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# Use of the Label “Litigation Neurosis” in Patients with Somatoform Pain Disorder

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**Abstract:** *The use of the term “litigation neurosis”—a condition with controversial clinical significance—might correspond to the expression for a difficult physician-patient relationship. The characteristics of patients with a DSM-III-R diagnosis of somatoform pain disorder who had been labeled “litigation neurosis” by their physicians were explored. Among 74 patients referred to a pain clinic, 30% had been labeled litigation neurosis, and among 81 patients referred while claiming disability benefits, 19% had been thus categorized. The attribution of this label was neither correlated to actually being involved in a claim for disability benefits nor to involvement in legal action. Patients who had been designated with litigation neurosis were characterized by a lower educational level, a higher rate of DSM-III-R major depression, and a much higher frequency of personality disorders than patients who were not thus labeled. We postulate that the communication style of patients with this constellation of characteristics, in particular the presence of psychiatric comorbidity, may have engendered a difficult doctor-patient relationship, leading physicians to use the label in the absence of objective evidence of litigation or involvement in legal action. We agree that the inappropriate use of labels such as “litigation neurosis” should be questioned.*  
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## Introduction

In a number of patients suffering from chronic non-malignant pain, there is no clear correlation between the somatic findings and the intensity of pain complaints or the severity of repercussions in per-

sonal and professional life. To the psychiatrist, such cases are labeled “somatoform pain disorder” in the DSM-III-R, newly defined as “pain disorder” in the DSM-IV [1], or in “persistent pain disorder” in ICD-10 [2]. In practice, most patients with chronic pain consult general practitioners, surgeons, and other medical specialists who are not necessarily familiar with the psychiatric nosography, and are sometimes skeptical of chronic pain complaints that are insufficiently explained by the somatic findings. With the additional issue of compensation or disability benefits, this can lead to tense relationships between the patients and their physicians. In these situations litigation neurosis or compensation neurosis are sometimes used to describe a “dramatization of symptoms,” or a “lack of motivation towards treatment” [3,4].

“Compensation neurosis,” otherwise known as “litigation neurosis” or “accident neurosis,” has attracted renewed interest in the pain literature in the last decade [3–5]. The following definition was given in a recent review [5]: “The condition develops in patients who have experienced a physical trauma, acute or continuous, real or imaginary. Exaggeration of complaints and distress are observed. The presence of a compensation claim is thought to be the most significant maintaining cause of symptoms.” However, the concepts of compensation or litigation neurosis have been criticized for lacking validity [6]. The alleged “dramatization of symptoms in order to maximize benefits” has been challenged by several authors who have shown that the expression of pain is not increased in patients seeking compensation [7–9]. Moreover, most recent research has shown persistence of symptoms after the settlement of litigation [4,10,11], contradicting pre-

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vious statements that litigants were “cured by the verdict” [12] and contributing to the debate on using the terms “litigation or compensation neurosis” [3–6]. A recent survey (Vannotti and Allaz, personal communication) showed that 8 out of 10 senior Swiss psychiatrists experienced in disability case evaluation thought that these terms should not be used because of insufficient evidence of their validity.

We postulate that these labels are used when difficulties arise in the doctor-patient relationship. The aim of our study was to identify in patients suffering from somatoform pain disorder which characteristics were associated with the use of the label “litigation neurosis” by the referring physician.

## Methods

### *Setting*

This study was undertaken in the context of the Swiss compensation system, where the disease or injury need not be sustained at work in order to be covered: irrespective of fault, patients who cannot work after a disease or an accident are entitled to be financially covered. The adversarial relationships of litigation between employer and claimant are thus avoided. If their health has not improved sufficiently to resume work after 1 year, the patients whose claims must be supported by a medical certificate can apply for long-term disability benefits, a monthly payment amounting to a percentage of the previous wage. The decision to grant long-term disability benefits is made after a thorough medical work-up in a medical center. This decision, made by the Swiss Disability Plan on the basis of this medical evaluation, can be reversed by legal action.

