Subjective Disorders:

Objective Proof of "Non-Visable" Conditions

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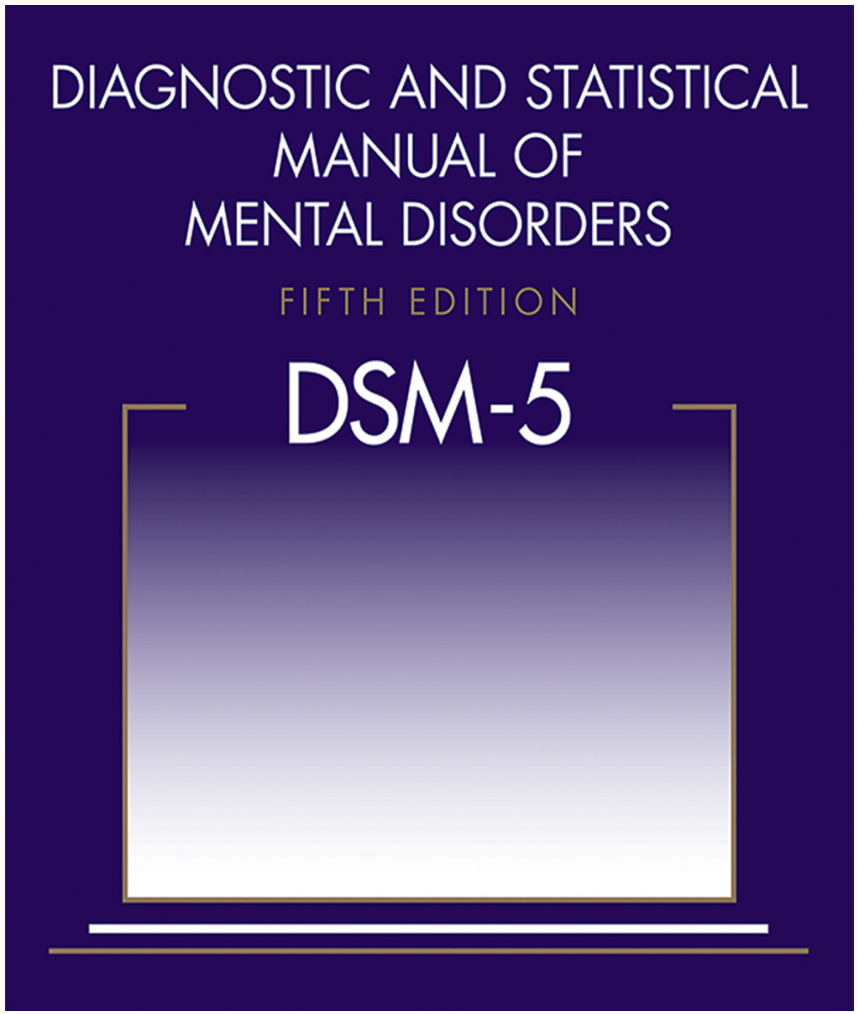
Mental Illness & the Potential Impact for Disability Litigation of the New DSM-5



Section I. Cautionary Statement for Forensic Use of DSM-5

(see handout)

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Perceived Shortcomings of DSM-IV

- High rates of co-morbidity
- High use of NOS category
- Treatment non-specificity
- Inability to find laboratory markers/tests
- DSM is starting to hinder research progress
  - NIMH launched Research Domain Criteria or RDoC a 10-year effort to define mental disorders based on behavioral and brain measures
  - DSM's approach by contrast relies on rulings by groups of psychiatrists about which symptoms characterize particular disorders. Thomas Insel, MD, NIMH Director: "This approach has yielded imprecise diagnostic labels that advance neither treatment nor research."

