

Psychologic Characteristics of Psychiatric Patients Having Pain as a Presenting Symptom

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IN a consultative practice with our colleagues in medicine and surgery, we became impressed by the number of patients whose chief complaint was pain for which no organic basis could be found. These patients had been subjected to extensive medical and neurologic evaluation that produced no explanation for the pain. Previous studies indicated that certain individuals may express anxiety and depression in terms of the symptom of pain. The purpose of this study was to examine the incidence of pain without organic cause and to determine what, if any, statistically significant psychologic and social correlates existed in such patients.

The case histories of 562 medical and surgical patients referred for psychiatric evaluation were studied to examine the relationships between life experiences and the symptom of pain in patients with no substantial physiologic or anatomic findings.

When information obtained from clinical interviews and the Minnesota Multiphasic Personality Inventory (MMPI)⁸ of female and male subjects with pain as a presenting symptom was compared with that from similar subjects without such pain, statistically significant differences were found in several spheres. These included depression, anxiety, phobias, hypochondriasis, childhood fainting spells, school phobias, close friendships in childhood, size of community in which subject was raised, age, education, religion, adequacy of menstrual education, and the diagnosis of conversion reaction. (A glossary follows the text; see page 394.)

The results of the Minnesota Multiphasic Personality Inventory expressed as mean profiles and two-point codes showed some differences. Attempts were made to form hypotheses and draw conclusions.

SUBJECTS

The 562 subjects in the study group comprised a representative sample of the 2847 patients seen in consultation by all the staff psychiatrists at the Mayo Clinic during one year. Specifically, the subjects included all patients seen in con-

secutive consultations by two of us (L.F.P. and T.L.B.) during that year. In every case, the patient had been evaluated initially by an internist, neurologist, or surgeon from another department who then had requested the consultation.

The subjects were outpatients seen in a clinic environment and did not include any who were hospitalized, seen in child psychiatry, referred directly to the psychiatric department, or undergoing continuing psychotherapy. Subjects ranged in age from 14 to 76 years (mean: 43.3 years). There was a preponderance of women, a ratio of 3:2; whereas the Mayo Clinic patient population is made up of approximately an equal number of men and women. Almost two-thirds of the patients had at least a high-school education. They were from all occupational groups. Among the men, skilled labourers made up the largest occupational group, being 33.0% of the total, and managerial and professional men comprised the next largest groups. Housewives constituted 58.1% of the women, and most non-housewives were either clerical or professional women. More than 73% of the subjects were married.

METHOD

In almost all cases the request for psychiatric consultation was made to the Section of Psychiatry and not to a particular psychiatrist. The assignment of patients, then, was made on a rotational basis to all members of the section.

Psychiatric information was obtained in a relatively unstructured interview which lasted approximately one hour. Immediately after the interview, some of the information obtained was recorded on a 63-item checklist devised by the authors. The items included information concerning the patient's present illness, past and present emotional adjustment, developmental history and pertinent general information.

After the psychiatric interview, each subject was given the Minnesota Multiphasic Personality inventory. This is the most commonly used structured personality test for evaluating basic personality characteristics. It is made up of a series of 566 behavioural descriptive statements to which the patient responds either "true" or "false". These statements are grouped into sev-

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TABLE I.—DEPRESSION AND ANXIETY AS PRESENTING SYMPTOMS IN SUBJECTS WITH AND WITHOUT PAIN

Presenting symptom	Male subjects (No. = 221)				Female subjects (No. = 341)			
	With pain (No. = 65)		Without pain (No. = 156)		With pain (No. = 117)		Without pain (No. = 224)	
	No.	%	No.	%	No.	%	No.	%
Depression	8*	12.3	55	35.3	17†	14.5	77	34.4
Anxiety	7*	10.8	50	32.1	11†	9.4	53	23.7

*Significant at the .001 level.