This study was conducted in two collaborating institutions in Switzerland. The DSM-III-R classification was used for the psychiatric evaluations. In order to control the role of psychological factors in the origin or maintenance of pain, only patients with a diagnosis of somatoform pain disorder (SPD) were included in the study. This diagnosis had to be made independently by at least two physicians (including one psychiatrist) experienced in the field of chronic pain.

### *Population*

The first sample was assessed between January 1993 and July 1994 at the ambulatory pain clinic of the University Hospital of Geneva, to which patients suffering from chronic nonmalignant pain of

various origins are referred by their physicians for therapeutic advice. Among 156 patients of working age (younger than statutory retiring age: 62 years for women and 65 years for men), 76 had a diagnosis of somatoform pain disorder. Two patients were excluded because of incomplete data. The first sample includes the 74 remaining patients. Their mean age was  $43 (\pm \text{SD: } 9 \text{ years})$ . Thirty-four percent were foreigners, and 50% were male. Pain had been present for  $5.2 \pm 5 \text{ years}$  (median 3.5 years, from 1 to 28 years). Mean pain intensity was  $8.5 \pm 1.9$  on the Visual Analog Scale (VAS).

The second sample was assessed during the same period at the Disability Medical Evaluation Center, affiliated with the University Hospital of Lausanne, where patients from the French-speaking part of Switzerland applying for disability benefits are referred for evaluation.

Among the 130 patients, 81 had a diagnosis of somatoform pain disorder and were included in the study. Their mean age was  $43 \pm 11 \text{ years}$ ; 76% were male, 64% of foreign origin. All were referred for a first evaluation while seeking disability benefits. All patients had been out of work for at least 1 year. The mean intensity of the pain was  $7.5 \pm 2.8$  on the VAS; it had been present for  $4.9 \pm 4.5 \text{ years}$  (median 3.9 years, from 1 to 27 years).

### *Procedure*

In both institutions, the evaluation at the time of referral included a complete medical interview with a special emphasis on the pain history, consequences of pain in daily activities including work, and a complete physical examination. Pain intensity was recorded on the VAS. Patients in the first sample received a self-administered questionnaire at initial presentation to the pain clinic, including demographic data, several questions on the characteristics of pain, its duration, and repercussions. In addition to the VAS, the pain was rated on the McGill Pain questionnaire [7].

To the question “Do you attribute your pain to one of the following causes?”, patients had to choose one of the seven answers proposed: no cause, illness, accident, operation, emotional event, doesn’t know, other. The question “What kind of explanation did you receive about your pain?” was open ended. Answers were categorized into seven groups according to preset categories, one of them being «question not answered» and another «no explanation at all,» including expressions such as «nothing at all,» «absolutely nothing.»

Details of whether patients in the first sample were seeking long-term disability benefits and whether they were still working were collected during the interviews. Additional information was obtained from the medical records, from the referring physicians and in the case of work leave or compensation, from the highly reliable health plan's official statement, which is systematically included in the record at admission to our clinic.

All patients in the second sample had been absent from work and officially seeking long-term disability benefits. Patients were considered to be involved in legal action when their claim for disability benefits was supported by an attorney, as evidenced by the patient's own declaration or by the presence of legal correspondence in the medical record.

In both institutions, each patient was subjected to a detailed interview with a trained psychiatrist. In addition to the established somatoform pain disorder, Axis I psychiatric diagnosis and Axis II personality disorder were determined following the DSM-III-R guidelines [1]. The diagnosis was reviewed during a subsequent interview by a second trained psychiatrist with teaching responsibility. Interrater agreement was high: there were five cases of disagreement on the presence/absence of a personality disorder in the total of the 155 patients of the two samples. In these five cases the diagnosis of personality disorder was not retained. On five other occasions, disagreement concerned the categorization of the personality disorder, which led to their classification as "nonspecific" type of personality disorder.