Perceived Shortcomings of DSM-IV for Somatic Symptoms & Related Disorders

- Overlapping Disorders
- Criteria so sensitive that they resulted in over diagnosis
- Criteria so specific that no one was being recognized by the disorder
- Thought to be pejorative
- Over emphasized mind-body dualism
- These disorders can co-exist with medical disorders
- Imponderable by primary care physicians
- Neither primary care nor psychiatrist used these diagnoses appropriately

Major Changes from DSM-IV to DSM-5 for Somatic Symptoms & Related Disorders

STRUCTURAL:

- Axis I through V Removed
- Some Diagnoses Removed, others Added
- Section III – Emerging Models and Measures Added
- Attempt to Combine Dimensional Approach with DSM's Set of Categorical Diagnoses

NEW DIAGNOSES FOR SOMATIC SYMPTOMS & RELATED DISORDERS

- **Somatic Symptom Disorder**
- **Illness Anxiety Disorder**
- **Psychological Factors Affecting Other Medical Conditions**
- **Factitious Disorder**
  - **Imposed on self**
  - **Imposed on another**
- **Other Specified Somatic Symptom & Related Disorder**
- **Unspecified Somatic Symptom & Related Disorder**

Major Changes from DSM-IV to DSM-5 for Somatic Symptoms & Related Disorders

STRUCTURAL:

- Some Diagnoses Removed

REMOVED & REPLACED DSM-IV SOMATIFORM DIAGNOSES:

- Somatization Disorder
- Hypochondriasis
- Pain Disorder
- Undifferentiated Somatoform Disorder

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Summary of DSM-5 Somatic Symptom & Related Disorders

DSM-IV DIAGNOSES:

- Somatization Disorder →
- Undifferentiated Somatoform Disorder →
- Pain Disorder →
- Factitious Disorder

- Hypochondriasis →
- Conversion Disorder

- Somatoform Disorder NOS →

NEW DSM-5 DIAGNOSES:

- Somatic Symptom Disorder

- Factitious Disorder
  - imposed on *self* or
  - imposed on *others*

- Illness Anxiety Disorder

- Conversion Disorder (functional neurological symptom disorder)
- Other Specified Somatic Symptom & Related Disorder

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Changes from DSM-IV to DSM-5 for Somatic Symptoms & Related Disorders

- Somatization Disorder → Somatic Symptom Disorder
  - but only if they have maladaptive thoughts, feelings & behaviors in addition to somatic symptoms

- Hypochondriasis→ Illness Anxiety Disorder
  - = high health anxiety but no somatic symptoms (unless better explained by primary anxiety disorder, e.g. GAD)

- Pain Disorder → Somatic Symptom Disorder with predominant pain

  or →Psychological Factors Affecting Other Medical Conditions

  or →Adjustment Disorder

New Somatic Symptoms & Related Disorders in DSM-5

- Conversion Disorder (functional neurological symptom disorder)
  - Emphasis on neurological examination
  - Relevant psychological factors may not be demonstrable at time of diagnosis
- Psychological Factors Affecting Other Medical Conditions
- Factitious Disorder
  - Somatic symptoms predominate in both Conversion Disorder & Factitious Disorder
  - Both are most often encountered in medical settings

SOMATIC SYMPTOM DISORDER 300.82 (F45.1)

Diagnostic Criteria:

A. One or more somatic symptoms that are distressing or result in significant disruption of daily life.

B. Excessive thoughts, feelings, or behaviors related to the somatic symptoms or associated health concerns as manifested by at least one of the following:

1. Disproportionate and persistent thoughts about the seriousness of one's symptoms.
2. Persistently high level of anxiety about health or symptoms.
3. Excessive time and energy devoted to these symptoms or health concerns.

C. Although any one somatic symptom may not be continuously present, the state of being symptomatic is persistent (typically more than 6 months).

Specify if:

With predominant pain (previously pain disorder).

Specify if:

Persistent: (more than 6 months).

Specify current severity:

Mild: Only one of the symptoms specified in Criterion B is fulfilled.

Moderate: Two or more of the symptoms specified in Criterion B are fulfilled.

Severe: Two or more of the symptoms specified in Criterion B are fulfilled, plus multiple somatic complaints (or one very severe somatic symptom).

ILLNESS ANXIETY DISORDER 300.7 (F45.21)

A. Preoccupation with having or acquiring a serious illness.

B. Somatic symptoms are not present or, if present, are only mild in intensity. If another medical condition is present or there is a high risk for developing a medical condition (e.g., strong family history is present), the preoccupation is clearly excessive or disproportionate.

C. There is a high level of anxiety about health, and the individual is easily alarmed about personal health status.

D. The individual performs excessive health-related behaviors (e.g., repeatedly checks his or her body for signs of illness) or exhibits maladaptive avoidance (e.g., avoids doctor appointments and hospitals).

E. Illness preoccupation has been present for at least 6 months, but the specific illness that is feared may change over that period of time.

