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Somatoform disorders in litigation: causation and prognosis

Orthopaedic experts will be familiar with litigated accidents in which there is a relatively minor soft-tissue injury that does not explain the persistent severity of pain and the ensuing marked disability. They will also usually be aware that 90% of patients with chronic low back pain do not have any reliable evidence of a significant structural causative defect or injury.[1]

The International Association for the Study of Pain (IASP) definition of pain emphasises the importance of psychological factors in its perception: pain is regarded as an unpleasant sensory and emotional experience. Many people report pain in the absence of tissue damage or any likely pathophysiological cause and this usually happens for psychological reasons: pain is always a psychological state.[2] This article examines how claimants with medically unexplained pain may be diagnosed by psychiatrists, and the implications for their treatment and prognosis are discussed.

DIAGNOSIS

The diagnosis of psychiatric disorders is generally made with reference to the current edition of the Diagnostic and Statistical Manual (DSM) published by the American Psychiatric Association[3] or the International Classification of Diseases published by the World Health Organization.[4] Both of these classification systems are recognised by the British courts and neither is regarded as more valid.

However, the relatively new diagnosis of a Somatic Symptom Disorder[3] is of little utility in personal injury litigation. The accompanying text in the DSM states that "the reliability of determining a somatic symptom is medically unexplained is limited" and on this basis the presence or absence of a medical explanation is irrelevant to the diagnosis. However, in court, the psychiatrist that continued to entertain a probable persisting medical cause would be acting outside their area of expertise if, for example, an orthopaedic expert had already excluded a physical cause. The Somatic Symptom Disorder diagnosis is intended to exist alongside unexplained and explained physical disorders. It depends only on the psychiatrist determining that the person is exhibiting disproportionate thoughts about the seriousness of their illness, having persistently high levels of anxiety about their symptoms or devoting excessive time and energy to their symptoms.

The ICD-10[4] is more useful in court in this respect. The Guidelines for the Assessment of General Damages in Personal Injury Cases[5] refer to somatoform disorders in the section on chronic pain and this is the same general category used in ICD-10. Where the claimant has unexplained pain for at least six months and comorbid psychosocial problems, the ICD-10 diagnosis of a somatoform pain disorder is applicable. This is a condition which can arise in any individual at any time. Where the non-organic physical symptoms are more varied, often include pain, have persisted for at least two years and the person does not accept a psychiatric explanation, then the diagnosis of a somatisation disorder is more appropriate. When the symptoms fall somewhere in between these two diagnoses, then an undifferentiated somatisation disorder can be diagnosed. Patients with somatisation disorders are very familiar to doctors in primary care. They are usually female and begin presenting before the age of 30 years. They often have voluminous medical notes. They will present many times per month, over decades, with a multiplicity of varying physical symptoms which never have a satisfactory physical explanation and for which medical reassurance is never adequate, and psychiatrists are to be avoided.

In ICD-10 the presence of a depressive illness is an exclusion factor for diagnosing a somatoform pain disorder. This recognises the importance of the close relationship between depressive illness and pain. Pain and depression are mutually reinforcing and inextricably linked. Painful physical symptoms are experienced by approximately half of patients with a depressive episode.[6] The number of comorbid pain-related complaints is positively correlated with the severity of depression to such an extent that some authors have considered pain to be considered a component feature of a depressive episode.[7] In a prospective study of 200 patients scheduled for orthopaedic surgery, it was found that early post-operative depressive symptoms could predict the severity of pain at discharge.[8]

In ICD-10 the diagnosis of a depressive illness is sufficient on its own to explain non-organic pain. The diagnosis of post-traumatic stress disorder (PTSD) has also been found to exacerbate the perception of pain.[9]

Psychiatrists, as a rule, do not diagnose conscious exaggeration or malingering based on a single clinical assessment. The finding of incompatibility between reported symptoms and an organic medical condition, such as some of the Waddell signs, is not sufficient to diagnose conscious exaggeration. In fact, in DSM-5, under conversion disorders, the demonstration of incompatibility between symptoms and a medical condition is a requirement to make the diagnosis. The main hallmark of malingering in personal injury litigation is the reporting by the claimant of a level of physical disability, which is objectively shown to be false, in a person of normal mental capacity and this usually requires surveillance.

CAUSATION

Predisposing risk factors for somatoform disorders include child abuse, personality difficulties and a history of depression or anxiety. However, collectively these factors are common in the

population and not sufficient to explain the development of this condition. On the other hand, they do provide some indication of the nature of the likely individual vulnerability.