### *Data Processing*

For both samples of patients, an additional category of litigation neurosis was used when this label appeared in the referral letter from the treating physician. Therefore, categorizing a patient to this subgroup does not mean that the patient actually presents a litigation neurosis but only that he/she had attracted this label.

### *Statistical Analysis*

The two samples were analyzed separately. For each sample, the subgroup with SPD and litigation neurosis was compared with the other subgroup of SPD patients. Variables were compared by univariate statistics: Chi-square for nominal variables and Fischer's exact test when expected cell values were

$<5$ ,  $t$  tests for normally distributed numeric variables (Shapiro-Wilk's normality), and Kruskal-Wallis's analysis for nonnormally distributed numeric variables.

## **Results**

### *Comparisons in the First Sample*

Among the 74 patients, 22 (30%) had been labeled "litigation neurosis." Comparisons between the subgroups with and without this label showed no differences in the intensity of pain measured on the VAS scale, or with the McGill Pain questionnaire (mean number of words  $12 \pm 7.9$ ) with an identical distribution among sensitive, affective, and evaluative words [5]. There were also no differences in other pain descriptors such as duration, frequency during the day, or how bearable the pain was. Pain repercussions in personal and family life were similar.

In contrast, patients labeled with litigation neurosis differed from the other patients in their socio-professional characteristics, as shown in Table 1. They were more often male, of foreign origin (almost always from Southern Europe), with a lower educational level, and they were more often on work leave. The percentage of patients actually seeking disability benefits was similar in the two subgroups.

Sixty-eight percent of the patients labeled with litigation neurosis attributed their pain problem to an accident, whereas only 31% in the other subgroup did so ( $p < 0.004$ ). When asked about the explanations they had received concerning the origin of their pain, 32% stated they had received "no explanation at all" vs 2% in the other subgroup ( $p < 0.01$ ).

There were also significant differences in the psychiatric diagnoses other than SPD between the two patient subgroups, as shown in Table 2. In patients labeled "litigation neurosis," the prevalence of major depression (55%) was two times higher than in the other subgroup. A striking finding was the high prevalence of 86% of personality disorder diagnosis in the subgroup labeled "litigation neurosis," twice as often as in the other subgroup. Detailed typology of the personality disorder in patients categorized as having litigation neurosis was as follows: paranoid 5 (26.3%), dependent 5 (26.3%), nonspecified 3 (15.8%), histrionic 2 (10.5%), narcissistic, borderline, schizoid, obsessive-compulsive each 1 (5.2%).

**Table 1.** Sociodemographic and pain-related characteristics of two samples of patients with somatoform pain disorder, with or without a label of “litigation neurosis”

Variables	Sample 1 (N = 74)			Sample 2 (N = 81)		
	Yes (N = 22)	No (N = 52)	p-value <sup>a</sup>	Yes (N = 15)	No (N = 66)	p-value <sup>a</sup>
Labeled “litigation neurosis”						
Age (years) ± SD	41.1 ± 8	45.1 ± 9	NS	44.4 ± 10	42.8 ± 11	NS
Male (%)	16 (73)	21 (40)	0.01	12 (80)	48 (73)	NS
Foreign origin (%)	13 (59)	12 (23)	0.004	12 (80)	40 (61)	NS
Educational level: primary school level (%)	17 (77)	22 (42)	0.007	11 (73)	25 (38)	0.02
On work leave (%)	18 (82)	30 (57)	0.037	15 (100)	66 (100)	—
Asking for disability (%)	11 (50)	21 (40)	NS	15 (100)	66 (100)	—
Involvement in legal action (%)	—	—	—	6 (32)	32 (48.5)	NS
Pain intensity (VAS) ± SD	8.6 ± 2	8.4 ± 2	NS	8 ± 2	7.3 ± 3	NS
Pain duration (years) ± SD	4.8 ± 5	5.5 ± 5	NS	5.6 ± 5	4.8 ± 4.5	NS
Attributed by the patient to an accident (%)	15 (68)	16 (31)	0.004	10 (67)	17 (26)	0.005

<sup>a</sup> p-values based on Chi-square tests for nominal variables, t-tests for normally distributed numeric variables, and Kruskal-Wallis’s analysis for nonnormally distributed numeric variables.