†Significant at the .01 level.

eral broad categories making up basic scales which can be objectively scored. Responses of the patient are compared with responses of large numbers of normal individual and individuals with psychiatric disorders. The test contains 10 basic "clinical" scales: hypochondriasis, depression, hysteria, psychopathic deviation, masculinity-femininity, paranoia, psychasthenia, schizophrenia, hypomania, and social introversion. There are also scales which measure "test-taking attitudes" and do an adequate job in identifying general defensiveness, conscious lying, mental confusion, and malingering. Since we use a form adapted for automated scoring,¹¹ all medical patients currently seeking examination at the Mayo Clinic could take the test routinely.

The 562 subjects were grouped according to sex. They were grouped further according to presence or absence of pain as a presenting symptom. Of 221 male subjects, 65 had pain and 156 did not; of 341 female subjects, 117 had pain and 224 did not. The "with pain" and "without pain" groups in each sex were compared using the information obtained from the clinical interview and from the Minnesota Multiphasic Personality Inventory given after the interview.

The chi-square technique was used, and a difference was considered significant if $P \leq .05$.¹⁰

RESULTS

Pain as a presenting complaint was present in 32.4% of the subjects. Women complained of pain more frequently than did men, but the difference was not significant.

Pain was the most frequent presenting symptom. In order of frequency, pain of the head or neck was most common, followed by pain in the back, abdomen, arm or leg, rectum or genitalia, and chest. When pain was present as a primary complaint, depression and anxiety were presenting symptoms significantly less often in both men ($P < .001$) and women ($P < .01$) (Table I).

Before our examination 35.8% of the subjects had been told that their symptoms had an emotional or functional etiology. A smaller number, 19.9%, had received psychiatric treatment. For patients of both sexes, those with pain tended to have received a psychiatric diagnosis or psychiatric treatment less often than those without pain. Male patients with pain had had psychiatric treatment significantly less often ($P < .01$) than had those without pain.

Psychiatric evaluation independent of presenting complaints revealed that depression was significantly less frequent in both men ($P < .05$) and women ($P < .01$) with pain. Women with pain admitted to phobias significantly less often ($P < .01$) than did those without pain. Hypochondriasis was significantly more common ($P < .02$) in men with pain than in men without pain. In general, women with pain were more hypochondriacal and less phobic, perfectionistic, suspicious, anxious and depressed than were women without pain. The men showed the same pattern as the women except that those having pain were slightly more anxious than those without pain. Table II lists the adult neurotic symptoms and their relationship to pain.

TABLE II.—ADULT NEUROTIC SYMPTOMS OF SUBJECTS WITH AND WITHOUT PAIN

Symptom	Male subjects (No. = 221)				Female subjects (No. = 341)				Significance	
	With pain (No. = 65)		Without pain (No. = 156)		With pain (No. = 117)		Without pain (No. = 224)			
	No.	%	No.	%	No.	%	No.	%	M	F
Depression	41	63.1	120	76.9	76	65.0	177	79.0	0.05	0.01
Phobia	20	30.8	55	35.3	43	36.8	117	52.2	>0.05	0.01
Hypochondriasis	48	73.8	88	56.4	75	64.1	127	56.7	0.02	>0.05
Anxiety	54	83.1	127	81.4	91	77.8	192	85.7	>0.05	>0.05
Perfectionism	39	60.0	103	66.0	72	61.5	147	65.6	>0.05	>0.05
Suspiciousness	7	10.8	22	14.1	21	17.9	43	19.2	>0.05	>0.05

