoform disorder, but will interact with his or her environment in a manner that is similar to the style of a person who has a somatoform disorder.

Game Player

The person who suffers from the Type II symptom magnification syndrome is called the Game Player. This is the person whose symptoms provide an opportunity for positive gain. The Game Player is an opportunist who appears to be in the daydreaming stage of career development. He has a long history of poor goal attainment in spite of having had strong goal orientation. He has goals that are few in number, very challenging, have high visibility, and are not well thought out. While the Game Player may present these goals with conviction, they have not been well-developed and may be more properly considered as daydreams rather than as actual goals. This type of person might have a goal such as, "To own a dump truck and go into the construction business," or, "To become a drug counselor". However, the Game Player's avowed goals are not backed up with any planning, specific knowledge, or sustained action. If we investigate further into the cause of the Game Player's poor goal attainment, we find that he or she is generally a poor planner. This person tends to be irresponsible while appearing to be responsible. When things go wrong, he or she will say, "It's not my fault. I told her she should have not done that." The Game Player has few true friends or significant others whom he can trust and who will rely on him. Conversely, he often has a large number of acquaintances and a wide social circle.

Malingerer

The Game Player is similar to the person who traditionally has been considered a malingerer, which is the most appropriate analogue in the psychiatric literature. In the Diagnostic and Statistical Manual of Mental Disorders-III-R (American Psychiatric Association, 1988), Malingerer is presented as a "V code", which characterizes conditions that are not attributable to a mental disorder that is the focus of treatment or attention. It is important to point out that the Game Player and the malingerer are similar but distinct. True malingererers represent a very small proportion of the number of people whose symptoms control their environments. Symptom magnification is a much more prevalent problem than is malingering. Additionally, symptom magnification behavior is largely unconscious, while malingering behavior is conscious and under the volitional control of the individual. While the Game Player may be interpersonally shallow, a Malingerer will usually have an Antisocial Personality Disorder, which is much more dysfunctional.

Confusing symptomatic occasion syndrome with malingering is a mistake for the health care professional for two very important reasons: The first is that symptom magnification syndrome is treatable and should be looked at like other self-destructive behavior that can be changed through intervention. Malingering is not treatable. When was the last time you successfully rehabilitated a person whom you had identified as a malingerer? If you think about it, this is quite rare. Why? Because "malingerer" is a pejorative label and is completely at odds with a therapeutic relationship. Instead of terminology that is disparaging or belittling, the symptom magnification syndrome approach allows us to discuss the behavior with the patient in a constructive manner. We can say, "this is a normal behavior pattern, but it is self-destructive and should not be continued. I can help you to change." The second reason to not confuse symptom magnification syndrome with malingering is that malingering is not a diagnostic label that can be defended. It is a medico-legal concept. Healthcare professionals often may use it as a psychiatric label, but, as may be seen above, this is incorrect. Malingering is actually a crime for which evidence must be gathered by attorneys and private investigators who should become involved with such a case. In its place, I recommend that healthcare professionals use the symptom magnification syndrome concept because it connotes something that can be identified and treated. Additionally, because SMS is based on behavioral observation, you can defend your opinion much more effectively than you can defend your opinion about malingering. The concept of malingering does not work in rehabilitation and healthcare. In its place, symptom magnification syndrome will be found to be less problematic and certainly will be less stigmatizing.

Identified Patient

The Type III symptom magnifier is the person whom we will call the "Identified Patient". This is the person who symptoms ensure survival and maintenance of the patient role. For the Identified Patient, the patient role eclipses and contains all other possible roles. Roles of father, husband, brother, uncle, friend, neighbor, and others are frequently seen to have been lost by the Identified Patient. While this person may continue to have the title, he or she is not treated in the customary manner associated with the role.

Behaviorally, the Identified Patient can be known in terms of three factors. First, this person has a few goals, all of which focus on psychological or physical survival. "To get through the week" or "To make it to my next disability check" are frequently stated as goals. Neither the frank absence of goals found with the Refugee or the grand scheme of the Game Player are present in this case. Second, the Identified Patient acts as if life is to be survived rather than to be enjoyed. Depression is common. A sense of hopelessness and inadequacy pervades this person's self-descriptive statements.