F. The illness-related preoccupation is not better explained by another mental disorder, such as somatic symptom disorder, panic disorder, generalized anxiety disorder, body dysmorphic disorder, obsessive-compulsive disorder, or delusional disorder, somatic type.

Specify whether:

Care-seeking type: Medical care, including physician visits or undergoing tests and procedures, is frequently used.

Care-avoidant type: Medical care is rarely used.

CONVERSION DISORDER – (Functional Neurological Symptom Disorder)300.11

A. One or more symptoms of altered voluntary motor or sensory function.

B. Clinical findings provide evidence of incompatibility between the symptom and recognized neurological or medical conditions.

C. The symptom or deficit is not better explained by another medical or mental disorder.

D. The symptom or deficit causes clinically significant distress or impairment in social, occupational, or other important areas of functioning or warrants medical evaluation.

(F44.4) With weakness or paralysis

(F44.4) With abnormal movement (e.g., tremor, dystonic movement, myoclonus, gait disorder)

(F44.4) With swallowing symptoms

(F44.4) With speech symptom (e.g., dysphonia, slurred speech)

(F44.5) With attacks or seizures

(F44.6) With anesthesia or sensory loss

(F44.6) With special sensory symptom (e.g., visual, olfactory, or hearing disturbance)

(F44.7) With mixed symptoms

Specify if:

Acute episode: Symptoms present for less than 6 months.

Persistent: Symptoms occurring for 6 months or more.

Specify if:

With psychological stressor*(specify stressor)*

Without psychological stressor

PSYCHOLOGICAL FACTORS AFFECTING OTHER MEDICAL CONSITIONS 316 (F54)

A. A medical symptom or condition (other than a mental disorder) is present.

B. Psychological or behavioral factors adversely affect the medical condition in one of the following ways:

1. The factors have influenced the course of the medical condition as shown by a close temporal association between the psychological factors and the development or exacerbation of, or delayed recovery from, the medical condition.
2. The factors interfere with the treatment of the medical condition (e.g., poor adherence).
3. The factors constitute additional well-established health risks for the individual.
4. The factors influence the underlying pathophysiology, precipitating or exacerbating symptoms or necessitating medical attention.

C. The psychological and behavioral factors in Criterion B are not better explained by another mental disorder (e.g., panic disorder, major depressive disorder, posttraumatic stress disorder).

Specify current severity:

Mild: Increases medical risk (e.g., inconsistent adherence with antihypertension treatment).
Moderate: Aggravates underlying medical condition (e.g., anxiety aggravating asthma).
Severe: Results in medical hospitalization or emergency room visit.
Extreme: Results in severe, life-threatening risk (e.g., ignoring heart attack symptoms).

FACTITIOUS DISORDER IMPOSED ON SELF, OR ON ANOTHER (Previously Factitious Disorder by Proxy) 300.19 (F66.10)

A. Falsification of physical or psychological signs or symptoms, or induction of injury or disease (in self or another), associated with identified deception.

B. The individual presents himself or herself (or another individual, victim) to others as ill, impaired, or injured.

C. The deceptive behavior is evident even in the absence of obvious external rewards.

D. The behavior is not better explained by another mental disorder, such as delusional disorder or another psychotic disorder.

Specify:

on Self

on Another

Specify:

Single episode

Recurrent episodes (two or more events of falsification of illness and/or induction of injury)

OTHER SPECIFIED SOMATIC SYMPTOM & RELATED DISORDER 300.89 (F45.8)

This category applies to presentations in which symptoms characteristic of a somatic symptom and related disorder that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not meet the full criteria for any of the disorders in the somatic symptom and related disorders diagnostic class.

Examples of presentations that can be specified using the "other specified" designation include the following:

1. **Brief somatic symptom disorder:** Duration of symptoms is less than 6 months.
2. **Brief illness anxiety disorder:** Duration of symptoms is less than 6 months.
3. **Illness anxiety disorder without excessive health-related behaviors:** Criterion D for illness anxiety disorder is not met.
4. **Pseudocyesis:** A false belief of being pregnant that is associated with objective signs and reported symptoms of pregnancy.