**Table 2.** Comparison of the psychiatric findings in two samples of patients with SPD, labeled or not with “litigation neurosis”

Variables	Sample 1 (N = 74)			Sample 2 (N = 81)		
	Yes (N = 22)	No (N = 52)	p value <sup>a</sup>	Yes (N = 15)	No (N = 66)	p-value <sup>a</sup>
Labeled “litigation neurosis”						
Major depression (%)	12 (55)	13 (26)	0.02	8 (53)	14 (21)	0.012
Personality disorder (%)	19 (86)	22 (42)	0.001	13 (87)	29 (44)	0.003
Alcohol abuse (%)	4 (18)	10 (19)	NS	2 (13)	10 (15)	NS

<sup>a</sup> p values based on Chi-square tests.

### *Prevalence of the Label “Litigation Neurosis” in Patients Seeking Disability Benefits*

In a separate analysis, we compared the prevalence of the label “litigation neurosis” in the 32 patients who were officially seeking disability benefits with the prevalence in the 42 patients not involved in such a claim. The label had been given with similar frequency in both subgroups: in 11 patients seeking disability benefits (34%) and in 11 patients (26%) not doing so ( $p = 0.4$ ).

### *Comparisons in the Second Sample*

Among the 81 patients officially seeking disability benefits, 15 (18.5%) had been labeled “litigation neurosis.” Comparisons of the main socioprofessional and pain-related characteristics between the two subgroups are shown in Table 1. The subgroup labeled “litigation neurosis” is characterized by a

significantly lower educational level. The higher percentage of males (80% vs 73%) and the higher percentage of foreigners (80% vs 61%) in this subgroup do not reach statistical significance.

Pain intensity measured on the VAS and pain duration are similar in the two subgroups. In contrast, the origin of the pain is attributed to an accident by two-thirds of the patients labeled “litigation neurosis,” almost twice as often as in the other subgroup ( $p = 0.005$ ).

There were significant differences in psychiatric diagnosis other than SPD in the litigation neurosis subgroup. As shown in Table 2, major depression was diagnosed in more than half of the patients in this subgroup. A diagnosis of a personality disorder was present in a high percentage of the patients (87%), twice the prevalence of 44% in the other subgroup. Detailed typology of the personality disorder in the litigation neurosis subgroup was as

follows: paranoid 5 (38.5%), dependent 3 (23.1%), borderline 2 (15.4%), nonspecified 2 (15.4%), histrionic 1 (7.6%).

An important finding was that involvement in legal action was as common in the litigation neurosis subgroup (six patients = 40%) as in the other subgroup (32 patients = 48.5%), ( $p = 0.6$ ), as shown in Table 1.

## Discussion

The results of the two samples were similar; however, they were analyzed separately since they belong to two different settings. In both samples, a significant number of patients had been labeled "litigation neurosis" by their physicians. It was expected that this designation would have been used for patients claiming disability benefits, but our study showed that this was not the case. In the first sample, litigation neurosis was attributed as often to patients seeking disability benefits as to patients who were not; in the second sample, where all the patients were asking for disability benefits, only 19% had been given this label. Moreover, our results show that the rate of involvement in legal action was not higher in patients designated with litigation neurosis.

The latter patients did not complain of a higher pain intensity than the other patients. However, they were characterized by a lower socioeducational level, a foreign worker status, a higher rate of sick leave; more frequently they attributed their pain problem to an accident and had a notably higher frequency of major depression and personality disorder.

Our study shows that the rate of personality disorders is two times higher in patients labeled "litigation neurosis" than in our other patients. It is also higher than the reported rates of 40%–60% in long-standing chronic pain sufferers [13,14]. This high prevalence could be partially related to the presence of a high rate of major depression in these patients. There is a known association between these two entities, with rates of personality disorder ranging from 40% to 85% in patients suffering from major depression [15,16].

