

Predicting Faking Good In Patients In Treatment For Chronic Pain

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Reports of chronic pain often occur in association with incentives to bias symptom reports. While there has been a considerable amount of research on malingering, little attention has been given to possible scenarios where chronic pain patients (CPPs) may be motivated to deceitfully portray themselves in a positive light. This failure to report the presence of physical or mental symptoms is associated with making socially desirable responses¹, and is alternately referred to as faking good (FG)² or negative malingering.^{3,4}

Motives for FG in medical patients may include both primary and secondary gain. With regard to primary gain, some patients may seek to conceal negative information about themselves because it is socially undesirable to do so. Consistent with this, studies have found that patients may under-report alcohol consumption⁵, substance abuse.⁶ Other denied conditions may include color blindness⁴, and depression.⁷ Interestingly, one study of organ donors undergoing psychological screening concluded that 26 to 29% were faking good.⁸

With regard to pain patients, one study showed that patients with chronic pain may simultaneously fake good and bad during the same assessment. For example, one study showed that patients who were trying to portray themselves in a more socially desirable manner reported less depression and anxiety, but higher levels of pain severity and disability. This study concluded that social desirability response biases should be considered in both research and clinical assessments of chronic pain patients.⁹ Similarly, using a different method, a cluster analysis study identified a “repressor” cluster, with patients reporting higher pain but less emotional distress.¹⁰

METHODS

Data was collected from 346 patients who were in treatment for chronic pain in 108 sites in 36 states using Battery For Health Improvement 2 (BHI 2) profiles and other variables. From these, 50 CPP were chosen at random. Additionally, 50 chronic pain patients were asked to subtly fake good (FG). The demographic characteristics of these two groups can be found in Table 1. The FG group was instructed to fake good in such a way so as to appear better than they really are, without faking in so extreme a manner that others might detect it. The 10 BHI 2 variables that were included as potential predictors are listed in Table 2.

A forward stepwise logistic regression procedure was performed on the combined CPP and FG groups, using BHI 2 scale scores as potential predictors of FG status. The conditions for predictor inclusion were $p < 0.05$ to enter, and $p > .10$ to remove.

RESULTS

The final regression model was achieved in two steps, and identified two predictors that were significant. Detailed information about each step of the forward stepwise logistic regression analysis can be found in Table 3. Variables predicting CPP vs FG were the BHI 2 Defensiveness scale and pain level. These variables produced a regression equation that accounted for 65% of the variance between the groups (Naglekerke R² square = .646), led to the correct prediction of FG status 83% of the time, and was statistically significant

(Omnibus Test of Model Coefficients $p=.000$). The exact coefficients, test statistics, p values, and odds ratios associated with each of these variables can be found in Table 4.

CONCLUSIONS

Although little research has conducted on this phenomena, there would seem to be a number of scenarios where patients would be incentivized to fake good. For example, as many opioid treatment guidelines conclude that patients with histories of substance abuse or psychopathology may be a poor risk for chronic opioid therapy¹¹, this may incentivize patients to conceal that. Similarly, as procedures such a spinal cord stimulation often requires psychological clearance, patients may be incentivized to conceal important information about their health or life in order to receive the treatment that they desire. Overall, there would appear to be multiple scenarios where the patient may fear that disclosure of important but socially undesirable information may lead to being stigmatized, or denied the type of care that the patient desires.

In this study, patients with FG status exhibited significantly different psychological profiles on the BHI 2 as compared to CPPs, and these differences could be detected psychometrically. This finding may have clinical utility. FG status is often overlooked in the clinical setting, but by identifying patients who are positively biasing the information that they are presenting, symptoms that the patient is concealing or minimizing are more likely to be detected, and receive appropriate consideration.

TABLE 1

Demographic Characteristics of Patient and Faking Good Samples

| Group | Random Chronic Pain Patients (N= 50) | Fake Bad Patients (N=50) |
|-----------|--------------------------------------|--------------------------|
| Gender | Male | 46.00% |
| | Female | 54.00% |
| Education | Attended College | 58.00% |
| | High school graduate or less | 42.00% |
| Race | White | 88.00% |
| | Nonwhite | 12.00% |
| Mean Age | 37.3 | 40.4 |

TABLE 2

Variables tested

| |
|--------------------|
| Depression |
| Anxiety |
| Hostility |
| Borderline |
| Somatization |
| Pain |
| Function |
| Muscular Bracing |
| Symptom Dependency |
| Defensiveness |

TABLE 3

Stepwise Logistic Regression Results by Step

| Step | Step χ^2 (df) | P value | Step Nagelkerke R ² | % of Cases Predicted Correctly by the Model |
|------|--------------------|---------|--------------------------------|---|
| 1 | 59.134 (1) | <0.001 | 0.567 | 83.20% |
| 2 | 11.593 (1) | <0.001 | 0.646 | 83.20% |

TABLE 4

Logistic Regression Results for Significant Independent Variables in Final Model

| Variable | B | Wald | P Value | Odds Ratio |
|---------------|--------|--------|---------|------------|
| Defensiveness | 0.157 | 11.287 | 0.001 | 1.17 |
| Pain | -0.145 | 9.731 | 0.002 | 0.865 |

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