UNSPECIFIED SOMATIC SYMPTOM & RELATED DISORDER 300.82 (F45.9)

This category applies to presentations in which symptoms characteristic of a somatic symptom and related disorder that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not meet the full criteria for any of the disorders in the somatic symptom and related disorders diagnostic class. The unspecified somatic symptom and related disorder category should not be used unless there are decidedly unusual situations where there is insufficient information to make a more specific diagnosis.

So-Called "Subjective Disorders"

- Fibromyalgia
- Chronic Fatigue Syndrome (CFS)
- Chronic Pain Syndrome (CPS)
- Complex Regional Pain Syndrome (CRPS) or
  Reflex Sympathetic Dystrophy (RSD)

Fibromyalgia

- Definition:
  - 1) History of widespread chronic pain in 4 quadrants of the body and
  - 2) Abnormal tenderness at 11 or more of 18 designated anatomic sites, called “tender points.”
  - 3) Appropriate Rule/Outs of other diagnoses.

Fibromyalgia

Source: American College of Rheumatology, 2010

Diagnostic Criteria:

1. Pain and symptoms over the past week, based on the total of:
11+ painful areas out of 18 parts of the body
Plus level of severity of these symptoms:
   - Fatigue
   - Waking unrefreshed
   - Cognitive (memory or thought) problems
   - Plus number of other general physical symptoms

2. Symptoms lasting at least three months at a similar level.

3. No other health problem that would better explain the pain and other symptoms.

Fibromyalgia

- Objective evidence:
  - No specific objective abnormalities, causes or evidence of inflammation have been identified to explain the symptoms.
  - Therefore no definitive testing and
  - No disease-modifying treatments.

Fibromyalgia Hypothesis: Does FM = Small-fiber Polyneuropathy (SFPN)?

- Small-fiber Polyneuropathy (SFPN):
  - Causes similar symptoms.
  - Is definitionally a disease caused by the dysfunction and degeneration of peripheral small-fiber neurons.
  - Has established causes, some diagnosable and definitively treatable, eg, diabetes mellitus.
  - Theory: some patients with chronic pain labeled as fibromyalgia may have unrecognized SFPN, a distinct disease that can be tested for objectively and sometimes treated definitively.
- Reference: Oaklander AL, Herzog ZD, Downs HM, Klein MM, "Objective evidence that small-fiber polyneuropathy underlies some illnesses currently labeled as fibromyalgia," *Pain*. 2013 Nov;154(11): 2310-6. doi: 10.1016/j.pain.2013.06.001. Epub 2013 Jun 5.

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Fibromyalgia

Cosey v. Prudential, 735 F.3d 161 (4th Cir., November 2013)

- "Objective Evidence of Disability" requirement

  (Jason Newfield)

Chronic Fatigue Syndrome (CFS)

- Definition from Centers for Disease Control & Prevention:
  - Chronic fatigue syndrome, or CFS, is a debilitating and complex disorder characterized by profound fatigue that is not improved by bed rest and that may be worsened by physical or mental activity. Symptoms affect several body systems and may include weakness, muscle pain, impaired memory and/or mental concentration, and insomnia, which can result in reduced participation in daily activities.

Chronic Fatigue Syndrome (CFS)

- No traditional objective medical evidence to confirm Diagnosis or underlying pathophysiology:
  - To date, there is no objective evidence (laboratory tests, imaging studies or neurocognitive test data) to confirm the presence of this disorder
  - There is no clearly identified organic pathophysiology associated with this disorder.
  - There are no objective criteria for who is disabled and who is not, among those who are diagnosed with this disorder.

Chronic Fatigue Syndrome (CFS)

However…

G. Lange, et al., "Objective evidence of cognitive complaints in Chronic Fatigue Syndrome: A BOLD fMRI study of verbal working memory," *Neuroimage,* 26:2, June 2005, 513-524.

- Individuals with CFS appear to have to exert greater effort to process auditory information as effectively as demographically similar healthy adults. Our findings provide ***objective evidence for the subjective experience of cognitive difficulties*** in individuals with CFS.