TABLE III.—SOCIAL FACTORS SHOWING SIGNIFICANT RELATIONSHIP TO PAIN

Factor	Male subjects (No. = 221)				Female subjects (No. = 341)				Significance	
	With pain (No. = 65)		Without pain (No. = 156)		With pain (No. = 117)		Without pain (No. = 224)		M	F
	No.	%	No.	%	No.	%	No.	%		
Age										
< 60 years.....	62	95.4	128	82.1	116	99.1	196	87.5	P = .01	P = .001
60 years or more.....	3	4.6	28	17.9	1	0.9	28	12.5		
Community size									P > .05	P = .01
50,000 or less.....	18	27.7	46	29.5	39	33.3	40	17.9		
> 50,000.....	47	72.3	110	70.5	78	66.8	184	82.1		
Education (grades completed)									P = .01	P > .05
8* or less.....	20	30.8	21	13.5	14	12.0	30	13.4		
12* or more.....	29	44.6	106	68.0	79	67.5	154	68.8		
Religion									P = .05	P > .05
Roman Catholic.....	21	32.3	29	18.6	24	20.5	61	27.2		
Protestant.....	39	60.0	117	75.0	86	73.5	148	66.1		
Other.....	5	7.7	10	6.4	7	6.0	15	6.7		

*Other grade levels not considered.

Some childhood symptoms commonly considered to be expressions of emotional conflicts were evaluated. No significant differences were found when the two groups of women were compared. On the other hand, men with pain admitted to school phobias ($P < .02$), the inability to form a close relationship with at least one friend in childhood ($P < .02$), and fainting spells ($P < .05$) significantly more often than did their non-pain counterparts.

Pain was present in all age groups, but subjects 60 years of age or older complained of pain significantly less frequently than did younger subjects (male $P < .01$, female $P < .001$). In this instance, the significance test had questionable validity since less than five patients 60 years or older had pain. However, the low incidence of pain in the elderly was striking (Table III).

Women reared in communities of more than 50,000 persons had pain as one of their symptoms significantly more often ($P < .01$) than did those who had lived in smaller communities. For the men, no significant relationship could be found between the size of the community during the first 15 years of life and the symptom of pain. Men who had completed 12 or more grades of school had pain significantly less often ($P < .01$) than did those who had completed no more than eight grades. A study of the religious affiliation of the subjects revealed that of the Roman Catholic men, more complained of pain than presented without pain, as compared to the Protestant men, of whom more presented without pain than complained of pain ($P < .05$) (Table III).

Among women, a significant relationship was found between the quality of menstrual education before menarche and freedom from dysmenorrhea ($P < .001$).

Criteria used for the diagnosis of the hysterical personality have been outlined by Chodoff and Lyons² (Table IV). Subjects who had at least six of the seven criteria of the hysterical personality were compared with those who had five or less. In both men and women, those who met six or seven of the criteria tended to have a higher incidence of pain.

TABLE IV.—CRITERIA FOR HYSTERICAL PERSONALITY

1. Egocentric, vain, self-indulgent
2. Self-dramatizing, lying, exaggerating
3. Labile, excitable, inconsistent
4. Emotionally shallow
5. Flirtatious, provocative, tending to sexualize communications
6. Frigid, immature, apprehensive, impotent (not organically)
7. Demanding and dependent

In 68 of the 562 subjects, a surgical procedure appeared to have precipitated or aggravated the presenting symptom. Despite this close relationship between the operation and the symptom, 33 of the subjects thought that the procedure had been successful.

There were 23 subjects whose symptoms related to an injury in which litigation was pending. The number was too small to permit any statistically significant conclusions; however, it should be noted that almost all of these subjects had pain as one of their presenting symptoms.

The official nomenclature of the American Psychiatric Association was used for the diagnostic categories.³ Psychoneurotic reactions made up the largest group of subjects both with and without pain. Pain was found in all disorders except the organic brain syndromes. For both sexes, subjects with pain were diagnosed as having psychoneurotic reaction, conversion type, significantly more often ($P < .001$) than were those without pain.

Table V lists items having equal incidence regardless of the presence or absence of pain; there were no statistically significant findings in these areas.