Third, the Identified Patient acts impulsively in what I call "accidental disregard" of his or her impairment. As a consequence, this person must be watched very carefully. These are the people that, as they make progress through the rehabilitation program, will cause "inadvertent" injuries to themselves near the end of the program, perhaps in active therapy, or perhaps at home.

The analogue to the Identified Patient in the psychiatric literature is the Factitious Disorder, which indicates an artificially-induced disorder. Factitious disorders are characterized by physical or psychological symptoms that are produced by the individual under voluntary control. Differentiation from malingering is based on a finding that there is no apparent goal for the individual other than maintenance of the patient role.

Symptom Experience vs. Symptom Behavior

Let us differentiate for a moment between symptom experience and symptom behavior. It is important to separate, both conceptually and actually, the experience of the symptom from the behavior that connotes or communicates the presence of the symptom. The symptom experience takes place at an intrapsychic level and is experienced only by the individual. It is not able to be directly known by another. In comparison, symptom behavior takes place at an extra psychic level and involves others.

Symptom behaviors are learned early in life from one's parents and other early caregivers. Selective reinforcement of spontaneously emitted symptom behaviors (based on symptom experience) by one's parents, leads to an appropriate display of symptom behaviors. Symptom behaviors are learned responses to symptom experiences. In addition, symptom behaviors quickly become learned responses to other situations in which the behaviors are perceived by the individual to be needed and can be expected to be effective. The timing of the behavior and the type of behavior emitted is based on when the behavior can be expected to be effective and what behavior will positively affect the person who is emitting the behavior.

Mobilizing Emergency Responses

With regard to pain, symptom behavior serves the individual as a means to mobilize emergency responses. The first emergency response that one mobilizes with these behaviors is from one's parents. Gradually as we mature, we begin to learn how to use symptom behaviors to mobilize emergency responses from others in our environment; our friends, our teachers, our doctors, and others with whom we share caring relationships. It is important to note that symptom behavior is contingently effective in eliciting a supportive and caring response from the environment. As responders learn how to read symptom

behaviors, the responses are modulated. An infant learns to read the contingencies of his environment and to control his symptom behavior to manipulate those around him. The infant and those people in his world are in a "dance" in which the infant has the lead and in which the infant uses symptom behaviors as a primary means of communication.

Development of the Syndrome

How does one develop a pattern of responding to the world that is maladaptive? Iatrogenesis of illness has been recognized since antiquity. While attention in iatrogenesis is usually focused on the physician as the agent, all health-care professionals are responsible for development of the symptom magnification syndrome. How does this occur?

Let's consider what happens when a person experiences pathology that leads to chronic disability. Initially, the alerting and warning effects of the reports and displays of symptoms are of crucial importance. Great attention is paid to them so as to effect an accurate diagnosis of the pathology in order to develop an appropriate treatment plan. As the pathology is diagnosed and the attendant impairment becomes stable, the reports and displays of symptoms become less important. Without an emergent crisis, the alerting effect of the symptoms is diminished. Additionally, for the responsible patient who has learned to care for his or her impairment so as to avoid exacerbation, the mobilizing effect of the symptoms is often socially maladaptive and alternate behaviors are reinforced. Because the chronic problem is clearly understood and its symptoms are anticipated, the mobilization of resources can be planned and easily controlled in a volitional matter by the patient.

In successful rehabilitation, the responsibility for symptoms and whatever control over them is possible is given over to the patient whenever the patient is competent to handle that responsibility. The person who experiences rapid, unexpected onset of pathology that leads to a chronic disability may not successfully take responsibility for his symptoms, and in fact may demonstrate that they function to control his life circumstances because he perceives the emergent situation and its aftermath as uncontrollable. His response to this uncontrollable situation may make him susceptible to the symptom magnification syndrome. All that the mature patient needs to do is "Pop a Nitro" for his angina pectoris, chew a sugar cube in response to his awareness of an on-coming insulin reaction, or modify his posture as he notices pain increase in his low back. These are all examples of symptoms that are indications of problems that are usually handled by patients with excellent effect.

The use of symptom behavior to elicit a supportive and caring response from the environment is adaptive as long as, first, the symptom behavior is not chronic;

second, the environment is healthy and appropriately reinforces symptom behavior; and third, other means of communication or relationship are available.