Chronic Pain Syndrome (CPS)

- Approximately 35% of Americans have some element of chronic pain, and approximately 50 million Americans are disabled partially or totally due to chronic pain. Chronic pain is reported more commonly in women.
- **Complications:** CPS can affect patients in various ways. Major effects in the patient's life are depressed mood, fatigue, reduced activity and libido, excessive use of drugs and alcohol, dependent behavior, and disability out of proportion with impairment.
- Chronic pain may lead to prolonged physical suffering, marital or family problems, loss of employment, and various adverse medical reactions from long-term therapy.
- Parental chronic pain increases the risk of internalizing symptoms, including anxiety and depression, in adolescents.
- A study by van Tilburg et al indicates that adolescents who have chronic pain and depressive thoughts are at increased risk for suicide ideation and attempts.

Chronic Pain Syndrome (CPS)

- Chronic pain syndrome (CPS) is a common problem that presents a major challenge to health-care providers because of its
  - complex natural history,
  - unclear etiology,
  - and poor response to therapy.

- CPS is a poorly defined condition. Most authors consider ongoing pain lasting longer than 6 months as diagnostic, and others have used 3 months as the minimum criterion. In chronic pain, the duration parameter is used arbitrarily. Some authors suggest that any pain that persists longer than the reasonably expected healing time for the involved tissues should be considered chronic pain.
- CPS is a constellation of syndromes that usually do not respond to the medical model of care. This condition is managed best with a multidisciplinary approach, requiring good integration and knowledge of multiple organ systems and psychology.

Chronic Pain Syndrome (CPS)

- The pathophysiology of CPS is complex and poorly understood.
- No objective evidence to support diagnosis or explain mechanism.
- Some authors have suggested that CPS might be a learned behavior, initially in response to a noxious stimulus and subsequently reinforced and rewarded both externally and internally so that eventually the noxious stimulus is no longer necessary to elicit the response.

- External reinforcers include attention from family members and friends, socialization with the physician, medication, compensation and time off from work.

- Patients with several psychological syndromes, (e.g. depression, somatic and related disorders) are prone to developing CPS.

Complex Regional Pain Syndrome (CRPS)

What Are the Symptoms of Complex Regional Pain Syndrome?

- vary in their severity and length. One symptom of CRPS is continuous, intense pain that gets worse rather than better over time.
- If after injury, pain may seem out of proportion to the severity of injury.
- With injury only to a finger or toe, pain can spread to include the entire extremity, even travel to the opposite extremity.

Other symptoms of CRPS include:

- "Burning" pain
- Swelling and stiffness in affected joints
- Motor disability, with decreased ability to move the affected body part
- Changes in nail and hair growth patterns: rapid hair growth or no hair growth
- Skin changes:
  - Changes in **temperature** – skin on one extremity warmer than on other.
  - **Color** may become blotchy, pale, purple or red.
  - **Texture** of skin may become shiny and thin.
  - **Moisture**: skin may become excessively sweaty.

CRPS may be heightened by emotional stress.

To Examine, Or Not To Examine

AMERICAN ACADEMY OF PSYCHIATRY AND THE LAW
ETHICS GUIDELINES FOR THE PRACTICE OF FORENSIC PSYCHIATRY

Adopted May 2005

IV. Honest & Striving for Objectivity:

Psychiatrists should not distort their opinion in the service of the retaining party. **Honesty, objectivity and the adequacy of the clinical evaluation may be called into question when an expert opinion is offered without a personal examination**. For certain evaluations (such as record reviews for malpractice cases), a personal examination is not required. In all other forensic evaluations, if, after appropriate effort, it is not feasible to conduct a personal examination, an opinion may nonetheless be rendered on the basis of other information. Under these circumstances, it is the responsibility of psychiatrists to make earnest efforts to ensure that their statements, opinions and any reports or testimony based on those opinions, clearly state that there was no personal examination and note any resulting limitations to their opinions.

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IME vs. Paper Review

Courts have provided mixed responses in evaluating whether it is appropriate to rely upon a pure paper review instead of conducting an actual examination of a claimant. The U.S. Supreme Court, in *Black and Decker v. Nord*, 538 U.S. 822 (2003) informed us that insurers were not obligated to adopt the opinions of treating physicians. At the same time, the Court advised that insurers could not simply reject out of hand these treating physician opinions. But, it was held, administrators need not automatically accord special weight to opinions of treating physicians, nor are they obligated to provide a discrete explanation when they credit evidence which conflicts with the treating physician.

Numerous courts have determined that it is appropriate to rely upon a paper only review of a claimant's medical records, while other courts have found this approach to be problematic, and indicative of a conflicted decision maker.