TABLE V.—CHARACTERISTICS HAVING EQUAL INCIDENCE IN PATIENTS WITH AND WITHOUT PAIN

Feeding problems	Conflict with teachers
Toilet training	Conflict with peers
Enuresis	Previous emotional diagnosis
Insomnia	Frigidity (F)
Nightmares	Social adjustment
Sleepwalking	Family adjustment
Long or frequent illness	Adjustment to sexual role in life
Masturbation guilt	Strength of religious belief
Tomboy (F)	Occupation
Academic difficulties	Present marital status
Closest parent in childhood	Relative age of spouse
Age at death of parents	Number of pregnancies (F)
Sibling number and rank	Number of children

The Minnesota Multiphasic Personality Inventory was completed and a valid profile was obtained in 90.4% of the subjects. A valid test result was defined as one in which not more than 120 questions were not answered and the raw F scores were not greater than 21. The F scale is a measure of test-taking attitude that objectifies malingering, mental confusion, and so on. Only 3.3% of the subjects with pain failed to obtain a valid MMPI, whereas 12.6% of the subjects without pain did so. This difference was significant at the .001 level.

The mean profile of the total group was clinically abnormal (Fig. 1). It was a neurotic profile with the four highest elevations being depression (D), hypochondriasis (Hs), hysteria (Hy) and psychasthenia (Pt). Because of the rather marked sex difference of the mean scores on the Mf scale, they are identified separately for men and women. In addition to profile analysis, a system of "code analysis" has been developed for MMPI profile interpretation. In coding, each clinical scale is assigned a number. Thus, the first scale, hypochondriasis, becomes 1; the second scale, depression, becomes 2; and so on. The last scale, social introversion, is given a zero designation. The digits representing the scales are then written down in order of T-score elevation from the highest to the lowest. For

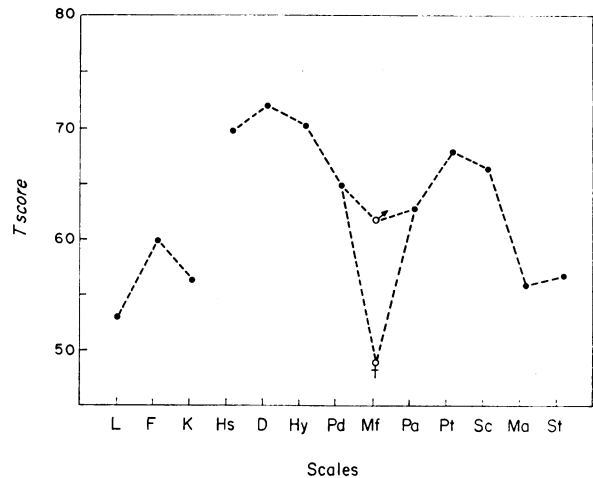


Fig. 1.—Mean MMPI profile of all subjects. Mean scores for male and female subjects are shown separately for Mf scale because of large discrepancy due to differing orientations.

example, if the depression scale (2) is the highest score and the psychasthenia scale (7) is the next highest score, the two-point code identification of that profile would be 27. The clinical scales are numerically identified as follows: hypochondriasis, 1; depression, 2; hysteria, 3; psychopathic deviation, 4; masculinity-femininity, 5; paranoia, 6; psychasthenia, 7; schizophrenia, 8; hypomania, 9; social introversion, 0. An evaluation of the two-point codes revealed that the subjects fit into relatively homogeneous groups, with the most frequently appearing codes being the following: 13 ($n = 57$), 31 ($n = 46$), 27 ($n = 42$), 12 ($n = 25$), 23 ($n = 22$), 21 ($n = 21$), 72 ($n = 15$), and 32 ($n = 12$).