The use of symptom behavior to elicit a supporting and caring response from the environment has a high probability of becoming maladaptive when four factors are present: first, the symptom experience is chronic; second, the symptom behavior is a primary means of communication or is the basis of the relationship between the individual and his or her environment; third, symptom behavior is indiscriminately reinforced by the environment; and fourth, non-symptom behavior is not reinforced by the environment.

These four issues are considered causative factors for the symptom magnification syndrome in that they immediately precede the development of the syndrome. After these dynamics have been in operation for several months, the individual stops emitting non-symptom behavior. The symptom magnifier is one whose non-symptom behaviors and style of interacting have been replaced by maladaptive behaviors on a persistent basis so that these behaviors become the individual's normal style of responding to his or her environment. This is similar to what has been identified as "learned helplessness" (Miller & Norman, 1979). As socially reinforced learned behavior, strategies are available to bring about adaptive behavior change (Beck, 1976; A. Beck, 1967; Matheson, 1988b; Matheson, Ogden, Violette, & Schultz, 1985).

The Symptom Dilemma

Reports and displays of symptoms are an important part of the relationship between health care professionals and the patients whom they serve. In fact, symptom behaviors are so important that they are reinforced by healthcare professionals who rely on accurate and precise perception of these behaviors in order to identify and treat an illness. This is the crux of the health care professional's dilemma with symptom magnification syndrome.

As long as the reports and displays of symptoms are simply part of the communication, and are *differentially* reinforced as *communicative* behavior rather than as *relationship* behavior or *role* behavior, the symptom magnification syndrome will not result.

However, symptom magnification syndrome becomes an iatrogenic problem when the reports and displays of symptoms begin to control the relationship. The health care professional is often responsible for precipitating the symptom magnification syndrome in a susceptible patient by:

Use of Language

Eliciting only reports or displays of symptoms.

For instance, the practitioner who requires the patient to report in detail about how he or she is feeling, but it ignores or handles in a perfunctory manner how the patient is doing at home or on the job is subtly reinforcing symptoms as the primary means of effective communication in the relationship. As another example, the utilization of symptom reports or displays as the primary indicator of status in an ongoing care situation, instead of reports and displays of function, naturally results in the reinforcement of these behaviors. Their value to the patient is a function of this reinforcement.

Selection of Goals

Focusing the therapeutic relationship on palliative goals.

A goal such as, "I will help you feel better" is so natural it may not be perceived by the caregiver as being the trap that can become until it is too late and the caregiver is himself or herself trapped. Many experienced practitioners have become trapped in a struggle with a chronically pain-disabled patient whose only goal is to "feel better" or to "get rid of the pain". While these may be acceptable goals for other types of patients, they are untenable for those patients whose pain continues to limit function after healing has taken place. It is much more adaptive to focus the relationship on a goal such as, "I will help you return to work at the highest level possible," or "I will help you get back to your job". Each of these goals allows a gradient of function that is measurable and can be documented. The ability to measure and quantify functional return helps the practitioner to stay out of the symptom trap that the patient controls.

Communicative Style

Maintaining an authoritative relationship with an adult patient.

Because symptom behavior is learned at a very early age, the possibility that early life experiences will contaminate adult behavior is very real. For one model of how the professional style of communication within the healthcare relationship can lead to symptom magnification syndrome, we can turn to Eric Berne and Transactional Analysis (Berne, 1964), in which the adult communication from one person precipitates an adult response in another person. Conversely, parental communication precipitates a child response in the other person. In some healthcare relationships, the professional assumes a parental role and communicates with the patient in a parental manner that can often bring about a childlike response. The "parent-child" response is one part of the iatrogenesis of symptom magnification syndrome.

Workers' Compensation Exacerbates the Problem

Many people are caught up in the symptom magnification syndrome as a consequence of a sense of helplessness that is, to a great degree, inherent in the workers' compensation system. Some of the dynamics that lead to the syndrome include:

Safety at work is perceived as being uncontrollable. The experience of the injury may or may not be perceived as uncontrollable.

Treatment is perceived as being uncontrolled by the patient. As the patient with a work-related injury treated in the workers' compensation system, an important focus of loss of control has to do with a loss of control over his life circumstances. The previously independent adult finds himself enmeshed in a quasi-legal system that is rigorously regimented.