It can be hypothesised that there is some central psycho-biological difference between patients who develop somatoform disorders and those who do not. The central abnormality that causes the vulnerability to the development of a somatoform disorder is distinct from a central disease process; for example, a thalamic pain syndrome caused by a thalamic infarct. There is evidence that differences in patterns of connectivity in the brain may predispose to the onset of chronic, non-specific, low back pain.[10] However, the phenomenon of neuroplasticity means that there is no clear boundary between the expression of psychological and physical differences at this level and so the distinction is somewhat meaningless. A relevant example of neuroplasticity is the increase in the volume of grey matter found in the brains of pain patients following psychological counselling.[11] Therefore, defining the precise, central biological or psychological vulnerability in somatoform disorder patients is largely academic for determining legal causation, provided one accepts there is some form of central vulnerability, at the time of the index accident, which sets these patients apart from others.

Somatoform disorders can be precipitated by stressful life events or by physical trauma of any severity, including very minor trauma. The person may or may not be under any observable or perceived psychological stress at the time of onset. Therefore, the triggering event can be of minor severity and thus the predisposing vulnerability is likely to be correspondingly relatively high. This sets the stage for the condition to occur, absent the index accident, should there be an identifiable similar minor triggering event.

TREATMENT AND PROGNOSIS

Depression

The effective treatment of depression is often a key factor in determining whether a person will recover from non-organic pain. Most Pain Management Programmes (PMPs) are not resourced to treat moderate or more severe depressive episodes because these conditions will often require a combination of expert psychopharmacology alongside 16 sessions or more of individual cognitive behavioural therapy.[12] In view of the strong reciprocal relationship between pain and depression it is therefore essential that moderate or more severe depression is properly treated, usually with referral to a psychiatrist, with treatment according to the NICE Guidelines (2010). The majority of cases of depression will recover with expert treatment. Overall, about 67% of patients with resistant major depression, requiring several different treatment approaches, can expect to recover.[13] Only about 10% of depressive episodes become chronic and persistent. Even persistent moderate depressive episodes, unresponsive to other forms of treatment, can respond to treatment with ECT.

The situation can arise where the claimant has persisting organic pain, which is not predicted by the orthopaedic expert to recover. It is true that the depression in patients with a depressive episode and comorbid chronic organic pain is more difficult to treat. However, this needs to be put into perspective.

About 20% of people with a chronic physical health problem have a comorbid depressive illness according to NICE.[14] This indicates that about 80% of these patients can psychologically adjust to their pain and physical disability. Therefore all patients with chronic pain and a comorbid depressive illness should receive the full range of the recommended treatment for depression in the NICE Guidelines. Comorbid depression should not be regarded as intractable.

Somatoform disorders

There is a view expressed by some medical experts, that patients with medically unexplained pain are difficult to treat and when this has been present for a number of years it can become entrenched. Evidence for the outcome from PMPs is difficult to disentangle because it is usually based on heterogeneous samples, including many patients with medical conditions such as osteoarthritis and rheumatoid arthritis. It may be more appropriate to look at homogeneous samples of patients with somatoform disorders and their outcome with various interventions.

There is evidence from a meta-analysis of 16 psychological treatment studies that, outside of litigation, psychological treatment is effective in severe somatoform disorders with an average duration of eight years.[15] In this review there was a large treatment effect size for the reduction of physical symptoms, which was maintained at 12 months' follow-up. There was a moderate treatment effect size for a reduction in functional disability, which was still improving one year after treatment. Longer treatment duration (of the brief interventions examined) was associated with larger effect sizes in terms of general functioning. Women benefited more from treatment than men in terms of physical symptoms. About 60% of somatoform patients with this form of treatment are at least 'much improved' immediately afterwards.[16] More recent studies, published since the meta-analysis of Koelen et al,[15] continue to support a favourable outcome for the psychological treatment of somatoform disorders that have been present for seven or eight years.[17,18]

A common question in litigation is whether or not the treatment of somatoform disorders should be conducted after the litigation is settled. The studies reported above do not include litigation as an outcome variable. The British Pain Society, when considering entry to a PMP, states: "Ongoing litigation may place participants in a dilemma in that improved function will reduce their anticipated compensation payment... evidence is mixed on whether this affects outcome".[19] There is prospective evidence that litigation impairs the functional outcome in chronic pain patients. A study examined 20 patients with chronic back pain, of whom 11 were involved in ongoing litigation. After treatment in a standard PMP, all of the patients showed significant improvements in pain. The patients without ongoing litigation showed significant improvements in disability. However, the 11 patients with ongoing litigation showed no improvement in measures of disability.[20] Clinical experience indicates that claimants who are experiencing marked psychological stress during the litigation due to anxiety about their finances or the adversarial process, are more likely to benefit from treatment when it is delayed until after settlement.

CONCLUSION

The diagnosis of somatoform disorders by psychiatrists is fairly straightforward using ICD-10 diagnostic criteria. Causation is probably due to an unknown central vulnerability, which usually renders the claimant at high risk of developing the condition even in the absence of the index accident. Contrary to some medical opinions, the published research indicates that the psychological treatment of even severe somatoform disorders of long duration has a relatively favourable prognosis, and does not need to lead to long-term physical disability. Whether treatment should be conducted after settlement of the litigation probably depends on individual factors.

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