A comparison of the mean profiles of the men and women revealed relatively higher elevations among the men (Fig. 2). This is a fairly con-

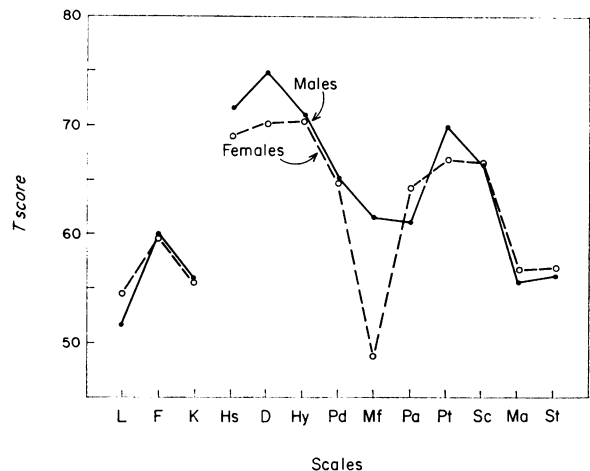


Fig. 2.—Mean MMPI profiles of male and female subjects compared.

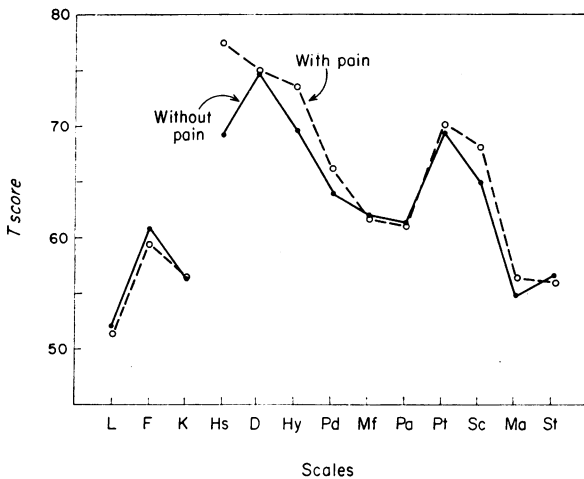


Fig. 3.—Mean MMPI profiles of male subjects with and without pain.

sistent sex difference for all ages in a typical medical population. Among the 10 clinical scales, the D and Hs scales showed the greatest sex difference. (The Mf scale difference was excluded from consideration here because of the greater sensitivity of the Mf scale in males to education and socioeconomic status.)

In female subjects both with and without pain, the most frequent two-point code was 31 (n = 40). This profile was uncommon in both groups of male subjects where 13 (n = 27) and 27 (n = 26) were the most frequent two-point codes.

Men having pain showed a relatively higher mean profile than did those without pain (Fig. 3). In male subjects with pain, the Hs, D, and Hy scales were all markedly elevated with a suggestion of a configuration which has been termed a "conversion V". This configuration of scales is characterized by a bipolar elevation of

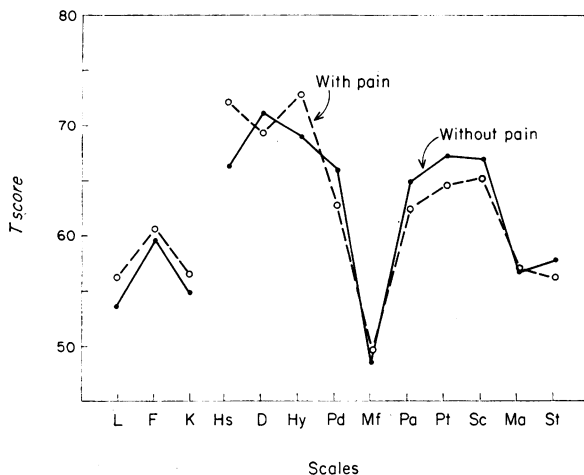


Fig. 4.—Mean MMPI profiles of female subjects with and without pain.

Hy and Hs scales; the intermediate D score is of a lower value. The men without pain showed the highest elevation on the D scale with somewhat lower scores on the H and Hy scales. The most common two-point code in men having pain was 13 (n = 15), and in those without pain, 27 (n = 20).

