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"I Hurt But They Think I'm Faking!"
What Are Somatic Symptom & Related Disorders & What Is Their Importance In Civil Litigation?

A passenger vehicle is rear-ended by a commercial vehicle traveling at 30 mph on a state road. The driver of the passenger vehicle is seat belted. The airbags deployed, and the vehicle suffered moderate rear end damage. Ambulance personnel note that the driver exited the vehicle without assistance, is awake, standing by the roadside and talking in sentences at the scene of the accident when first responders arrive. Passenger witness denies loss of consciousness. Glasgow Coma Scale score is a normal 15 at the scene and again in the local hospital emergency department after transport. There is no evidence of head trauma, no scalp laceration or bruising. Medical history includes no loss of consciousness. In the emergency department, the individual complains of a severe headache, feelings of "anxiety" and "confusion," as well as neck and back pain. Superficial scalp abrasions on an upper extremity are cleaned and bandaged by ED personnel. No abnormalities are found on a brain CT or MRI. Cervical, thoracic and lumbosacral x-rays are unremarkable for any evidence of spinal injury. The patient is discharged in the company of a family member and instructed to contact the primary care physician.

Nevertheless, the patient files a personal injury lawsuit and alleges that the driver of the commercial vehicle caused a traumatic brain injury, emotional distress and multiple symptoms of cognitive and physical dysfunction, including chronic headache, insomnia, employment disability, marital problems, diffuse musculo-skeletal pain, ambulatory problems, visual processing problems and disabling symptoms of PTSD, depression and anxiety. Multiple neurological, orthopedic and chiropractic appointments with prescribed medication and supportive treatment over the next twenty-four months fail to confirm any major organic injuries other than neck sprain or to relieve the subjective symptoms from various organ systems.

Question: Could the plaintiff's persistent, multi-organ system, psychophysiological symptoms be evidence of a ***Somatoform Disorder***?

1. Somatoform Disorders are psychiatric conditions in which a person converts his or her emotional distress into physical dysphoria and dysfunction.
Examples would be people who experience their feelings of loss and depression or fear and anxiety, as symptoms of headache, backache, abdominal pain, impaired cognition, paralysis or even blindness.

2. Unconsciously Driven Somatoform Disorders. Outside of conscious awareness, people may automatically convert their emotional symptoms of distress into physical symptoms of pain or

dysfunction (often called “depressive equivalents”). They may also do so with conscious intention, creating and falsely alleging specific symptoms of pain and dysfunction. When people unconsciouslyconvert their emotional dysphoria into physical dysphoria, it is called a Somatic Symptom Disorder (“SSD”). Alternatively, when the unconsciously driven symptoms primarily involved motor or sensory dysfunction, the condition is called a Conversion Disorder. **SSD and Conversion Disorder are NOT evidence of faking. They are NOT examples of malingering.** They can be functionally disabling.

- *An example of an acute SSD would be a hard-driving, competitive male executive who at age fifty-five, under the stress of an imminent corporate merger, suddenly develops acute crushing chest pain and believes he is having a heart attack. He is rushed to the emergency department of a local hospital where the results of the physical examination and all laboratory tests of his cardiac function are all normal. The emergency physician tells him that he did not suffer a heart attack, rather, it was an “anxiety attack.” He is referred to a psychologist for “stress management.”*

According to the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5),

- *Individuals with **Somatic Symptom Disorder** typically have multiple, current, somatic symptoms that are distressing or result in significant disruption of daily life, although sometimes only one severe symptom, most commonly pain, is present. Symptoms may be specific (e.g., localized pain) or relatively nonspecific (e.g., fatigue). The symptoms sometimes represent normal bodily sensations or discomfort that does not generally signify serious disease. Somatic symptoms without an evident medical explanation are not sufficient to make this diagnosis. The individual’s suffering is authentic, whether or not it is medically explained.*
- *The symptoms may or may not be associated with another medical condition. The diagnoses of somatic symptom disorder and a concurrent medical illness are not mutually exclusive, and these frequently occur together. For example, an individual may become seriously disabled by symptoms of somatic symptom disorder after an uncomplicated myocardial infarction even if the myocardial infarction itself did not result in any disability.*