A multitude of life circumstances are perceived as out of control. The injured worker may experience a loss of control over his health at the same time that he experiences the loss of his job, income, security, and perhaps loss of his occupation.

Loss of Personal Agency and Helplessness

The loss of real control over one's life circumstances, combined with the loss of a sense of competency easily can lead to helplessness. In a workers' compensation case, the expectation that the situation is uncontrollable and is independent of whatever response is initiated by the injured worker produces several outcomes.

The first outcome is diminishment of voluntary responses that control his or her life circumstances because voluntary responding is based on the individual's expectation that the response will succeed (Bandura, 1989). The experience of uncontrollability leads individuals to the expectation that responses will not succeed. Hence, responses that may have been used to attempt to directly negotiate with "the powers that be" to control a person's life circumstances are not attempted. The absence of voluntary responses or attempts to negotiate with the environment becomes a self-fulfilling prophecy. However, it appears to the outside observer as a motivational deficit. It appears that the individual is not taking responsibility or, worse, is not trying.

The second consequence of the perception of a situation as uncontrollable is that the symptom magnification syndrome sufferer is not able to learn that responding is able to control the outcome. An expectancy has developed that future efforts will be futile. Once a person has had experience with uncontrollability, he has difficulty learning that his response has succeeded,

even when it is actually successful (C. Peterson, Seligman, & Vaillant, 1988; Seligman, 1975). The expectation of uncontrollability distorts the perception of subsequently achieved control. This is called a "negative cognitive set". This negative cognitive set is such that people believe that success and failure is independent of their own action and they therefore have difficulty learning that subsequent (actually effective) responses will work.

The third consequence of the perception that the situation is uncontrollable occurs early in the process of adjustment to disability and has to do with heightened anxiety and fearfulness. As the person's disability becomes clear, anxiety and fear diminish and the individual begins to adjust. It is at this point that, if the individual believes that he is helpless and unable to control the consequences of his injury, a disability-induced reactive depression can occur (C Peterson & Seligman, 1987).

Summary

In summary, the value of the symptom magnification syndrome in rehabilitation has to do with concept's ability to assist us to work with our patients effectively so that the patient can drop the use of reports and displays of symptoms as a means to control the environment and to cope with a sense of helplessness that often results from a painful chronic illness. This assists the patient to not only avoid the problems to which such strategies inevitably lead, but also to take full advantage of the opportunities that are available in rehabilitation.

References

- American Psychiatric Association. (1988). *Diagnostic criteria from DSM-III-R*. Washington DC: American Psychiatric Association.
- Bandura, A. (1989). Human agency in social cognitive theory. *American Psychologist*, 44(9), 1175-1184.
- Beck. (1976). *Cognitive Therapy and the Emotional Disorders*. New York: New American Library.
- Beck, A. (1967). *Depression: causes and treatment*. Philadelphia: University of Pennsylvania.
- Berne, E. (1964). *Games People Play: the Psychology of Human Relations*. New York: Ballantine Books.
- Matheson, L. (1988a). How do you know that he tried his best? Reliability crisis in industrial rehabilitation. *Industrial Rehabilitation Quarterly*, 1(1), 1, 11-12.
- Matheson, L. (1988b). Integrated work hardening in vocational rehabilitation: An emerging model. *Vocational Evaluation and Work Adjustment Bulletin*, 22(2), 71-76.

Industrial Rehabilitation Quarterly

- Matheson, L., Ogden, L., Violette, K., & Schultz, K. (1985). Work hardening: Occupational therapy in industrial rehabilitation. *American Journal of Occupational Therapy, 39*(5), 314-321.
- Miller, I. I., & Norman, W. (1979). Learned helplessness in humans: a review and attribution-theory model. *Psychological Bulletin, 86*(1), 93-118.
- Peterson, C., & Seligman, M. (1987). Explanatory style and illness. *Journal of Personality, 55*(2), 237-265.
- Peterson, C., Seligman, M. E., & Vaillant, G. E. (1988). Pessimistic explanatory style is a risk factor for physical illness: A thirty-five-year longitudinal study. *Journal of Personality and Social Psychology, 55*, 23-27.
- Seligman, M. (1975). *Helplessness: On depression, development, and death*. New York: WH Freeman and Company.