A comparison of the mean profiles of the two female groups showed primarily a qualitative difference (Fig. 4). The mean profile of the subjects with pain showed a "conversion V" pattern. On the other hand, the elevation of the depression scale was the highest in the mean profile of the female subjects without pain. The two-point codes most frequently seen in female subjects with pain were 31 (n = 24) and 13 (n = 17). In those without pain, 31 (n = 16), 27 (n = 14) and 13 (n = 13) were most common. It should be noted that 27 was not the most frequent profile for women without pain as it had been for men without pain. However, it was much more frequent than for women with pain (n = 14 as compared to n = 2).

DISCUSSION

In examining any relationship of pain to emotional factors, it must be remembered that the data on pain are entirely dependent on the subjective report of the person perceiving it. This may be reported in concise terms and correspond to the doctor's understanding of a clear-cut medical syndrome. However, as is occasionally the case, the description may fit no particular pattern and be somewhat poorly reported. Our observations led us to concur with the impressions of others that the patients with psychologic problems commonly spoke to their physicians in terms of pain or other organic symptoms rather than anxiety, depression and the like. There are some readily apparent reasons for this. For instance, we are taught to speak to physicians in medical terms with increasing sophistication from childhood. In addition to this, often because of the degree of their anxiety and their lack of understanding of its source, patients find it difficult to give precise bases for their emotional problems. This is true even when the patients are quite perceptive. Anxiety appears to be harder for many to tolerate or understand than pain, hence the usefulness of the symptom, pain.

Also, the doctor has difficulty comprehending emotional problems for reasons related to his medical training and because of the particular response of his patients, mentioned above.

The psychologic meaning of the complaint of pain depends on the amount of concern the patient has for his body, on whether he is un-

consciously trying to solve some conflict, and on what specifically this conflict may be. In the process of maturation, the ability to condense and symbolize various unique experiences of the individual increases so that many types of painful experience may simply be subsumed under the one broad category of pain.

When the patient unknowingly talks to the doctor as a figure in authority from whom help might have been rightly expected in the past, such as a parent, pain may be only the core of this usually hostile, demanding patient's problem. Expressions of pain in a medical setting, then, may be pleas for help in a non-medical problem unrecognized by either the patient or his physician.

Some of the additional common clinical characteristics of these patients with pain described by Engel⁴⁻⁶ are: (1) the equating of pain and punishment in which pain may become a means of alleviating guilt feelings and (2) the associating of pain with feelings and actions of aggression enabling the individual to control his aggressive behaviour by substituting pain for it. In short, pain as a symptom may be relatively less distressing than these other types of feelings.

The results of this study suggest that pain is substituted for anxiety and depression.

In this study, the relatively greater percentage of female patients than in the general Mayo Clinic patient population suggests that, in this medical setting, women are more likely to receive psychiatric consultation than are men. Hollingshead and Redlich⁹ in a study of mental illness in an urban community also found in the higher socioeconomic classes a higher incidence of female subjects receiving psychiatric care. Several factors may account for the preponderance of women in the present study. Conversion hysteria, which has been reported to be more common in women, was diagnosed in 106 of the 562 subjects studied. Because of the frequency of somatic symptoms in conversion hysteria, a high incidence of this condition in a medical population is not unexpected. It may also be that men are less inclined to seek help from a physician when they have mental disorders or that male physicians are less inclined to refer them to a psychiatrist.

The high incidence of pain as one of the primary presenting complaints of the subjects is to be expected because, generally speaking, people perceive the Mayo Clinic as primarily interested in the diagnosis, treatment and management of physical disorders.

The low incidence of psychiatric diagnosis and treatment for those patients with pain, before the patients came to this clinic, suggests

that pain as an expression of emotional conflict may not be recognized or considered by the physician.

There is a tendency for physicians to attribute symptoms to organic pathology when it is present, and the process of ageing has supplied many organic changes to which pain may be ascribed. Perhaps for this reason the older age group with pain is referred to medical specialties other than psychiatry, such as physical medicine and neurology. This selection of patients for referral may explain the significantly lower incidence of pain in the elderly in this study, since in two other studies done by neurologists a higher incidence of pain was found in the elderly.^{1, 7}

The low incidence of anxiety and depression in subjects having pain may be understood when it is considered that pain may be an equivalent of either of these symptoms. Psychiatric evaluation independent of the presenting complaints, however, revealed that the subjects with pain were no less anxious than subjects without pain. This was probably because pain was perceived by the psychiatrist as a manifestation of anxiety.