IME vs. Paper Review

(Mental Health Claims)

The issue may differ when dealing with claims based on mental health impairments. Some Courts have found that a paper review is improper for addressing impairments due to mental health conditions, finding it unethical to formulate opinions in the absence of a face to face meeting with a claimant, while other courts have accepted such practices as sufficient.

- *Westphal v. Eastman Kodak Co*., 2006 U.S. Dist. LEXIS 41494 (W.D.N.Y. 2006).
- Court found administrator's decision to be arbitrary and capricious, where it based its determination upon two doctors who never examined or treated the claimant.
- Court stated "In the context of psychiatric disability determinations, it is arbitrary and capricious to rely on the opinion of a non-treating, non-examining doctor because the inherent subjectivity of a psychiatric diagnosis requires the physician rendering the diagnosis to personally observe the claimant. Because a psychiatric opinion that is based solely on a review of medical records is **inherently less reliable than an opinion based on a face to face examination**, it is an abuse of discretion to rely solely upon such opinions, particularly in cases such as this, where the opinion of every physician who actually examined the plaintiff agreed that the plaintiff is disabled."

- *Morse v. The Corning Inc. Pension Plan*, 2007 U.S. Dist. LEXIS 12645 (W.D.N.Y. 2007)
- Same Judge as in *Westphal*
- "The psychiatric treating model requires that a doctor treating a psychiatric patient conduct an interview, and medical examination of the patient."
- "Therefore, in the context of a psychiatric evaluation, an opinion based on personal examination is inherently more reliable than an opinion based on a cold record because observation of the patient is critical to understanding the subjective nature of the patient's disease and in making a reasoned diagnosis."

But wait a minute….

Gannon v. Aetna Life Ins., 2007
U.S. Dist. LEXIS 72529 (S.D.N.Y. 2007)

- Court rejected the application of *Westphal* and *Morse*, distinguishing them, on the basis that we do not utilize the treating physician rule in ERISA cases, and relying upon the Supreme Court holding in *Black & Decker v. Nord*, 538 U.S. 822 (2003), and by noting that the medical support from both *Westphal* and *Morse* were substantially greater.

And now…..

West V. Corning Inc. Pension Plan, 2009
U.S. Dist. LEXIS 87207 (W.D.N.Y. 2009)

- This Court explored the issues, and considered *Westphal*, *Morse,* and *Gannon*.

- Did not determine any *per se* rule, but held that failure to have examination on mental health claim, was a significant factor as to why decision was arbitrary and capricious. This comports with the Supreme Court's guidance in Met Life v. Glenn, to address factors for consideration.

Paper Review v. Actual Examination

- For physical impairment cases, most courts are permitting insurers to sustain a claim decision on the basis of a paper only review. It does remain a factor for consideration, under *Met Life v. Glenn*.

- Standing alone, the paper only review is unlikely to be determinative that a decision is arbitrary and capricious. In mental health claims, there is a stronger argument from the case law to support that it would be an abuse of discretion.

Fitzpatrick v. Bayer Corp. , 2008 U.S. Dist. LEXIS 3532 (S.D.N.Y. 2008).

- Claimant alleged to have suffered from Chronic Fatigue Syndrome and Fibromyalgia.
- Court rejected argument that failure to conduct in person examination rendered claim determination arbitrary and capricious.
- "[a]ny suggestion that an administrator's physicians are *required* to conduct an in-person, physical examination of a plaintiff rather than a review of the record in a case such as this is unsupported by law. Plaintiff cites no authority for this proposition. To the contrary, courts in this district have found that an administrator's reliance on the opinions of non-examining physicians over the plaintiff's own treating physicians is not, in and of itself, arbitrary and capricious."

Topalian v. Hartford, 2013 U.S. Dist. LEXIS 70197 (E.D.N.Y. 2013)

- Court goes even further than *Fitzpatrick*, noting that Hartford was permitted to rely upon the paper reviewing opinions of doctors who were not specialists in treating Lyme Disease, despite the fact the claimant's doctor was a Lyme expert.
- "[t]he board-certified physicians retained by Hartford in the instant case were sufficiently qualified to evaluate all of plaintiff's medical conditions and to provide an opinion regarding plaintiff's functional capacity based on all of the objective medical evidence and clinical data. Upon independent review of the Administrative Record, the court finds that Hartford's reliance upon those independent peer review opinions was not arbitrary or capricious."