3. Conversion Disorder (Functional Neurological Symptom Disorder), another form of unconsciously produced somatization disorder, is described by the DSM-5 as follows:

- ***In Conversion Disorder**, there may be one or more symptoms of various types. Motor symptoms include weakness or paralysis; abnormal movements, such as tremor or dystonic movements; gait abnormalities; and abnormal limb posturing. Sensory symptoms include altered, reduced, or absent skin sensation, vision, or hearing. Episodes of abnormal generalized limb shaking with apparent impaired or loss of consciousness may resemble epileptic seizures (also called psychogenic or non-epileptic seizures). There may be episodes of unresponsiveness resembling syncope or coma. Other symptoms include reduced or absent speech volume (dysphonia/aphonia), altered articulation (dysarthria), a sensation of a lump in the throat (globus), and diplopia (double vision).*

The important “take-away” is that both **Somatic Symptom Disorder** and **Conversion Disorder** are psychiatric conditions in which there is an unconscious conversion of severe emotional distress into symptoms of physical distress and/or dysfunction. Neither are intentionally or consciously produced or faked.

4. Consciously-driven Somatic Symptom and Related Disorders.
On the other hand, **Factitious Disorder** and **Malingering** are the two conditions in which a person **consciously intends to misrepresent** to physicians and others that they have physical symptoms of disabling illness. People with **Factitious Disorder** (previously called Munchausen Syndrome) do this in order to become “patients” and obtain from medical caregivers what they distortedly misinterpret as “love.” They not only consciously lie about having physical symptoms, they even actively induce them (e.g., rubbing feces in healing wounds in order to cause infection), often causing serious harm to themselves in their obsessive pursuit of medical care.

Malingering, on the other hand, involves conscious and intentional misrepresentation of alleged symptoms in order to obtain financial compensation (e.g. through litigation or insurance claims) or to avoid responsibility (e.g., within their military service or civil incarceration).

5. When a litigant alleges subjective symptoms in the absence of organic pathology or in excess of what is expected from minimal organic findings, one of the forensic psychiatric challenges is to determine whether these symptoms are unconsciously driven, or intentionally produced.
This is not an easy task as there are no objective tests for motivation i.e. intention, although there are objective tests for “effort.” Medical diagnosis, however, is based upon pattern recognition. There are recognizable patterns that emerge from a careful review of the plaintiff’s medical records over an extended period of time, that are consistent with either **Somatic Symptom Disorder** or **Factitious Disorder**. In addition, obvious financial incentives combined with poor performance on symptom validity “effort” tests and scales within other robust psychological tests

may also suggest Malingering as a possible etiologic factor.

6. Functional impairment is compensated; diagnosis is not. These diagnosable conditions are only signposts along the highway of litigation. It is functional impairment, not diagnosis, for which litigation may award compensation. An assessment of functional impairment through direct examination, objective testing and a careful review of all records is a critical component of every forensic psychiatrist's opinions and conclusions.

7. Causation of Somatic Symptom and Related Disorders. Somatic Symptom Disorders are real. With the exceptions of **Factitious Disorder** and **Malingering** (which is not in fact classified as a "mental disorder"), none of these somatic conditions are consciously manufactured or faked. The core questions addressed by a forensic psychiatric opinion are: (1) what are the plaintiff's emotional damages, if any; (2) what caused them; and (3) were they pre-existing or generated by the defendant's actions? These questions are easy to ask but difficult to answer with evidence based accuracy. Nevertheless, in any given civil case, by applying a disciplined forensic psychiatric methodology to examining all of the relevant data, forensic psychiatric and psychological experts can accurately assess actual emotional damages and determine causation with reasonable medical probability.

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