Hypochondriacal concern as evaluated by the psychiatrist was higher in subjects with pain than in those without—significantly so in men. This hypochondriacal concern about pain is an indication of the degree of anxiety being contained by the symptom and is borne out by the difficulty patients have in relinquishing this type of pain.

Psychoanalytic theory has stressed the importance, in the genesis of emotional illness, of psychologic conflicts in the developmental years. However, in an evaluation of the developmental years, few significant differences were found in subjects with pain as compared with those having no pain. This paucity of findings is probably accounted for by the known inadequacy of information obtained through history taking. Emotional conflicts in developmental years must often be repressed from conscious memory because of the anxiety and pain associated with them.

The statistically significant findings relating to community size in the developmental years, education and religion will require further investigation before any conclusions can be drawn.

Adequacy of menstrual education is one factor in evaluating the quality of the relationship between mother and daughter. The strikingly statistically significant relationship between quality of menstrual education and absence of dysmenorrhea in this study suggests that menstruation and all it implies is accepted more

comfortably by the woman who has had a good relationship with her mother. Painful menstruation or dysmenorrhea appears to be the discomfort experienced by women who find the feminine role uncomfortable.

The number of subjects who met at least six of the seven criteria of the hysterical personality was small; therefore, valid statistical studies could not be undertaken. However, pain was more common in this "highly hysterical group", a finding which was not surprising since pain is a frequent symptom in hysteria.

For both sexes, subjects diagnosed as having conversion reaction had a significantly higher incidence of pain. This was not true of subjects in any of the other diagnostic categories. The suggestion of a "conversion V" pattern on the MMPI profile of subjects with pain supports this clinical impression. This suggests, as other studies have, that pain is a common symptom in conversion reactions.

Button¹ studied patients with chronic pain who had been referred to a neurologist and compared them with neurologic patients without pain. It was significant that those with pain came from larger families. Gonda,⁷ in a separate study, had similar findings. The results of the present study of pain in a psychiatric consultative practice did not confirm their results because, when the occurrence of pain and the number of siblings were compared, the findings were not significant. Perhaps patients referred to neurologists differ significantly from those referred to psychiatrists.

Results of the Minnesota Multiphasic Personality Inventory suggest that the subjects in this study formed a relatively homogeneous group (Figs. 1 to 4). This was particularly true of the subjects with pain. The significantly higher incidence of failure to complete a valid MMPI and the greater variability of T scores in the subjects without pain suggest that they were less homogeneous, inasmuch as certain members of this group by these criteria were obviously markedly disturbed. The relatively higher mean MMPI profile for men, with the greatest sex difference in depression and hypochondriasis, suggests that male patients referred to a psychiatrist from a medical population, are likely to display more evidence of psychiatric disturbance than are female patients. Since this was a fairly consistent finding in a representative medical population, regardless of the reason for referral, it probably reflects the male patient's greater concern over his health. This seemed to be particularly true of male subjects with pain; the patients with this complaint had a relatively higher mean profile than did those without pain.

Summary A psychiatric study was made of patients who complained of pain that could not be explained by extensive medical and neurologic evaluation. The purpose of the study was to determine the incidence of pain in patients seen in psychiatric consultation and whether any significant psychological and social correlates existed. Psychiatric information was obtained by means of a relatively unstructured interview, a 63-item check list, and the Minnesota Multiphasic Personality Inventory (MMPI). Subjects were grouped according to sex and the presence or absence of pain as a presenting symptom. The "with pain" and "without pain" groups of each sex were compared, using the results of the MMPI and the information obtained from the clinical interviews. Significant differences were found in the following: depression, anxiety, phobias, hypochondriasis, childhood fainting spells, school phobias, close friendships in childhood, size of community in which subject was raised, age, education, religion and conversion reaction. Results of the MMPI, expressed in mean profiles and two-point codes, also showed some differences. Our observations supported the impression of others that patients with psychologic problems commonly speak to their physicians in terms of pain or other organic symptoms rather than in terms of anxiety, depression, or other symptoms of emotional conflict.