Objective Evidence: Required or Not?

- Courts have also reached different conclusions on whether it is appropriate to require objective evidence, particularly with medical conditions which do not lend toward objective evidence.

- As stated by one Court, “While plaintiff argues that the plan itself does not state that objective evidence is necessary to establish disability, the plan does state that "proof" of continued disability must be provided, and the **very concept of proof connotes objectivity**. In any event, it is hardly unreasonable for the administrator to require an objective component to such proof.” *Maniatty v. UNUM*, 218 F.Supp. 2d 500 (S.D.N.Y. 2002).

Objective Evidence: Required or Not?

- *Fitzpatrick v. Bayer Corp*., 2008 U.S. Dist. LEXIS 3532 (S.D.N.Y. 2008) addresses this issue in the CFS/Fibromyalgia context.

- "Likewise, at least one court in this District has made a similar finding, stating that it is reasonable "to insist on some objective measure of claimants' capacity to work, so long as that measure is appropriate as applied to each specific condition." *Cook v. The New York Times Long-Term Disability Plan*, 2004 U.S. Dist. LEXIS 1259, (S.D.N.Y. 2004)

OBJECTIVE PROOF OF IMPAIRMENT

- While it might be improper to require objective proof of the existence of a condition, particularly where that condition does not have objective testing to verify, it may be appropriate to require objective evidence of how or why it is impairing.
- As noted in *Boardman v. Prudential Ins. Co. of Am.*, 337 F.3d 9 (1st Cir. 2003), "[w]hile the diagnoses of chronic fatigue syndrome and fibromyalgia may not lend themselves to objective clinical findings, the physical limitations imposed by the symptoms of such illnesses do lend themselves to objective analysis.'"
- Is this merely a distinction with no difference or is this meaningful? How does one provide objective evidence of how it is impairing if they cannot provide objective evidence of the condition?

OBJECTIVE EVIDENCE IN CFS CASES

- Cardiopulmonary Exercise TESTING (CPET) – is this the answer?
- Many consider this the gold standard for determining disability. It is a two day testing protocol, which objectively assesses an individual's capacity for work. It will often be able to document post-exertional malaise and symptom exacerbation following physical activity, which will be interpreted for purposes of evaluating one's capacity to engage in sustained activity.

NON-BELIEVER PAPER REVIEWS

There have been cases decided where Courts have found insurers to be arbitrary and capricious where they relied upon a paper reviewing opinion of a doctor who does not believe that a particular condition could be impairing. These "non-believer" cases are not rare, but appear to be the exception.

Hoffpauir v. Aetna Life, 2009 U.S. Dist. LEXIS 55972 (W.D. La. 2009)

- Court took Aetna to task, relying upon an opinion of a doctor who does not recognize fibromyalgia as a disease. Aetna's sole reviewing physician does not recognize that fibromyalgia is a disease; instead, he classifies it as a "functional somatic syndrome." Dr. Anfield states that fibromyalgia is "a definitional construct not intended for clinical use, and intended only to identify populations for research." Thus, from Dr. Anfield's report, this Court gleans two points: 1) he does not recognize that fibromyalgia is a disease but is a definitional construct used only for clinical research, and 2) someone with fibromyalgia, or any "functional somatic syndrome" is not eligible for disability benefits because treatment for all of these individuals should include continued activity in their vocational, recreational, and vocational activities.
- "This Court finds that premising the denial of LTD benefits solely on a report of a physician who does not believe a particular disease exists, and does not believe that the proper treatment for that "definitional construct" can include the award of disability benefits, is an abuse of discretion."

Magee v. MetLife
632 F.Supp.2d 308 (S.D.N.Y. 2009)

- Met Life relied upon Dr. Dennis Payne, who determined that a diagnosis of CFS "is a syndrome (constellation of symptoms) rather than an illness or disease as a result of there being no histopathological correlate specific for the condition not present in controls.“

May v. MetLife, 2004
U.S. Dist. LEXIS 18486 (N.D. Cal. 2004)

- Met Life relied upon opinion of Dr. Amy Hopkins, who stated that “Fibromyalgia is not necessarily, in and of itself, a disabling disorder, and many people who carry this diagnosis are able to work.” Court was troubled by generic statement that people with fibromyalgia are often able to work.