The prevalence of major depression found in our two samples is similar to the 30%–60% prevalence reported in the majority of studies on patients suffering from somatoform pain disorder [17,19]. The higher frequency of major depression found in the subgroups categorized as litigation neurosis could be explained with the following hypothesis: a ma-

jority of patients labeled litigation neurosis attributed their pain problem to an accident, a concrete exterior factor. Although litigation about the responsibility of the accident is not an issue in the Swiss compensation system, the traumatic experience might have induced feelings of resentment of not being sufficiently acknowledged as a victim, a situation known for inducing dysphoric mood in predisposed individuals [4,20]. There is evidence that marked distress can be evoked by trivial accidents, and that it attracts insufficient medical attention [21].

The association of a personality disorder with chronic pain complaints may have led to difficulty in communicating with the physicians. In the general medical setting, individuals with personality disorders and somatization are often considered "difficult patients" [22–24]. However, the concept of the difficult patient has to be reconsidered as a "difficult doctor-patient relationship," where the physician's feelings of helplessness and rejection play a key role [25–27]. In our study, the persistent, demanding complaints commonly found in somatization disorders [28–30] by patients with a personality disorder [14,25,31] may have contributed to mounting irritation and frustration in the physicians. We suggest that the labeling of patients with litigation neurosis reflects these feelings.

The patient's presentation style might have attracted the physician's attention to the presence of a psychological problem. However, when the precise underlying psychopathology remained insufficiently recognized, the term "litigation neurosis" may have been attributed. It has been shown that lack of confidence in describing psychological problems can lead to the use of unpleasant labels [22,31]. Litigation neurosis may be an inadequate terminology for a loosely identified psychiatric morbidity or it may reflect difficulty in the physician-patient communication in the presence of a psychiatric morbidity.

The existence of a communication problem is corroborated in our first sample by the statement "no explanation at all" by one-third of the patients labeled "litigants." In these patients, communication barriers related to cultural and educational differences [20] and requests to prolong sick leave may also have contributed to the tension build up between patients and physicians. Individuals with a lower educational level, immigrant status, on sick leave, a high rate of depression, and personality disorder may have been more readily considered to be influenced by secondary gains of illness, al-

though they did not claim compensation more often nor were they more often involved in litigation.

Our findings may have important clinical implications for the care of patients with somatoform pain disorder; assigning them with labels of uncertain clinical significance such as litigation neurosis is inappropriate. The term is poorly defined, its use relies on subjective criteria, and it may be confused with more or less conscious motivation to seek compensation. Moreover, it obscures the identification of a doctor-patient communication problem and may add obstacles to the recognition of the patient's genuine suffering, especially in the presence of an underlying psychopathology. In contrast, if feelings of frustration with a patient were acknowledged by physicians, they could serve as a signal to explore psychiatric problems, look for conflicting expectations, and recognize the patient's suffering. Such an approach of counter-transference has been proposed by other authors [22,25,26]. We believe our findings should contribute to question the inappropriate use of potentially pejorative labels such as "litigation neurosis."

### Limitations

Since the population studied involved patients who had been in pain for several years, data on the frequency and type of personality disorders should be interpreted cautiously [18]. The methodological problems associated with the determination of personality disorders in chronic pain conditions apply similarly to all our patients. Therefore they do not alter the significant differences in prevalence between patients who had been labeled "litigation neurosis" and those not so categorized. The same argument holds for the reliability of clinical interviews for detecting and categorizing personality disorders [16].

Since we did not obtain information on the physicians' motivation to use (or avoid) the label "litigation neurosis," we can only observe that this term was given to patients with risk factors for a difficult doctor-patient interaction. Further studies on this subject should also explore the communication skills of the physicians as well as their familiarity with psychiatric diagnosis.

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