Résumé Une étude psychiatrique a été réalisée chez des malades qui se plaignaient de douleur inexplicable malgré un bilan médical et neurologique complet visant à déterminer la fréquence de la douleur chez les malades consultant des psychiatres et pour déterminer s'il existait une corrélation sociologico-psychologique appréciable. Les renseignements psychiatriques furent obtenus au moyen d'une entrevue relativement peu structurée d'une liste comprenant 63 points et du Minnesota Multiphasic Personality Inventory (MMPI). Les patients ont été groupés d'après leur sexe et d'après la présence ou l'absence de douleur comme symptôme de consultation. Les groupes "avec" et "sans" douleur des deux sexes ont été comparés grâce au résultat du MMPI et des renseignements obtenus au cours des entrevues cliniques. Les différences appréciables rencontrées se rattachaient aux points suivants: dépression, anxiété, phobies, hypochondriases, pertes de conscience dans l'enfance, phobies scolaires, amitiés d'enfance, grosseur de l'agglomération où le sujet a été élevé, âge, éducation, religion et réaction de conversion. Les résultats du MMPI, exprimés par courbe de moyenne et code de deux points, montraient également des différences. Les observations des auteurs confirment l'impression de certains autres chercheurs que des malades qui présentent des problèmes psychologiques décrivent souvent à leur médecin des symptômes de douleur ou d'autres symptômes organiques plutôt que de leur parler d'anxiété, de dépression et d'autres symptômes de conflit émotif.

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GLOSSARY

Anxiety: An unpleasurable affect marked by a feeling of apprehension and uncertainty.

Conversion Reaction, Conversion Hysteria, Hysteria: One of the psychoneurotic reactions marked by functional symptoms relating to organs or parts of the body, usually those that are under voluntary control. Seen most frequently in persons characterized by egocentricity, immaturity and heightened suggestibility.

Depression: A clinical syndrome consisting of lowering of mood and loss of interest in most aspects of life.

Hypochondriasis: An obsessive morbid anxiety about health, often associated with a simulated disease.

Hypomania: An affective disorder characterized by elation or irritability, with overtalkativeness, flight of ideas, and increased psychomotor activity.

Masculinity-Femininity: An MMPI scale developed to give a measurement of interest patterns.

Paranoid: Inclined to be sensitive, suspicious, jealous, and stubborn, developing delusions of persecution or grandeur.

Perfectionistic: Having a tendency to be fussy, meticulous, and compulsive. Seen most often in obsessive-compulsive disorders.

Phobia: A persistent abnormal dread or fear of objects, situations, or both.

Psychasthenia: Obsessive rumination, compulsive behaviour, abnormal fears, worrying, difficulties in concentration, and guilt feelings.

Psychoneurotic Reaction: A disorder characterized by anxiety felt directly or expressed unconsciously and automatically as in phobias, obsessions, dissociative states, conversion reactions, and depressions.

Psychopathic Deviate: One who manifests repeated and flagrant disregard for social customs and mores, with an inability to profit from experience or punishment.

Schizophrenia: A group of psychotic disorders characterized by fundamental disturbances in reality relationships and concept formations, with affective, behavioural, and intellectual disturbances in varying degrees and mixtures.

School Phobia: A neurotic symptom of childhood which appears to be a fear of school but which basically is anxiety over separation from mother.

Social Introversion: An MMPI scale developed to measure the characteristics of introversion-extroversion in thinking, social participation, and emotional involvement.

Suspicious: Inclined to mistrust. Seen most often in paranoid disorders.